Veecare Ltd

Tralee Rest Home

Inspection report

38-40 Tankerton Road
Whitstable
Kent
CT5 2AB

Tel: 01227276307
Website: www.carehome.co.uk

Date of inspection visit:
26 June 2017

Date of publication:
02 August 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 26 June 2017 and was unannounced.

Tralee Rest Home is registered to provide personal care and accommodation for up to 36 people. There were 17 people using the service during our inspection who were living with a range of care needs. These included diabetes and mobility support; and people were living with different stages of dementia.

Tralee Rest Home is a large detached and extended house situated in a residential area just outside Whitstable. The service had a large communal lounge available with comfortable seating and a TV for people and a separate, quieter lounge. There was a small dining room in which people could take their meals.

A registered manager was in post, and had registered since our last inspection. A registered manager is a person who has registered with the care Quality Commission to manage the service. 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.

We last inspected Tralee Rest Home in January 2017. We found significant shortfalls and the service was rated Inadequate and placed into special measures. The provider had failed to provide sufficient numbers of staff to meet peoples assessed needs. The provider had failed to assess, prevent and the control the spread of infections. The provider had not ensured the safe management and administration of medicines. The provider had not ensured that care and treatment was being provided in a safe way. The provider had failed to ensure that people received adequate diet and fluids to maintain their health and well-being. The provider had failed to ensure staff had the necessary skills and experience to enable them to carry out their duties. The provider had failed to ensure staff consistently treated people with dignity and respect. The provider had failed to take people's preferences into consideration when planning care and treatment. The provider had failed to establish and operate an effective process for managing complaints. The provider had not ensured that the systems and processes that were in operation to assess, monitor and improve the quality and safety of the service. The provider had failed to maintain accurate and complete records in respect of each person.

We took enforcement action and required the provider to make improvements. This service was placed in special measures. Services that are in special measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. The provider sent us regular information and records about actions taken to make improvements following our inspection. At this inspection we found that although improvements had been made in some areas, other significant problems had emerged and some new breaches were identified.

Risks relating to people's care and support were not always assessed and mitigated. People had experienced choking episodes, fallen or displayed behaviour that could be challenging and appropriate

action had not been taken to protect them from risk of harm. A wardrobe had fallen and trapped a person in their bedroom and no action had been taken to prevent this from happening again. The registered manager had not consulted with the local safeguarding team about this and staff did not always document incidents when they occurred, meaning we could not be sure other incidents, leaving people at risk, would be dealt with appropriately.

People did not always receive the support they needed to eat and drink effectively. Staff did not always follow the guidelines in place for people when they needed assistance to eat, and some people were not given the equipment they needed to eat independently. The registered manager had not made necessary referrals to healthcare professionals when people had choked or fallen. People did see doctors, dentists and opticians regularly.

Staffing levels had been increased following our last inspection but the competency of those on duty was not sufficient. Training and supervision had not been wholly effective in some areas and staff were unclear about what to do if people choked or became distressed. Staff were recruited safely.

There had been some improvements regarding the cleanliness of the service. However, we found that infection control procedures were not always followed and some people had extremely dirty fingernails, increasing the risk of infection being passed on. A number of non-magnetic, non-automatic fire doors were propped open during the inspection. Some automatically closing ones were also propped open with heavy items; which may prevent them closing in the event of a fire, this was a hazard.

Medicated creams were not stored securely. People were living with dementia and there was a risk they could have ingested or applied too much of the cream. Other medicines were stored safely and people received them as prescribed.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services. These safeguards protect the rights of people using services by ensuring that if there were any restrictions to their freedom and liberty, these had been agreed by the local authority as being required to protect the person from harm. Although the registered manager had applied for people's DoLS when necessary, one person had a condition on their DoLS to ensure they received support in the least restrictive manner and this had not been acted on. The registered manager had not assessed people's capacity or undertaken best interest meetings when people's movement was restricted by the use of bedrails.

Information regarding the support people wanted at the end of their life was not clear, accurate or documented fully. People's relatives told us they had made complaints but these had not been documented or responded to.

The manager had registered with CQC since our last inspection. People and their relatives said that the registered manager had made a positive impact on the service. Staff said there was a good teamwork and open culture in the service and that the registered manager was supportive. However, improvements the registered manager had made had not had time to be implemented fully. Checks and audits had not picked up the serious issues relating to risk management that we identified. Notifications had been submitted as required by law.

People told us that staff were kind and caring. Information about people's life histories had been complied to give staff a sense of people's personalities and achievements. People engaged in a variety of group and individual activities.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

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

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people had not been recognised, assessed or mitigated. Staff did not document incidents fully so we could not be assured safeguarding issues would be identified and reported as necessary.

Infection control procedures were not always followed.

Medicated creams were not stored safely. People received their medicines as prescribed.

There were enough staff but this did not ensure people were kept safe. Staff were recruited safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights had not consistently been protected by proper use of the Mental Capacity Act (MCA) 2005.

People did not always receive the support they needed to eat and drink effectively.

The registered manager had not always made referrals to health care professionals as necessary.

Staff training was not wholly effective in some areas.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some people's dignity was not respected by staff as they had dirty fingernails and were not always dressed appropriately.

People were not supported to be as independent as possible.

Most staff delivered support with consideration and kindness.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Although care plans were written in a person-centred way; they were not always reflective of the actual care given. People and their relatives were not always involved in planning their care.

People enjoyed a variety of activities in groups and one to one.

Complaints were not documented and responded to effectively.

Is the service well-led?

Inadequate

The service was not well-led.

There was a new registered manager in post since the last inspection, but improvements they had implemented had not had time to take effect.

Not all concerns raised during the last inspection had been addressed and other significant issues had emerged. People's feedback had been requested but this had not been analysed or acted on.

Staff said there was a good teamwork and open culture in the service and that the registered manager was supportive.

Tralee Rest Home

Detailed findings

Background to this inspection

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

This inspection took place on 26 June 2017 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. The expert had personal experience of caring for older people and those living with dementia. We did not ask the provider to complete a Provider Information Return (PIR) because we inspected sooner than originally planned. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority to obtain their views about the care provided. We considered the information which had been shared with us by the local authority and other people, looked at any safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We met with fourteen of the people who lived at Tralee Rest Home. Not everyone was able to verbally share with us their experiences of life in the service. We therefore spent time observing their support and carried out a Short Observational Framework for Inspections (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four people's relatives. We inspected the home, including the bathrooms and some people's bedrooms. We spoke with four of the care workers, kitchen staff, the registered manager, area manager and the provider.

We 'pathway tracked' ten of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. This allowed us to capture information about a sample of people receiving care.

During the inspection we reviewed other records. These included four staff training and supervision records, four staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at the service. One person said, "I'm happy and contented and I feel safe." Another person told us, "I have no complaints, I feel safe." A relative said, "Yes now since the new management I do feel [my loved one] is safe." Although people told us they felt safe we found that risks had not been adequately assessed and minimised. At our previous inspection we had found the same issues, this left people at risk of harm.

There had been occasions when people displayed behaviours that may challenge. There was a risk that they may hurt themselves or other people. There were no step by step guidelines in place to explain to staff how to support people in a way that suited them best. There was a risk that staff would be inconsistent in their approach and the risk would not be reduced. During the morning of the inspection we saw one person become distressed. A member of staff approached them and took both their hands. The person became more distressed and started to shout and hit the member of staff. Another member of staff also approached the person and also took both their hands to encourage them to move. The person hit this member of staff also.

One member of staff told us, "They are like that most of the time…If you hold one hand to guide them they will hit you with the other, so that is what we have to do." The person's risk assessment for violence and aggression stated, '[The person] exhibits aggressive behaviour and can lash out at staff. [The person] can be verbally aggressive. This usually happens during personal care.' There was no mention of the person becoming distressed outside of personal care, what may cause them to become distressed or how their aggression may be shown. A number of statutory notifications had been received by the CQC from the service in recent weeks about physical altercations between people. This included hair-pulling, punching and slapping and this person was involved in several of these incidents. Despite this, there was no action plan to ensure that the two people who were generally abusive to each other were kept away from each other as much as possible.

Staff did not attempt to talk to the person about their family at any point during this incident, which was directed in the care plan as a method for calming them. Staff used an electronic daily notes system, which they were able to update instantaneously. There was no record of this incident on the system. Staff had recorded that the person had been 'content' for the entire morning. We found other instances of behaviour that could be challenging that had not been recorded. Without accurate records of incidents they could not be collated or analysed to identify why they had occurred and if anything could be changed to prevent them from happening again. People remained at risk because there was a lack of tailored information about supporting them when their behaviour became challenging.

There were no accurate assessments in place, or guidance for staff about the risks relating to choking. Three people had recently experienced choking or coughing episodes whist eating or drinking. Only one of these people had been referred for specialist advice from Speech and Language Therapy (SaLT); who provide guidance when people experience swallowing difficulties. This person's care plan about eating said that they should be watched during mealtimes, have a soft diet, be encouraged to alternate sips of fluid between

mouthfuls and have their food cut into small pieces. At lunch and tea during our inspection, this person sat at a table in the dining room with others to eat. They were not proactively watched by staff as they ate and there were occasions during both meals when there were no staff in the dining area. At teatime they had a plate of baked beans with quarters of toast which had their crusts on. This was not a soft diet and the toast had not been cut up any smaller than in quarters. Staff did not supervise the person to ensure they were alternating sips of fluid with their meal and the person got up from the table and walked away on several occasions.

Another person had choked on a piece of meat but there was no incident report about this. Staff had noted in a communication book that this person should have meat cut up into small pieces in future but their care plan about eating and drinking had not been updated to show this.

We spoke with three staff about how they would respond to a person choking; and each gave a different response about what they would do. Staff said they had received advice about managing choking in recent Basic First Aid training. However their knowledge and understanding was inconsistent and could place people at risk. Following the inspection the registered manager sent us an information sheet about choking and a knowledge test that they had produced to improve staff knowledge and competency.

We read accident reports about falls and looked at the provider's falls audit. The accident reports showed a trend for unwitnessed falls happening during the night shift. For example; one person fell on two occasions at 02:15am and 02:20am. Another person fell three times in the night and we read reports about another four people who had experienced falls during the night. All of these falls were unwitnessed and the falls audit did not record the time or place that they happened, so the registered manager had not picked up on any trends to investigate and remedy the cause of them. They were unaware of the timings of falls until we brought this to their attention during the inspection.

Records relating to people's falls had not been updated to ensure the information held was current and accurate. For example one person's care plan about falls said they were at high risk and had been referred to a physiotherapist in February 2017. There were no records about the physiotherapy input for this person. The registered manager told us that the physiotherapist had attended once but felt the person did not need assistance. There was no record of this visit or outcome. A 'falls diary' in the same person's care file was last updated on 21 August 2016 and did not include the recent falls or document any actions taken. There was no guidance for staff about how to prevent the person falling, although there was an alarm mat in their bedroom. Falls were not consistently recorded in daily notes. For example; one person fell on 13 May 2017 at 02:15am but this was not mentioned in the notes of night checks.

Another person's care plan about falls said they were independent when mobilising and usually fell when tired. It stated, 'One carer to watch [Person's name] carefully and while mobilising and if unsteady encourage to sit for a while.' This assessment made no reference to night time when this person had experienced several falls. The mobility care plan for them had been updated monthly but made no mention of the recent falls they had. An 'Accident/fall follow up sheet' in their care plan was last updated on 17 January 2017; after which they had fallen at least three further times. This lack of up to date information meant that the increased risks to this person were not clear for staff to see and address.

Most people were unable to use call bells because they lived with dementia. The registered manager told us that people were checked every hour during the night to keep them safe. The service used an electronic barcode system whereby staff scanned the barcode on a person's bedroom door when entering and again when leaving. This created a computerised audit trail of attendances to that person. We looked at night checks for one person who had fallen during the night and they showed that there was a gap of three hours

and 15 minutes between one set of checks and two hours and 46 minutes on the next night. This person had not been adequately protected from known risks to their safety.

A message in the staff communication book stated that a wardrobe had fallen over in a person's bedroom, trapping them inside. There was no record of this incident in the person's daily notes and it had not been recorded on an incident form. We spoke with the registered manager and they confirmed that the incident had occurred. We asked them how this had happened and they told us, "I do not know." Neither the registered manager nor staff had recognised the seriousness of this incident or the potential outcome had the wardrobe fallen on the person. No investigation had been completed into how it had occurred and no steps had been taken to prevent the wardrobe falling again. We visited this person's bedroom and found that the wardrobe had not been secured to the wall or affixed in any other way. It was a heavy piece of furniture but moved easily when pushed with a hand.

We asked the registered manager to ensure the wardrobe was safe before we left the inspection and a maintenance man attended to secure the wardrobe to the wall.

The provider and registered manager had failed to mitigate risks relating to people's care and support. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and staff had failed to recognise the serious risks posed by the lack of action relating to falls, choking and a wardrobe falling and trapping a person in their room. They had not consulted with the local authority safeguarding team regarding these issues, to see if a referral should be made. Incidents were not always documented or recorded so there was no guarantee that other, potential safeguarding issues would be referred or dealt with appropriately. We discussed our concerns regarding this with the registered manager and they agreed to speak with the local authority safeguarding team after the inspection.

At our last inspection, people had not been provided with a clean environment to live in. At this inspection there had been an improvement in the overall cleanliness of the service. However we had concerns about the way in which soiled items were being disposed of. An open black sack containing used continence pads was found in the shower room off the main lounge. There was also a red plastic bag containing soiled clothing and bedding that had been placed on the floor there. The registered manager could not explain why these items were there or why the pads were not in individual disposal bags inside a yellow bag, which she said was the correct practice. The items were removed immediately when we made the registered manager aware of them.

Several people were noted to have extremely dirty and grimy finger nails which were long in some cases. People were not given the opportunity to wash their hands effectively before eating and we observed one person placing their hand into their underwear and then to their mouth with a biscuit. The registered manager said people had regular showers or baths and could not explain why people's nails remained unclean. The care plan of one person who had very dirty nails stated that they were unable to cope with their own personal care needs and staff should 'Ensure[person's name] is clean and tidy at all times.' This had not happened and there was a risk that infection could be spread through poor personal hygiene.

The provider and registered manager had failed to take appropriate action to prevent the risk of the spread of infection. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection, people now had individual named hoist slings and staff did not walk through the kitchen to access other areas of the service. Cleaning staff wore gloves and aprons and could explain the order in which they cleaned rooms; which was now appropriate. Toilets and bathrooms were clean and fresh throughout and there was no longer an odour in communal areas.

A number of non-magnetic, non-automatic fire doors were propped open during the inspection. Some automatically closing ones were also propped open with heavy items; which may prevent them closing in the event of a fire, and was a hazard. We made the provider aware of this risk during the inspection and they closed the affected doors. All other fire safety and equipment testing had been carried out and the service was in a good state of repair. Air-flow mattresses were now at the correct settings for peoples' weights.

At our last inspection one person's known allergy to Penicillin had not been recorded on their medicines administration record (MAR). At this inspection the issue had not changed and this person's MAR still stated 'None known' in respect of allergies; despite the care plan recording them to be allergic to Penicillin. All other allergies for people had been recorded appropriately on their MARs.

At our last inspection prescribed creams were not locked away. These can pose a risk for people living with dementia, who may apply more of them than is directed or ingest them. At this inspection a number of medicines cupboards in bedrooms were unlocked and accessible. The medicines cupboards installed were too small to contain some larger bottles of cream, and these were kept on top of bathroom cabinets or shelves in people's rooms. This situation had not improved despite our last report highlighting the issue. We spoke with the registered manager about these issues regarding medicines. They agreed that these oversights needed addressing. They told us they would speak to staff to ensure creams would be stored appropriately.

At this inspection another person had a current pressure wound .They indicated to us that it hurt them but the MAR showed they had no prescribed pain relief at all, even on an 'as and when needed' basis. The registered manager told us she had not thought to ask the GP to prescribe pain relief but would now do so.

The provider and registered manager had failed to ensure that medicines were managed safely. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All other medicines, storage, administration and recording was safe and appropriately managed at this inspection. Creams applications were now being consistently recorded in line with the prescriber's instructions.

At our last inspection we reported that there were not enough staff to meet people's needs. At this inspection there were four care staff including two seniors on duty all day and three care staff including a senior on duty at night. Rotas showed that these numbers had been consistent in the month leading to our inspection. People told us they felt there was enough staff. One person said, "There is enough staff most days." A relative told us, "I think they've got the staff just about right." People's needs were met promptly and any call bells were answered in reasonable time. There were just 17 people using the service during our inspection and the staffing levels meant there were sufficient numbers to consistently support people with their care needs.

Before staff started working at the service written references were obtained and checks were carried out to make sure staff were of good character and were suitable to work with people. A full employment history had been gained for each member of staff. Disclosure and Barring Service (DBS) criminal records checks had

been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they enjoyed the food served. One person said, "Meals are on time and always served in a very nice way." A relative told us, "Food looks inviting. Staff always report on how [my loved one] is eating especially if they are not eating well." Staff asked people individually what they would like to eat for lunch. On the day of the inspection people were able to choose between fish cakes or chicken kiev for lunch. Although people were asked this, many people living at the service had dementia and could be confused at times. There was no additional information provided to people, such as pictures, to help them make their choice.

At our previous inspections in July and December 2016 people's nutritional needs were not consistently met. Although we found some improvements, people did not always receive the support they needed to eat and drink effectively.

We observed one person being fed by a member of staff. Their care plan stated they were able to eat independently, with encouragement and that a plate guard should be fitted to support them to do so. A member of staff confirmed this was the case, saying. "They can do it themselves, they just need encouragement." There was no plate guard in place to facilitate the person's independence.

Another person used a special spoon to help them eat effectively. We observed the person eating their lunch from a small plate, using a knife and fork. The person was visibly struggling to cut their meal, and transfer it into their mouth. A staff member bought the person their spoon when they had finished eating. The person looked at the member of staff, and said, "Too late." They had not been provided with the correct equipment to enable them to eat with ease.

Staff now recorded the total amount of liquid that people drunk, to ensure they remained hydrated. However, some people were prescribed specific high calorie drinks to help them maintain a healthy weight. These drinks were recorded on people's medicines administration record, and not included in the daily totals of people's liquid intake. This meant the total amount of liquid drunk each day would be inaccurate.

One person had a catheter in place, which is a flexible tube inserted through a narrow opening into the bladder, for removing fluid. This left them at an increased risk of infection. Staff needed to monitor their fluid input and output to ensure they were drinking enough and the tube was not blocked. We identified some anomalies between input and output, for example; on 20 June 2017 input was recorded as 485 mls and output was recorded as 1400mls and on 26 June 2017 710mls input was recorded as at 4pm but no output had been documented. We asked staff to check how much urine was in the person's bag at 4:10pm and they said it was 100mls. However, they also said they had emptied 550mls at 12:24pm, but this was not showing on the output sheet. The registered manager said the person sometimes emptied the catheter bag themselves so they could not be sure that the output record was correct. The lack of accurate record keeping regarding people's fluid intake and output meant there was a risk issues would not be identified quickly, leaving people at risk of infection.

Staff did not always seek advice from health care professionals when people's health needs changed or deteriorated. We found instances where people had choked and no advice had been sought from a speech and language therapist (SALT) regarding their swallow. Other people had fallen and staff had not always consulted with specialist nurses regarding the reasons why.

The provider and registered manager had failed to ensure that people received adequate diet and fluids to maintain their health and well-being. This was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were now weighed regularly, and when they were losing weight staff sought advice from health care professionals, such as dieticians.

At our previous inspections staff had received training but did not have the necessary skills and experience to enable them to carry out their duties. At this inspection, no improvements had been made.

There was an ongoing programme of training which included face-to-face training and online training. Staff completed basic training in topics such as safeguarding, mental capacity and first aid. Most of this training was up to date, and staff had been booked onto refresher courses in line with the provider's policy. Staff had also received training on people's specific needs such as dementia, nutrition and hydration and managing challenging behaviours. The registered manager was in the process of implementing competency checks for staff, as part of their supervision process.

Although this training was in place staff and the registered manager had failed to recognise potential safeguarding issues such as a wardrobe falling and trapping a person in their room. When people displayed behaviours that challenged staff did not always record the incidents and we observed a situation escalating when two members of staff were injured, and had not followed the basic guidance in the person's care plan. There had been several instances of choking at the service and staff did not know the appropriate action to take if this occurred.

The provider and registered manager had failed to ensure staff had the necessary skills and experience to carry out their duties. This was a continued breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff received support during formal one to one meetings with their line manager. They discussed issues that had happened in the service and reflected on their practice. New staff worked through induction training which included working alongside established staff. New staff completed the Care Certificate as part of their induction, which is an identified set of standards that social care workers work through based on their competency.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager had applied for DoLS for people when their liberty was restricted, and made new applications when some were due to expire. However, some people had conditions on their DoLS, which were not being met. Sometimes the local authority will place a condition on people's DoLS to ensure they receive care in the least restrictive manner. One person's DoLS stated, 'The managing authority should consider the importance of [the person] accessing the local community and environment outside of Tralee and look at ways this should be facilitated.' No action had been taken regarding this, and the registered manager told us they were not aware of this condition. They told us, "To be honest, no I was not aware of that. Sorry."

Other conditions, such as reviewing the administration of covert medicines and seeking advice from the local mental health team had occurred.

Some people had bedrails fitted to their beds. When bed rails are fitted they prevent people from leaving their beds easily, and this is a restriction of their liberty. Some people were able to consent to the use of these rails, and this had been documented and recorded. However, when people were unable to consent to their use no action had been taken to ensure the rails were fitted lawfully and in their best interests.

The provider and registered manager had failed to ensure that care was provided in the least restrictive manner. This was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were able to make day to day choices about what they wanted to do, eat and wear. Staff asked people for their consent before placing an apron over their clothes, to protect them when eating and entering their room.

Requires Improvement

Is the service caring?

Our findings

At our last inspection people were not always treated with dignity. People's fingernails were dirty and staff did not always speak to people in a respectful manner. Although we observed some kind and caring interactions during our inspection, we also found that this had not improved.

Some people's finger nails and clothes looked dirty, while others were better presented. One person had a large amount of facial hair and their care plan said they were unable to look after their own personal care needs. One person was wearing trousers which did not fasten at the top and this was not dignified for them. Another person's relative told us, "I bought two new tops and one has already disappeared. When I got here she was not adequately dressed and prepared to go out."

People told us that staff could sometimes be short with them. One person said, "Staff get a bit tetchy I don't think they mean it." A relative told us, "The attitude of staff has a lot to be desired not dedicated, just a standard job." Throughout the inspection we observed one member of staff being brusque or short with some people but kinder to one other person. They were observed giving people steaming food and saying "Careful-It's hot" and "Blow on it" over their shoulder. These people were living with dementia and should not have been left with food that staff felt was too hot for them to eat.

Staff did not always provide people with the support they needed to remain independent. One person had been assessed as being able to eat independently, with encouragement, as long as they were provided with aids to keep their food on their plate. We observed staff feeding this person instead. Relatives told us that they had requested assessments to ensure their loved ones were able to remain independent, and go out of the service, however, these had not always been arranged. One relative told us, "If we don't get some better form of continence control [my loved ones] independence will be at risk". Another relative reported "I have been asking for a wheelchair assessment for couple of months so I can take [my loved one out.]" We spoke with the registered manager about this and they said they would follow up on these concerns.

The provider and registered manager had failed to ensure that staff treated people with respect and dignity. This was a continued breach of Regulation 10 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At our last inspection we found that staff were not properly trained to deliver end of life care. At this inspection we read the care plan of a person who had recently passed away. There was limited information in this about their particular wishes or hopes for their last days. The end of life care plan recorded that the person would prefer to be taken to hospital if their life was coming to an end, but this had not happened. The registered manager told us that this was a clerical error and that the person had actually voiced a preference to stay at the service. Accurate records could be crucial in ensuring that people's last wishes were respected and is an area for improvement. Other people's care plans contained scant information about any personal wishes they may have or things which staff could do to make their final days as pleasant as possible, through, for example their choice of music being played or favourite tastes being provided.

The provider and registered manager had failed to ensure that people received care in line with their preferences at the end of their life. This was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that staff were kind and caring. One person said, "They're good girls they keep us under control." Other people said, "I'm quite happy" and, "I am very pleased, very happy friendly atmosphere."

People were supported to stay in touch with their friends and relatives and visitors were always welcome at the service. A relative told us, "I'm welcome anytime, I have been asked if I would like dinner and I was invited to Christmas dinner."

People's care plans and associated risk assessments were stored securely and locked away so that information was kept confidentially. When we asked questions about people staff answered in a quiet voice so not everyone was able to hear.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection the provider had failed to establish and operate an effective process for managing complaints. At this inspection, improvements had not been made. The registered manager told us there had been no complaints since our last inspection. However, relatives we spoke with told us they had made complaints that had not been resolved. One relative told us they had complained as their loved one had requested a fridge for their bedroom and had still not been given one. In the minutes for a relatives meeting, dated 21 February 2017, it was recorded that the person had requested a fridge. We spoke with the registered manager about the fridge, and they said, "To be honest I had completely forgotten about it. I will deal with it." Other concerns or requests, such as referrals being made to healthcare professionals and preparing people before their loved ones visited were also not recorded or formally responded to. Without a record of these concerns and the themes and outcomes there was a risk that the registered manager would not be aware or forget about them and therefore, not use them to improve the service.

The provider and registered manager had failed to establish and operate an effective process for managing complaints. This was a continued breach of Regulation 16 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

No new people had moved into the service since our last inspection. People's care plans had been reviewed by staff and the registered manager. However, when people's needs had changed, such as an increased risk of choking or falling their care plans had not always been updated accordingly.

When people displayed behaviour that could be challenging incidents were not consistently documented and recorded. This meant the registered manager was unable to analyse them to look for any trends, patterns or triggers.

The provider and registered manager had failed to involve people and their relatives in planning their care and people did not always receive person-centred care. This was a continued breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Care plans included basic information about people's preferences such as what time people liked to get up and go to bed. There was information from people and their family members about each person's life history. This included past events and achievements and things that had been important to people before they moved into the service. The activities co-ordinator spoke to us with knowledge and understanding about people's different interests.

During the inspection people participated in a range of activities. There was a lively and active music session during the morning of the inspection. Music played and people enjoyed listening to it, singing and laughing. One person stood up and sang in front of the whole group and people cheered and clapped when they were finished.

The activities co-ordinator told us they also took part in a range of one to one sessions with people. One

person enjoyed reading the book, 'little women' and another person enjoyed talking about their trips abroad. The activities co-ordinator spent time with people each day talking about the things that were important to them. One person told us, "They, [the activities co-ordinator] are good, aren't they?"

Staff had recently organised a 'Mocktail Hour' event for people. We were shown pictures of people smiling and enjoying a range of non-alcoholic cocktails. Some people were eating slices of frozen watermelon jelly and others were drinking brightly coloured drinks from a range of interesting glasses. The activities co-ordinator told us that it had been an interesting and unusual way of encouraging people to drink as much as possible.

Inadequate

Is the service well-led?

Our findings

At our previous inspections in July and December, there was no registered manager in place. There had been a lack of direction and guidance for staff and the management team had failed to identify the issues we highlighted. People's feedback regarding the service had not been sought. Some records were not accurate and not up to date, such as food and fluid charts and the support people needed with eating and drinking. The systems and processes to manage complaints was not effective. Incidents and accidents had not been analysed to look for any similar themes or patterns in order to adjust support to reduce further incidents. At this inspection improvements had been made, in some areas, however, there were still significant shortfalls relating to risk management and some continued breaches of regulations which needed to be addressed.

People and their relatives told us that they felt the new registered manager had made a positive impact on the service. One person told us, "The new manager is stricter and she gets things moving." Another person said, "It's improved a lot since this manager took over they've spent a lot of money on the place. Put pictures up and generally made it look nicer." Relatives told us, "The manager is regularly around the home, in fact she let me in today." And, "The new manager is brilliant I have noticed changes for the better."

Staff said they felt able to speak out with any concerns and that the registered manager would listen to them. One staff member told us the registered manager was, "More involved and more confident and they are very approachable and they do listen." The registered manager told us they attended regular meetings with the managers of the provider's other services, so that good practice could be shared between them. However, the registered manager had only been in post for six months so it was too early to see that improvements had been embedded or sustained.

Auditing had been carried out but was not always effective; for example, medicines audits did not include checks of medicines cupboards for topical creams or that all allergies had been transposed to MAR.

The falls audit carried out by the registered manager had been purely a numeric exercise in recording the number of falls each person had in a month. The audit did not go far enough to assess when and where these falls were happening, so that the registered manager could take action to prevent further falls occurring where possible.

The registered manager, area manager and provider checks had not identified the lack of proper mitigating actions in risk assessments about choking, falling and challenging behaviour. Although statutory notifications had been sent to CQC about repeated physical incidents between the same people, there was no action plan in place to try to prevent contact between these people as far as practicable. There had been no proper risk assessment following a wardrobe falling and trapping a person in their room, no actions to remedy the situation and make it safe and no service-wide audit of other people's furniture to ensure it was safe.

A firm of consultants had carried out a mock inspection of the service on 17 May 2017. Their findings

included that there were no MCA assessments or best interest decisions for bedrail use, that care plans did not demonstrate people and relative involvement and that an environmental safety risk assessment should be undertaken. An action plan was produced for these areas but they had not been effectively addressed by the date of our inspection almost six weeks later.

The area manager's monthly audit dated 1 June 2017, did not highlight the issues found at our inspection, although it did result in an action plan for other matters. The registered manager told us that they carried out an informal call bell audit by pressing a buzzer and waiting to see how long staff took to respond. However, they had made no records to document these checks or the outcomes.

Following the inspection the registered manager sent us a 'Guide to choking' which had been disseminated to staff and a 'Choking quiz' with true or false answers for staff to complete. No information was provided about how staff performed in this quiz. Similarly a handout and quiz about nutrition had been passed to staff.

The provider and registered manager told us they had asked for feedback from people, their relatives and other professionals involved in the service since our last inspection. However, this feedback was unavailable at the inspection. No analysis had been completed on this feedback to look for any trends or areas for improvement. A relative told us, "We have had a couple of questionnaires since the new manager has been here and I believe they have residents meetings every three months."

The systems in place to assess, monitor and drive improvement in the quality and safety of the service were not effective. The provider and registered manager had failed to mitigate the risks relating to the health, safety and well-being of people. The provider and registered manager had failed to keep an accurate, complete and contemporaneous record in respect of each service user. The provider and registered manager had failed to act on feedback from relevant persons. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had notified the Care Quality Commission of important events as required.