The Orders Of St. John Care Trust

OSJCT Trevone House

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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 13, 14 and 15 December 2017 and was unannounced.

During a comprehensive inspection on 1, 2 and 3 June 2016 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Regulation 9 Person centred care and Regulation 17 Good Governance. We asked the provider to complete an action plan to show us what they would do and by when to improve the key questions "safe, effective, responsive and well-led" to at least good. They told us these would be addressed by 31 December 2016 to, ensure people's care and treatment was delivered in such a way which would meet their individual preferences and choices and to ensure accurate and relevant care records were maintained.

We undertook an unannounced focused inspection of Trevone House on 21 February 2017. This inspection was done to check that the above legal requirements, and improvements, planned by the provider, had been completed. During this focussed inspection the service was inspected against the key questions "safe, effective and well-led". At this inspection we found the provider was compliant with the prior breaches of Regulation. However, a period of consistent and sustained improvement was required and the rating remained at Requires Improvement.
At this comprehensive inspection completed on 13, 14 and 15 December 2017 we found the service had sustained the improvements we found in February 2017 and this inspection therefore rated the service as Good overall.

Trevone House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Trevone House accommodates 47 older people in one adapted building. At the time of the inspection there were 31 people living there.

People are provided with a single occupancy bedroom. Each room has a sink, bedroom furniture and necessary equipment, a window and radiator. Additional communal toilets, bathrooms and rooms to sit and eat in are provided. The accommodation is across two floors; the second floor accessed by stairs or a passenger lift. There is a garden at the front of the home and off road car parking is available near to the building.

A registered manager was in place. 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.

Arrangements were in place to keep people safe from potential abuse, discrimination and risks which could have a negative impact on their well-being. Staffing requirements were monitored and had been adjusted to ensure people's needs could be met safely. People's medicines were managed in such a way which ensured

they received as prescribed and needed. People lived in a clean environment where there were measures were taken to prevent and minimise the impact of infection. Staff worked with other health care professionals to ensure people's health needs were both assessed and met. Risks to people's health were identified and managed.
People's consent to be cared for and treated was sought. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice. Where people could not provide consent and make independent decisions about their care and treatment, the principles of the Mental Capacity Act 2005 were adhered to in order to protect them. People were lawfully deprived of their liberty where this was needed to keep them safe and in receipt of the care they required.

People and those who mattered to them were cared for in a compassionate way. Staff supported people in a personalised way to ensure their specific and diverse needs were met. People privacy, dignity and rights were upheld. People were supported to be as independent as possible. People's care was planned with them and where appropriate, their relatives or representatives could speak on their behalf. Complaints and any areas of dissatisfaction were taken seriously and addressed. People's end of life wishes were explored with them and advanced care planning ensured these were met at the appropriate time. Staff were experienced and trained to meet people's end of life needs. Staff were supported by other health care professionals who worked together to ensure a person's death was dignified and pain free.

The registered manager had provided strong and consistent leadership since being responsible for the management of the home. They had made changes to how the home was run and its culture. Subsequently a far more open and supportive atmosphere existed. People and staff felt able to raise any concerns and they were confident these would be looked at and addressed. Effective communication existed between staff groups and people. Staff and management were working together to improve services for people. Effective monitoring of the service ensured it remained compliant with necessary regulations and continued to improve.

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.

People were protected from potential abuse, discrimination and risks which could have a negative impact on their health and well-being.

Risks to people's safety were managed and people received their medicines as prescribed

Information kept about people was kept secure and confidential.

Is the service effective?

Good

The service was effective.

People's diverse needs were identified, assessed and met.

Staff were recruited safely and then trained to meet these needs.

People were supported to make independent decisions. People unable to do this were protected against decisions which may not potentially be made in their best interest.

Staff worked closely with other relevant professionals and agencies in order to ensure peoples nutritional and other health needs were met.

Is the service caring?

Good

The service was caring.

People were cared for by staff who knew them well and who knew how to communicate with them. Care was tailored, as much as possible, to people's individual needs.

People's family and friends were provided with support and a caring and compassionate culture existed. This extended to the staff team who supported each other.

People's privacy, dignity and rights were upheld.

Is the service responsive?

Good

The service was responsive.

Where it was possible to do so people planned how their care was to be given. Where they were unable to do this relatives were able to speak on their behalf.

People were supported to take part in meaningful activities.

Complaints were listened to, responded to and learning was established from these.

People's end of life wishes were respected and met.

Is the service well-led?

Good

The service was well-led.

People and staff had benefitted from strong leadership having been in place and the subsequent changes made to how the service was run.

Feedback received from people, relatives and staff was valued and reflected on in order to make further improvements to the services provided.

The service's on-going performance was effectively monitored to ensure outcomes for people improved and any shortfalls in practice were addressed.

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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 13, 14 and 15 December 2017. It was carried out by one inspector and was unannounced. Before a visit to the home we reviewed the information we held about it. This included information which had been shared with us since the last inspection on 21 February 2017 and statutory notifications. These notifications contain information about incidents and events which have taken place which the provider must legally make us aware of. Prior to this inspection we did not request 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. Instead we gathered this information during the inspection.

During the inspection visit we spoke with and gathered the views of six people who lived at Trevone House, including those of three relatives and one friend. We inspected six people's care files which included pre-admission assessments, care plans, risk assessments and other relevant records. We reviewed four people's repositioning and food and fluid intake charts. We also reviewed records and documents relating to the care of three people under the Mental Capacity Act 2005 and who had authorised Deprivation of Liberty Safeguards. We spoke with the registered manager, deputy manager, operations manager and regional operations director. We also spoke with one registered nurse, head chef, activities co-ordinator, maintenance person, two housekeepers, two care assistants (one day and one night) and two care leaders.

We looked at other records related to the management of the home. These included three staff recruitment files, the staff training record, a selection of audits and one action plan. We reviewed the maintenance records and various service certificates. We read the minutes of a staff meeting and those of reflective meetings held with staff. We reviewed the information made available to people in the reception area and on designated noticeboards. We attended two staff handover meetings. We visited all areas, inside and outside of the building, which were accessible to people.

Good

Is the service safe?

Our findings

People told us they felt safe and respected whilst living at Trevone House. Relatives told us they considered the home to be a safe place. People were protected from potential abuse and their rights were upheld. There was zero tolerance of any behaviour which did not aim to achieve this. Staff understood people's diverse needs. They appreciated the fact that people were older and had different physical and mental needs. They were aware that these, at times, made people totally reliant on them to keep them safe. People's risks were assessed and managed in order to keep them safe. People were not discriminated against because the staff treated each person equally and respected their individual beliefs and preferences. Staff had received training on how to safeguard people and on how to treat people equally. The provider's policies and procedures supported this approach. Staff knew how to report any concerns they may have and senior staff liaised with other agencies and professionals in order to protect people from abuse. A designated noticeboard provided information for people, visitors and staff on how to safeguard people from abuse. In practice we observed people being treated in a respectful way. This included people who lacked mental capacity and who were less aware of things that happened around them.

We observed staff adhering to safe ways of working when supporting people to remain healthy and safe. Risk assessments recorded people's specific risks, for example, falling, development of pressure ulcers, loss of weight and choking. The assessments determined the level of risk and care plans gave guidance on what action was needed to lower the risk. We observed people being moved safely, sometimes, with specific equipment, such as mechanical hoists. Different types of equipment were used to keep people safe. For example, people at risk of falling from their bed were provided with beds which could be lowered almost to the floor. A protective mat was then placed alongside the bed in order to reduce injury to the person if they rolled off their bed. This arrangement was often used instead of bed-rails. Bed-rails were sometimes found not to be appropriate for an individual and could be potentially restrictive. Several people had pressure reducing mattresses and cushions in place to help prevent the development of pressure ulcers.

People who had been assessed as being at risk of choking were provided with appropriately textured food to help reduce this risk. Catering staff were aware of whom this applied to and the importance of making sure food and drinks were correctly prepared. People suspected of having or who were being treated for, an infection, for example, a chest infection, were isolated so as to reduce the risk of others becoming infected. The cleaning staff were aware of who these people were and followed correct guidance when carrying out the cleaning.

Electronic equipment was sometimes used for the purpose of reducing risks. One member of staff told us about the use of an alarmed sensor mat for one person who was at risk of falls. This person often stood up and because they lived with dementia, frequently forgot they needed the support of a walking frame and would subsequently fall. The purpose of the mat was to alert staff to the fact the person was moving and needed additional support.

Potential risks relating to the building, equipment and main systems were reduced. The same process applied to these risks as to people's personal risks. Risk assessments were completed and action taken to

minimise and prevent risks to people, visitors and staff. These were also managed in a way which applied the least restrictions possible. Relevant records were kept of regular monitoring, planned maintenance and servicing by the maintenance person and specialist contractors. For example, this applied to the passenger lift, all care, catering and laundry equipment as well as the main systems such as the fire detection system, water system, electric and gas utilities and waste management.

Accidents, incidents and near misses were recorded and the information analysed in order to identify trends and patterns. This process was carried out by the home's managers and the provider, on a regional basis, to see if any areas of risk management required review or alteration. Reflective meetings were used to discuss areas of identified unsafe practice, the outcome of complaints, national safety alerts and the provider's own safety alerts. The provider had arrangements in place to cascade any relevant safety information to all its homes nationally. This included information received from the Department of Health's (DoH) central alerting system as well as its own necessary safety alerts. These alerts made staff in different homes aware of any safety issues. They included a directive on actions that needed to be taken to address the safety issue. The operations manager explained that a recent meeting for staff had been held in response to one of the provider's safety alerts. A visit by the provider to another of its homes, in another area, had prompted the need for a review of the night-time security arrangements. To ensure night-time security was therefore as it should be throughout their homes, the provider sent out a national safety alert with a directive that night-time security was to be reviewed in all homes. This had been completed at Trevone House and one member of the night staff confirmed that they and several other night staff (of which we saw a list of) had attended a meeting about this. We saw an action plan which had included staff reading and discussing the provider's relevant policy and procedures and ensuring in practice, these were met.

The registered manager followed the provider's policies and procedures in order to protect people from poor or unsafe practice. They had made staff aware that any behaviour which did not aim to achieve this would not be tolerated. We saw that where necessary significant conversations had been held with staff about their practice. If needed, additional training and support had also been provided to help improve staff practice. However, disciplinary action was also taken, when required, to ensure people were treated appropriately and remained safe.

The registered manager told us they monitored the staffing needs of the home to ensure there were enough staff to meet people's needs. They told us they were able to adjust staffing numbers and make suggestions about changes in how the home was staffed to the provider. They sometimes used agency staff to ensure a full complement of staff. This was the case on the night duties during the inspection visit where one agency member of staff was used to make up a full complement of three care staff and one nurse on duty. The number of hours covered by agency staff had reduced significantly since the last inspection visit. This had been due to the registered manager's successful staff recruitment.

One member of staff told us there were not enough staff to enable staff to supervise and support people sufficiently when they were in the main lounge area. The registered manager told us people's needs had altered and they had agreed that an additional member of staff was needed to help "support people's well-being" once they were in the lounge. The registered manager had been in discussion with the provider about this and a couple of days prior to the inspection visit, finances to recruit an additional member of staff had been agreed. This was to be a new role of which the title had not yet been agreed and not all staff had yet been made aware of this decision. The member of staff who spoke with us was unaware of this. We were told the new staff role would be to specifically support people's well-being when in the communal areas. We were told this member of staff would not be diverted from this role to cover absent care staff. The need to cover absent care staff would be managed as it currently already was. This additional role showed the provider had responded to a change in people's needs and the needs of the home.

Throughout the inspection we observed a member of staff present in the main lounge most of the time. Staff told us they had tried to ensure this was the case most of the time prior to the inspection visit. Staff had done this by making adjustments to how they worked, For example, care staff wrote their daily records in the lounge instead of in the staff room and the member of staff administering medicines administered these from the medicine trolley, which they parked in the lounge as opposed to elsewhere. This meant that in-between administering medicines elsewhere they were re-visiting the lounge area on a regular basis. People using the lounge were provided with pendent call bells and alarmed sensor mats had been used to help alert staff when people, who were at risk of falling, required support. All staff were aware of who was unable to call for help independently. They also checked on people as they walked through to ensure they were safe and settled. One member of staff told us that one person could become very distressed at times because they lived with dementia. They explained that this person's increased anxiety sometimes had an impact on others around them. This distress, could at times, be expressed through behaviour which could be perceived by some as being challenging. This member of staff explained that all staff were aware of this as this could potentially lead to unsafe situations. We observed staff being particularly aware of this person and supporting them at times of distress.

There were robust procedures in place to support the safe management of medicines. Medicines were administered only by staff who had completed relevant training and who had been supported to maintain their competency in this task. We observed current good practice when medicines were administered to people. Medicines were stored securely at all times and were stored according to the manufacture's guidelines. For example, the temperature of where medicines were stored was checked on a daily basis to ensure this was within manufactures' recommended guidelines. This ensured optimum effectiveness of the medicines. People's medicine records were maintained and checks were in place to ensure this remained the case. This helped to ensure people were protected against medicine errors. However, where a medicine error had occurred these were fully investigated, advice always taken from the person's GP to ensure the person was safe and learning from these errors was identified.

People told us they received their medicines when they should. One person said, "The staff keep in touch very well with me regarding my pain." This person told us staff always asked them if they were in pain and gave them pain relief if they were due this. Several people had been prescribed an antibiotic by their GP for a chest infection. A nurse confirmed these were usually dispensed by the pharmacy, delivered and started on the day they were prescribed. One person required continuous oxygen. A safety sign alerted staff, visitors and other people that oxygen was in use and stocks of this were organised to ensure the person always had this available. The person confirmed they always had access to this.

People were protected from those who may not be appropriate to care for them. Staff recruitment files showed that a robust recruitment process had been followed. Before staff started work in the home, employment histories, specifically the reasons why they had left previous employment/s and the gaps in their employment were explored. Checks and references had been completed which included a police check and a check against the list held by the Disclosure and Barring Service (DBS) of those unsafe to work with vulnerable adults. The registered manager recruited staff according to the skills and experience required by the home. The registered manager said, "We need to recruit the right staff." An interim deputy manager had been employed to support the registered manager, but we also met the person who was to be the home's permanent deputy manager. They were waiting for final recruitment checks to be completed before they could start work. The registered manager was still looking to recruit more nurses and care staff.

Information about people's care and health needs was recorded accurately and held in such a way which could be accessed quickly by those who needed to do this. Care records were kept secure and only accessed by staff and professionals involved in supporting people's care and health needs. Information about

people's care and health was shared appropriately with other interested parties, for example, a designated relative or legal representative. Any breaches in confidentiality were taken seriously and dealt with according to the provider's policy and procedures. Staff received training on confidentiality when they first started work. We attended two staff hand-over meetings where verbal information about people's care was discussed by the care staff going off duty with the care staff coming on duty. This ensured that the appropriate staff were kept up-to-date with people's care needs. These meetings were held in such a way which kept information confidential. All electronic (computer) held records and information was kept secure through password-only access. Offices which contained sensitive information were keypad protected and kept secure.

Good

Is the service effective?

Our findings

People told us that moving into Trevone House had been a good decision for them and that their needs were met. One person who had been able to make an independent decision about this said, "I find it very good here. I had been falling and needed looking after." Another person who had not been able to make that initial decision independently said, "I'm glad I'm here because I'm looked after. I don't have to worry." Another person told us they considered their needs to be well met. They said, "Oh they are wonderful (referring to all staff). I have been in other places (care homes) and if you need to be somewhere you need to come here." When talking with one member of staff about how well they considered people to be looked after they said, "I would have no objection to my mother being here."

People told us their care needs had been assessed prior to their admission to the home. Relatives we spoke with were aware their relatives' needs had been assessed. In these people's cases, their relatives had been actively involved in the assessment process. The registered manager told us she spent a good proportion of her time carrying out pre-admission assessments. This process helped them to be sure that their staff could meet a person's needs. The interim deputy manager told us four recent enquiries for admission to the home had been turned down by the registered manager following a pre-admission assessment. This was because the assessment had concluded that these people's needs could not be effectively met at Trevone House. The interim deputy manager said, "It's not always about the bottom line; we want to get it right for people and [name of registered manager] has integrity."

We reviewed people's pre-admission assessments. These had explored their health and care history, gathered information about their current care needs and gave a general summary of what would be required to meet these needs. During the pre-admission assessment period, senior staff also liaised with other health and social care professionals to ensure they had all the relevant information they required. Following an agreement to admit a person the staff then made sure they had all the necessary equipment and medicines to be able to meet the person's needs. Following admission necessary follow-ups with appropriate health care professionals were organised.

We asked the registered manager how they approached people, about diverse areas of their life which they may perceive as being more personal and of a sensitive nature. The type of information which, if staff were not aware of or did not have an understanding of, could potentially result in a person's needs not being fully met. For example, this potentially included information about people's personal relationships, individual religious and cultural beliefs, specific disabilities, sexual needs or sexual identity. The registered manager told us that meaningful conversations with people started during the pre-admission assessment and continued after a person's admission. They explained that they and the staff were aware that people had very diverse needs and to be able to deliver truly personalised care, it was better to be aware of these more personal facts. However, they were also aware that some people may not wish to share information about these areas of their life. They explained that the conversations they had with people were designed to proactively broach these and to give people opportunities to discuss their particular preferences and needs. The registered manager told us they took the same approach when speaking with their staff. They told us that all diverse needs were treated with respect and each individual was treated equally.

Pathways of care were followed to ensure people received care which followed best practice. These were in line with nationally and locally agreed guidelines. These pathways were recognised by other health and social care professionals and helped to ensure people received equal and consistent support. The care pathways followed for the people we reviewed during the inspection predominantly related to dementia and end of life care. Individual decisions, needs, preferences and choices were then subsequently woven into people's care planning.

Where possible, decisions about care and treatment were made with the person receiving this. One person spoke with us about how decisions about their care were made. They said, "They (staff) usually ask me first and discuss things with me." This person had mental capacity to provide consent for this. Where people had been unable to provide consent and make decisions about their care and treatment, because they lacked mental capacity, or they were just too frail, relatives and legal representatives had been consulted and had contributed to this process. The three relatives we spoke with had been actively involved in discussing their relatives' care with the staff. These relatives did not hold power of attorney for health and welfare but they had been consulted and had been able to speak on their relatives' behalf. Two relatives described their relative as "totally withdrawn" at the time of admission so they had needed to speak for them. This person had experienced a period of acute confusion and had, at that time, diminished understanding of what was happening to them. They had been unable to make independent decisions about their care and treatment at that time. A third relative had been consulted fully about their relative's care because on admission, this person had been assessed as being near the end of their life. As these people's health had improved following admission, they had become more able to make decisions and they had been actively supported to make these.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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 make 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Statutory notifications received prior to the inspection had informed us of when DoLS had been authorised for people. During the visit we reviewed several records pertaining to how staff protected people under the MCA. We also reviewed the conditions attached to these authorisations and checked if these were being met. For example, one condition stated that a best interest decision in relation to one person's medicines must be made in consultation with family members and the person's GP and the use of these medicines was to be kept under review. Records showed that family members had been consulted about the decisions made about these in the person's best interest. This had all been appropriately recorded. GP visit records recorded the regular reviews and discussions held about these to ensure these medicines remained effective and relevant. These records showed that at times these medicines had been adjusted to better suit the person's needs. Conditions listed in another person's DoLS stated, that relevant care plans must reflect the fact the person was deprived of their liberty and that their mental health medicines were to be reviewed at least three monthly. We reviewed records which showed that both these conditions were being met.

Care records stated whether a person was able to make independent decisions. Care plans highlighted where people needed help to do this. We observed one person, who lived with dementia, being supported throughout the inspection visit to make simple day to day decisions. This included what they wanted to eat

and how they wanted to spend their time. Another person, who also lived with dementia, was unable to verbally give permission for their care to be delivered. This person's "communication" care plan recorded how they expressed happiness or unhappiness with something that was either being suggested or done. For example, a wash or being moved. Care records showed that staff subsequently responded to the person's non-verbal communication. Care plans recorded the care which had been planned with people or which was to be delivered in their best interest. There were several recorded examples of where people had also refused care by expressing, in some way, their displeasure or distress. In these cases the care records stated that staff had withdrawn and returned later to try and provide the necessary care. They also recorded examples of where staff had been patient and supported a person with something else first and then successfully delivered the care that was needed following this.

People received care from staff who had been provided with appropriate training and support. Training started when staff were first employed and continued at regular intervals throughout their employment. In the last year the registered manager had ensured that all staff had either completed the training considered necessary by the provider, or this training was booked for a future date. The central training record showed that most staff had already completed training in subjects such as safeguarding adults, health and safety, fire safety, safe moving and handling, nutrition and well-being, prevention of infection and infection control, emergency life support and falls prevention. Staff also completed training in dementia awareness. Staff were provided with regular opportunities to discuss their training needs and reflect on their progress with their immediate manager.

The competencies of registered nurses employed by the home were checked. They completed competency checks in numerous areas of practice. We reviewed one competency booklet being completed by a nurse. The process of checking nursing competencies was completed by all nurses who worked at Trevone House and was re-visited after every two years of employment. The provider also supported nurses to maintain their registration with their registering body; the Nursing and Midwifery Council (NMC).

The interim deputy manager said, "Finding time for staff to attend training is always a challenge but [name of registered manager] has really pushed this." One member of staff had completed recent update training and told us this had been "very good." Another, more recently employed member of staff said, "So far I have had two discussions with [name of their manager] about how I'm getting on and I feel well supported." Staff were supported and encouraged to take on new roles and responsibilities. Another member of staff told us about their newly designated role of dignity champion and how this had made them more aware of people's particular needs. For example, their toilet needs. A further member of staff said "I feel well supported." This member of staff was to receive training which would enable them to administer insulin. Already trained to administer other medicines, they told us this would ensure people's insulin could be administered when it best suited the person, would avoid requesting support from community health care professionals and enable them to better support the nurses employed by the home. Training was also tailored to specific staff roles. The head chef for example, told us they had been encouraged by the registered manager to complete a nationally recognised course for professionals in cooking for the elderly. They told us they were looking forward to this. They had also attended a learning session delivered by a dysphagia (difficulty in swallowing) specialist. The registered manager was aware of different learning needs in the staff team and ensured these were supported.

The registered manager had also identified further training needs which they were keen for their staff to receive training on. Training on these subjects had been requested from the Care Home Support Team; a team of health care professionals employed by the NHS who specifically supported care homes to meet people's needs. This training included for example, further end of life care, care planning and the management of people's behaviour.

People were supported to eat and drink and to maintain their nutritional well-being. People had a choice in what they ate and drank and where they took their meals. One visitor said, "There seems to be a reasonable choice and the standard of food is very good." We observed one person being provided with their meal a little while after others. They explained that staff brought this to them after they had woken from their "nap". This person told us they preferred to go down to the dining room for their lunch but preferred to take breakfast and evening meal in their bedroom. We observed other people being supported with similar choices. One person told us they liked to add salt to their food but staff often forgot to bring this with them on the tray. We observed one member of staff needing to fetch salt for two people because it was not automatically placed on their tray. We fed back our observation to the registered manager and the head chef so they could ensure this was not an on-going issue for people.

People were not only supported to eat and drink at set mealtimes, but also in-between meals, particularly when they needed an increased calorie intake. For example, for people who lived with dementia and who did not rest much and for those who only ate small amounts at mealtimes. The head chef had some flexibility in the way they purchased food and was able to purchase items outside of the main food order in order to meet people's particular preferences. They said, "[Name of registered manager] is happy for me to get anything people request or that staff know people like if it helps them to enjoy their food more." One example was of a person who enjoyed a eating a particular cake, made by a particular manufacturer. The type of cake had been ordered through the normal catering supplier but not eaten by the person as it was not made by their preferred manufacturer. As this person required additional calories and they could obtain these by eating cake, this had been purchased separately in a local shop so it was always available for this person.

People's weight and their appetites were monitored, nutritional risks were identified and any concerns relating to these were discussed with the person's GP. Nutritional risk included for example, loss of weight which was managed by fortifying foods. This meant the calorific value of food was increased by adding for example, extra butter, cream and powdered milk. Since the last inspection individual snack baskets were also provided to people who required additional calories. The basket included items of fruit, snack bars, crisps and confectionary. We saw these baskets in easy reach of people, on their beds and bedside tables and people enjoying the items in them. During the inspection visit 16 people were provided with a replenished basket on a daily a basis. Some of these people also enjoyed a daily fortified milkshake.

We observed mealtimes to be generally unrushed. People were supported to eat and drink in a dignified way. Clothes protectors were placed on people and staff sat down and conversed with those they supported. Menus were present on each dining table with a written and pictorial example of what was on offer at each mealtime. This helped people to remember what the options were and what they had previously ordered. If people changed their minds or wanted an alternative to eat this was not a problem. To further help those who needed an immediate and visual prompt to help them make a choice, the chef always plated up each mealtime option. These could be taken by the care staff to the person to help them make a choice.

Staff in the home reported a good working relationship with most external agencies and other health care professionals. However, in some instances staff had needed to apply patience and adopt a professional but assertive approach to ensure people received the support they required. Staff discussed with us, the times they had forwarded requested information or had expressed concern about a person and where this had not been effectively responded to. One situation was resolved during and just after the inspection and another was to require further involvement by the registered manager to ensure both people and their staff received appropriate responses.

Staff worked closely with many health and social care professionals to ensure people's needs were met. This included a pharmacist who advised staff on all medicine related matters. In the case of one person, staff had liaised with and were still taking advice from, a mental health specialist. Care records showed that the GP and the mental health specialist had reviewed the person's progress, with the staff, many times. There was evidence in several people's records of collective professional working in order to find the best medical and care options for the person. People's records recorded that various health related appointments had been attended. These were sometimes attended with the support of family members and at other times with a member of staff. Records for example, showed when people had accessed optical (eye) care and when a chiropodist (foot care) had visited. Both were available at regular intervals. NHS auditory (hearing) and hearing aid clinics and dentists were also accessed when required.

Staff in the home also worked closely with the community nursing service. Community nurses visited people and looked after the health needs of those who were not funded to receive this from the home's own nurses. For example, they had assessed people's risk in relation to developing pressure ulcers, they had organised pressure reducing equipment where needed and provided necessary wound care. Staff also called on the emergency ambulance service when people were taken suddenly ill, which was the case during the inspection visit. Sometimes, the services of the NHS Rapid Response Team were called on to manage a health issue in the home without a need for admission to hospital. When people were in hospital senior staff liaised with the ward staff and sometimes staff visited people.

The home's building had been built to accommodate people who required care. Over the years it had been maintained and further adapted to better meet the needs of those with more complex physical needs and those who lived with dementia. We therefore for example, saw call bells in each bedroom and in communal rooms. Corridors and doorways were able to accommodate wheelchairs and hoists. Hand rails were seen in corridors and safety rails in toilets and bathrooms to help people maintain their balance when walking, sitting down or standing. The main communal room and dining area was arranged in such a way which enabled wheelchairs, armchairs and hoists to be used at the same time. There were larger bedrooms which could accommodate people who required a lot of equipment to help meet their care needs. Other bedrooms were smaller and were occupied by people who were mobile and did not require so much care equipment. One relative told us the registered manager had been "very patient" with them and had let them decide which larger bedroom they wanted for their relative when it had been determined that their relative would be staying for a longer period of time. Signage was seen around the building which helped people orientate themselves. Signs were seen in both word and picture form. The outside area could be accessed and used safely by people in wheelchairs and by those with mobility aids.

Good

Is the service caring?

Our findings

People told us the majority of staff were caring, thoughtful and compassionate. One person told us this had not been the case in one situation but they had felt able to report this. We saw evidence of where the registered manager had taken this seriously and had taken action to address the issue. They said, "I want good care here at all times and I will pick up on poor care." Staff had also felt more able to report incidents to the current registered manager of an uncaring nature because they told us they knew she would do something about this. The registered manager told us they had worked hard with staff to improve the attitude and approach of some staff. They told us a far more open and caring culture existed, which had benefitted both people and staff.

When asked how staff were towards them one person said, "The staff are really good to me." One particular example for this person was how staff were "so kind" when they delivered their personal care. They said, "They are always also so respectful." Another person referred to the "boys" (male care staff) as being "lovely", "very "kind" and "sensitive" to the person's feelings. Another person described the staff as being "very caring". This person told us staff had "bothered to take time to decorate my bedroom" (ready for Christmas) and they had considered this to be a "particularly thoughtful and caring act." Another person said, "You can't fault the staff here, they are all lovely." All relatives we spoke with considered staff to be caring and because of this they felt able to leave their relative after visiting time feeling reassured they were being treated well and cared for.

We observed staff communicating with people in different ways and according to what worked best for the individual person. One person's distress was responded to each time, by a different member of staff (not just care staff) in a kind and reassuring way. We could see that staff helped this person to feel as if they mattered by giving them time and by stopping to talk with them. Staff knew the people they looked after well and in this person's case, staff told us the person responded well to a hug, lots of patience and being told they had done well. We observed staff giving this person a hug and providing lots of positive interactions. We also observed staff laughing and joking with people. People had good relationships with the staff and we often heard playful banter being exchanged. One person said, "We have a laugh here." Each relative told us they always felt welcomed by the staff and made to feel at home.

People were supported to be as independent as possible. One relative described the journey their relative had taken to be able to walk again. The relative said, "[Name] could not weight-bear (take any of their own body weight) when they arrived here. They [the staff] have worked hard with [name]. The hospital said [name] would never walk again, but it's amazing what they [staff in the home] have done. They [staff] used to use a hoist, the physiotherapist was involved and the staff persevered slowly with [name]." We observed this person walking independently to the toilet and to the dining room for their meals. This person told us they were now also able to go on trips out for lunch with the activities coordinator which they said they really enjoyed.

Care and compassion was also afforded to those who mattered to people. Staff organised little things which made a difference to people. For example, the head chef told us they sometimes cooked for people's

relatives and provided for parties held at the home. In one couple's case, the person's spouse now stayed for lunch each day. The head chef told us they felt good about this because they knew the relative was leaving to go to their own home having had a hot meal. They were also pleased to see that this had resulted in an improvement in the appetite of the person receiving care who now had the opportunity to eat a meal again with their spouse.

Making sure that people's personal needs were met, in a way they wanted them met, was obviously important to all the staff we spoke with. The staff told us that the provider fundamentally cared about people. One member of staff told us they enjoyed working for the provider because they said, "they do actually care". The registered manager said, "Person-centred (personalised) care is pivotal to our success and I'm still a nurse inside my heart." Staff told us they aimed to provide personalised care to everyone and to give people the time they needed to be listened to. Some staff told us they sometimes felt despondent about their ability to achieve this. They put this down to constraints on their time. However, we observed staff treating people as individuals, having meaningful conversations with them and meeting their particular preferences and choices. People told us they were happy with the support staff provided and told us they felt staff met their particular preferences most of the time. Information about people's personal preferences and about their life history and background was gathered in order to help personalise their care. This information helped staff to have meaningful conversations with people.

Staff were aware of the small details which made a difference to people's quality of life. One person told us they particularly liked to keep their nails short and clean because they felt others noticed this if they weren't. This was clearly important to this person. This small piece of information was known by staff and we observed one member of staff, without prompting, offering to come back later to clean and file the person's nails. They said, "I'll come back and do that because I know you like it done."

People who required support from an advocate, other than a family member or member of staff were supported to access appropriate help. Information about advocacy services was seen in the reception area. Staff had explained to people that it was sometimes necessary to share information about their care and treatment with other professionals and agencies involved in supporting them. Consent forms had been signed in relation to this by people or their legal representatives.

People's privacy and dignity was maintained when their personal care was delivered. This meant for example, that we observed staff delivering personal care, at all times, behind closed doors. We observed staff maintaining people's modesty when, for example, they moved people in a hoist by covering their legs with a blanket. We observed staff knocking on people's bedroom doors and waiting for an invite before they entered. Only once did we experience a member of staff knock and then enter without an invite. On this occasion they apologised and left immediately and the person told us this was unusual. People were supported to express particular wishes with regard to their care. For example, they had been asked what gender of staff they wanted to deliver their intimate personal care and this had been recorded in their "personal care" care plans. One member of staff told us they had just completed a review of care with a person and their preference in this area had been re-visited to ensure they were happy with the current arrangements.

People's right to a private family life was respected and people could receive visitors at any time. Visitors were able to see their friends or relatives wherever the person was happy to receive them. We observed relatives visiting people in their bedrooms or the main communal areas. Two relatives told us they usually visited their relative in a smaller lounge area and were always offered tea and cake to have with their relative. They told us they really appreciated this because this is what they would have done when visiting their relative in their own home.

Good

Is the service responsive?

Our findings

People told us staff always responded to their need for support. One person said, "They're here when I ring the bell for the toilet, I don't have to wait long." Another person said, "I don't have to ask them (the staff), they just know what is needed." How quickly staff responded to people's requests for help was monitored. Call bell response times were audited and since the last inspection these showed a significant improvement. The few calls which had been responded to after five minutes had been investigated. We found that during one 24 hour period, over 600 (the average was 300 to 400) call bells were activated and only five calls had taken over 5 minutes to respond to. Investigations showed the reasons for this which for example, had included, being unable to leave others during personal care and an emergency had taken place in the home. The majority of calls had been answered in less than two minutes. We observed staff leaving the staff handover to ensure people's call bells were responded to.

People's care plans, on the whole, gave detailed information about how people preferred their care to be delivered. They gave staff guidance on how to safely meet people's needs. One visitor expressed a concern about their friends care to us, which we followed up. This person's relevant care plan had not been specific about what products should be used on the person's body, and where on their body they should be applied. Staff records showed that one particular product had only been used on one area of the body; it had also been prescribed for another area as well. The person told us they were experiencing symptoms on the one area of the body not recorded as always treated with the product. A lack of clear guidance in the care plan could have caused some confusion for staff in the application of this product. This care plan and other related records relating to this were improved during the inspection to make the guidance clearer. The same lack of detail was seen in four people's "elimination" care plans where a lack of specific detail relating to the type of continence aid (continence pads in these cases) was seen. There was no evidence to suggest people had been affected in a negative way from this and the registered manager told us the detail would be added to these care plans straight after the inspection. In total we reviewed a total of 41 individual care plans and only these six lacked some specific detail. These six care plans however gave other detailed guidance on how people's particular needs should met.

People's differing abilities were recognised and recorded in their care plans so staff were aware of what people could do independently and what they required support with. Monthly care plan reviews showed how changes in people's needs and abilities altered with time. Care plans had been altered to reflect these changes. The registered manager told us they had been supporting staff to write and review care plans in a more personalised way. This had involved staff having more discussions and care reviews with people to ensure their care plans reflected their preferences and needs. Staff told us this took time to complete, but we could see, so far, this had resulted in more personalised care planning. The provider's expectation was that a care review, involving the care plans, took place with people six monthly. We saw some evidence this had happened but not in all care files reviewed by us. The registered manager explained that staff had effectively been reviewing people's care with them as part of improving the overall care plan content.

One person's review had been completed with them personally following their admission. This had helped to further personalise the care plans which had been written, initially after their admission. We therefore saw

recorded, what the person now felt they could independently achieve and what they still required help with, compared to when they were admitted. The person's "communication" care plan was more detailed referring to the person's need for their glasses to be near to hand, which we observed to be the case each time we visited them. The person had lost weight since their admission so staff had wanted to monitor more closely the person's food intake to ensure they were eating well and regularly. We reviewed these records and they had been consistently completed by the staff. Other monitoring records such as people's repositioning charts were also well maintained. The above person's specific interests had been explored and recorded and had been reviewed again during the more recent review. Records showed that the person was choosing what social activities they preferred to take part in. They told us they enjoyed some of these but were not interested in others. The "activities" care plan told us they were a social person and recorded what they had told staff they were interested in.

We spoke to the activities coordinator about how they helped this person meet their particular interests. Although the activity coordinator kept their own record of activities completed with people, they told us they did not write the "activities" care plan. Through discussion with them and by cross-referencing information from the person's review, their "activity" care plan and the activity coordinator's records we could not see how this person's particular interests were being supported. We fed back to managers what we considered to be an inconsistency in how information about this person's particular interests had been initially gathered and recorded, then how information about this had been communicated and then how the person was supported with meaningful activities. We fed this finding back because in their review the person had commented that, although they were happy in the home, they also stated that they sometimes felt lonely. A local forum held to promote best practice in meeting people's social needs promotes the need and importance of activities being meaningful to individuals and for people to have opportunities for meaningful interactions. The registered manager was aware of the forum and they told us they would review how information was gathered and used in relation to people's social needs and activities.

Equally so, the activity coordinator's records showed that many people were supported to take part in activities which they enjoyed. Records showed these were predominantly group based activities and some records gave an evaluation of how each person had engaged with a particular activity; how meaningful it had been to them. Records showed that the evaluation process was in its infancy but the activity coordinator told us it was helping them to make adjustments to the activities they provided in order to make them more meaningful to people. When we observed activities taking place people looked to be engaged and enjoying themselves. The activities coordinator had contact with several external entertainers who came into the home to provide entertainment for people. One person told us that since their admission they had enjoyed activities which they previously probably would not have considered. We also observed simple activities being introduced by care staff as distraction therapy. For example, we observed the person who frequently became distressed being supported through an activity which helped to improve their wellbeing.

The home had some links with the immediate community which included the local church. The activities coordinator also took people out to use the wider community on a regular basis. The operations director however, told us that an initiative would be starting in 2018 to improve how all the provider's services connected and integrated with other groups in their community.

The provider had a complaints policy and procedures in place. People told us they felt comfortable in raising any areas of dissatisfaction with the registered manager. Information on how to do this was available to people, their relatives and visitors and could be provided in different formats. One person told us they had raised a complaint and action had been taken to ensure they did not experience the same problem again. They told us they had been satisfied with this action. All complaints received were recorded in a

complaints file. The complaints we reviewed had been received and managed by the current registered manager. Three complaints were received; one about the attitude of a member of staff, one about how a person's recurrent falls had been managed and problems with being able to communicate with the home out of office hours and one about the choice of bed time and how responsive the night staff had been to a request.

Two of these complaints had been acknowledged, investigated and responded to within the provider's stated time frame of 28 days. One which had initially been forwarded to the provider's head office had not been managed within the stated time frame. The operations director explained this had coincided with a period of reduced staff at head office which had come about for various reasons. They told us it was not normal practice for a complaint to be responded to late. Action had been taken since then to ensure that complaints sent straight to head office were managed more effectively. We saw evidence which confirmed that as soon as the registered manager had been made aware of this complaint, they had responded to it. Where evidence concluded that the complaint had been upheld and improvements were required to the services provided to people, action had been taken to address the issues raised and for learning to take place from these.

The statutory notifications reviewed prior to the inspection visit told us that staff at Trevone House provided end of life care to many people, on a regular basis. Care records showed that staff tried to explore people's end of life wishes and preferences from admission onwards. The purpose being that these, sometimes, difficult discussions could then be held with people and advanced end of life care planning could begin, with people, whilst they were able to contribute to this. Records showed that this was still a difficult subject for people to discuss as often limited information was recorded. This subject had been broached by staff, with one person, twice and the relevant record still stated, "Does not wish to discuss." Other people's records gave details of for example, funeral directors and who to contact at the time, but little else. One person said, "I have no particular wishes and I trust them (the staff) to do what is needed at the time."

The registered manager had completed additional training in end of life care and many other staff had a lot of experience in providing end of life care and support to family members. The registered manager as well as other nurses working in the home had appropriate skills which enabled them to manage and administer end of life medicines. The registered manager explained that in the last days of life all previously active care plans ceased and one specific end of life care plan commenced. Trevone House followed a locally agreed end of life pathway, which was in line with guidance provided by the National Institute for Clinical Excellence (NICE): "Care of the dying adult". This ensured people received a recognised standard of care at the end of their life. All professionals involved with people's end of life care were aware of this pathway, for example, the GP and community nursing teams. It therefore promoted collective (multi-disciplinary) working between professionals. A designated noticeboard in the home provided information about end of life care. It provided people and their relatives with information about what they could expect. It told people there was a member of staff in the home that took a lead on this and who they could talk to if they wished. People who had died were missed by staff who had built up fond relationships with the people they had cared for. This was evident in the way people were spoken about and remembered by staff when discussing them during the inspection. Unless specifically requested not to, members of staff always attended people's funerals in order to represent the staff and people at Trevone House who had known the person.

Good

Is the service well-led?

Our findings

People, relatives and staff told us the registered manager was approachable, supportive and interested in what they had to say. Most people told us they considered the home to be well-run. One person's feedback to us was based on an incorrect understanding of how many hours the registered manager worked and how visible they were in the home. The registered manager worked long hours, many in excess of their contracted hours and often late into the evening. We spoke with this person about this. The registered manager sometimes worked nursing shifts (day and night) to ensure the home was appropriately staffed, but predominantly worked additional management hours in order to improve the quality of the services provided in the home.

The registered manager had managed the home since December 2016 when the previous registered manager left. They were registered with the CQC in August 2017. They had previously worked as the deputy manager so knew the people, staff and provider's systems well. They had a clear vision for the home. They said, "I want it to be the best home in Gloucester. I'm going to improve this home and I'm going for it." The staff we spoke with were also committed to improving the service. One member of staff said, "The team is working well together, far better than a year ago." Another told us they had specifically returned to work at Trevone House once they knew it was to be managed by the current registered manager. Another member of staff said, "I feel things are really improving. [Name of registered manager] is very methodical, hardworking and committed." People we spoke with knew who the registered manager was and they liked her. All three relatives told us they considered the home to be well-managed and they felt able to approach the registered manager about anything.

We observed a highly visible registered manager. When they were not with us we observed them to be involved in and following up things with staff and people. It was clear that they knew what was going on both with people's care and in the home generally. We saw them attend an early morning staff handover meeting which staff told us was usual practise for the registered manager. When working in their office we observed their door to be open and we could see them observing what was going on in the immediate vicinity. At one point they observed something they wanted to be done differently and they got up and discussed this with the member of staff immediately. One senior member of staff said, "Not a lot misses [name of registered manager]." We also observed them giving staff praise where this was due and thanking them. The operations manager said, "[Name of registered manager] has a good relationship with the staff."

A caring and respectful culture had been promoted within the staff team. The registered manager said, "I treat the staff as I would want to be treated and I expect them to do this with each other." One fairly new member of staff told us how they had felt really welcomed back after a period of absence. They said, "They (staff) just really welcomed me back….it was lovely and I felt I really belonged to the team." The health needs of another member of staff were known to their colleagues and they confirmed that their colleagues "looked out for them." The registered manager told us they were aware of some staffs' domestic circumstances and their need, sometimes, for additional support and to be able to talk. They said, "My door is open if staff want to talk." A fairly recent occurrence had resulted in several staff needing additional emotional support. The provider had demonstrated a caring and compassionate approach towards their

staff during this time. They had arranged for staff shifts to be covered by other staff members from some of their other care homes. They had ensured that all staff were aware of the free and confidential counselling service available to them. The registered manager explained that staff members had supported each other during this time.

The registered manager held various meetings with different groups of staff in order to communicate their expectations, to receive feedback and to hear their ideas and suggestions. We reviewed the minutes of a recent staff meeting. This meeting had discussed issues which had been received through various forms of feedback, from complaints, verbal feedback from visitors, from people living at Trevone House and the findings of recent audits. Feedback from people, relatives and other visitors placed on a website used for this purpose were monitored by the registered manager. We reviewed some of the comments people and relatives had made. In October 2017 one person had received respite (short-term care) and had been "very happy" with their stay. A relative had described their relative's stay in Trevone as being "a very positive experience". Reviews specifically about the management of the home were included and these included "satisfactory", "good" and "excellent". One comment from September 2017 said, "Nothing is too much trouble and they always take time to explain things to you". A comment referring to a complaint we had seen addressed through the provider's complaint process was also seen (this referred to the issue of not being able to get through to the staff by telephone).

The performance of the home was monitored by the provider. Regular monitoring and support visits were carried out by the operations manager on behalf of the provider. The registered manager also completed a weekly report which was forwarded to the provider's head office. This kept the provider up to date with bed vacancies, particular staff issues, current risks and how these and any complaints were being managed. The registered manager completed set audits in order to ensure the home was meeting current regulations and best practice. We reviewed several audits which had been completed, either on a monthly basis, like the medicines audit or on a three monthly basis, like the infection control audit. These audits identified required actions which had then been addressed. During the operation manager's visits the actions were checked to see if these had been completed. They were then signed off on behalf of the provider. Actions plans were sometimes used to manage a specific group of actions or for the management of future, planned improvements. For example, an action plan had been followed and completed to address the provider's alert regarding the night security of the home. The registered manager also had their own identified and planned actions, which they wanted to complete in the next year. For example, these included the refurbishment of several bedrooms.

The registered manager ensured they kept personally up-to-date and in turn, kept the staff group up to date, with best practice by consulting with specialist practitioners. Sometimes these were practitioners who visited the home but also, the provider employed at national level, specialist who ensured the provider's policies, procedures and guidance adhered to best practice and current legislation. For example, there was a national lead on infection control and specialists in dementia care employed to advise the registered managers. The registered manager attended, or other staff also attended, local professional forums which supported best practice and could provide advice.

The registered manager ensured that requirements made by the Care Quality Commission (CQC) were met. This included making sure the home's previous rating (issued by the CQC in 2016) was clearly displayed in the home. The provider had ensured this was displayed on their website. Both the registered manager and provider ensured CQC were correctly notified of any changes, events and situations through the statutory notification process. The registered manager, on a regular basis, kept the CQC Inspector up to date with information relating to previously sent notifications and actions.