Veecare Ltd

Tralee Rest Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
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 25 and 26 January 2017 and was unannounced.

Tralee Rest Home is registered to provide personal care and accommodation for up to 36 people. There were 21people using the service during our inspection who were living with a range of complex needs with some people 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 seating and a TV for people and a separate, quieter lounge. There was a small dining room in which people could take their meals. Accommodation for people was on two floors and a lift available for access.

A registered manager was not in post. 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. A new manager was in post who had been employed at the service for three weeks. The manager and area manager were based at the service to assess and implement improvements required.

Tralee Rest Home was last inspected in June 2016, when it was rated as Inadequate and placed in 'Special measures'. Following that inspection we took enforcement action. Positive conditions were placed on the service on 9 September 2016. These were to not admit any person to the service without the Commission's prior written agreement. They are required to send monthly audits of care plans and risk assessments, mattresses and air pump settings. The Commission received these audits as requested along with an action plan of how they would make improvements to the service. This inspection was to see if the improvements had effected the change required to meet the regulations.

At this inspection in January 2017 we found continued breaches of the Regulations and the overall rating of the service remains 'Inadequate'. The service therefore remains in 'Special measures'. Services that remain in special measures will continue to be kept under review whilst we consider what action we take under our enforcement procedures. The expectation was that the provider found to have been providing inadequate care should have made significant improvements between now and the last inspection in June 2016. For adult social care services the maximum time for being in special measures would usually be no more than 12 months.

People were not protected against identified risks to their health, safety or well-being. This included risks associated with the control of infection. The cleaning regime throughout the home was ineffective in ensuring all areas of the service and equipment was clean and controlled the risk and spread of infection.

The management of medicines was unsafe and people were at risk of not receiving medicines prescribed to them by their GP. The storage, administration and recording of medicines did not follow recommended

guidance to keep people safe from harm.

Staffing levels remained insufficient to support the needs of the people at the service. Some essential training had been delayed and staff did not all have the necessary skills to enable them to carry out their duties and provide effective care and treatment for people.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. Staff understood how to follow the principles of the MCA had been appropriately sought. Staff had received safeguarding vulnerable adults training. However, safeguarding concerns had not always been raised with the local authority.

Staff were focused on completing tasks and not how they treated people. People were not treated with dignity and respect. They did not consider how their actions had an impact on people's well-being. However, some staff treated people with kindness and consideration.

Care plans were person-centred and detailed but they were not always an accurate reflection of the care people received. Information about people's life histories had been complied but was not accessible to staff. People engaged in a variety of group and individual activities.

Regular checks of equipment and services took place to ensure the environment was safe for the people who lived and worked at the service.

People were referred to health care specialists such as opticians, doctors and chiropodists as required. However, People's nutrition was not effectively monitored and supported to ensure they received sufficient amounts of food and drink.

The complaints process was not effective as concerns raised had not been recorded and the complaints log, which was used to record how a complaint was responded to, could not be found.

The service was not well-led and quality assurance processes had continuously failed to identify a range of issues highlighted by the inspection. Records did not reflect the care that was to be provided to people to keep them safe from harm.

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.

The management and administration of medicines was not effective in keeping people safe.

The premises and equipment were not clean and sanitary to manage and control the spread of infection.

Risks to people's well-being had not consistently been minimised.

Appropriate checks were undertaken before staff started to work at the service. However, there were not enough skilled and competent staff on duty to support people and keep them safe.

Is the service effective?

Inadequate

The service was not effective.

People had access to community health care professionals when needed. However, nutritional advice had not always been followed to ensure people's health and well-being.

Staff did not all have the necessary skills, training or supervision to support people with their individual needs.

Staff understood how to follow the principles of the Mental Capacity Act (MCA) 2005 and Deprivation of liberty safeguards.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect. People were not always involved in day to day decisions about their care.

Not all staff delivered support with consideration and kindness.

Some adaptations had been made to the environment for the benefit of people living with dementia.

Is the service responsive?

Requires Improvement

The service was not responsive.

Care plans were written in a person-centred way; however, they were not always reflective of the actual care given to people.

The management of complaints was not effective in ensuring any shortfalls in the service were identified and acted on.

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

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not made improvements since the last inspection despite the conditions imposed.

Systems were in place to assess the quality and safety of the service. However, the provider had not addressed the safety and quality issues that had been identified.

Records relating to people's care and treatment were not fit for purpose or easily accessible.

The management and leadership of the service had not been consistent. There was no registered manager.

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 25 and 26 January 2017 and was unannounced. The inspection was carried out by two inspectors. Before the inspection, we looked at information about the registration of the service and 'notifications' about important events that had taken place at the service. A notification is information about important events, which the provider is required to tell us about by law.

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 looked at the environment of the service including the bathrooms and some people's bedrooms. We spoke with five care workers, including senior, night and agency carers, the area manager, the manager, the activity coordinator, the cook, the laundry assistant and two cleaning staff. We also received feedback from two representatives from the local authority and three health care professionals.

We looked at eight plans of care and spoke to the person or staff about their care needs and where possible, observed the support they received. This was to help us understand people's experiences of the service. We also reviewed other records including the staff rota, training and supervision records, recruitment records of eight staff, medicines records, risk assessments, daily notes, accidents and incident records, behaviour charts, mental capacity assessments, safeguarding referrals, cleaning schedules, quality audits and the complaints policy.

Inadequate

Is the service safe?

Our findings

A relative told us, "There aren't enough staff right now as they have recruitment issues". At times people appeared relaxed and at ease, but at other times some people were agitated which had a direct impact on the safety of people and staff.

At our last inspection in June 2016 there were not enough staff to meet people's needs. At this inspection there had been no improvement. It had been assessed that four care staff were sufficient to meet people's needs during the day and there were four on duty on the first day of our inspection. The area manager was not part of the staffing quota, but told us that as they were based at the service they supported people to eat, served meals, completed food records and directed staff. On the first day of the inspection the area manager had to direct staff in the lounge on how to support one person to eat and advised one person required specialist cutlery and with which hand the person ate. Despite the extra staff during the lunchtime the area was chaotic and people were rushed. People became agitated and unsettled and one person drank another person's drink because staff were not present to observe and respond appropriately to people's needs.

On the second day of the inspection two extra staff were made available to support people. The activity coordinator was deployed to support people to eat and there was an additional agency member of staff. As a result of this extra staffing the mealtime was calmer and more relaxed. However, extra staff including the management team and activity coordinator were not on duty at the weekend. Therefore, there was not sufficient staff on duty at all times to meet people's assessed needs.

During the inspection call bells rang for long periods of time at different points throughout the day. This had a direct impact on the quality of care people received. On one day a senior staff member, who was administering medicines, was interrupted on three separate occasions to support people. On one occasion they left the medicine round to defuse a volatile situation which the staff involved in were not competent to address. As a result there were 12 missed signatures on the MAR as the member of staff was not able to focus on administrating medicines. This was unsafe practice and demonstrated there were not enough staff on duty to meet people's needs.

Prior to the inspection the Commission received information of concern that there were not enough staff working in the service. It had been assessed by the management team that three staff were needed at night to meet the needs of people. However, there were three occasions since 12 December 2016 when there were only two staff on duty at night and two occasions when the afternoon shift was one carer short. This meant that staffing did not meet the levels assessed as necessary within the service.

The provider failed to provide sufficient numbers of staff to meet peoples assessed needs. This is a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in June 2016 people's bed mattresses had not been cleaned adequately and the laundry facilities were not operated appropriately. At this inspection the laundry had improved, however,

people's mattresses remained dirty and unhygienic. Some mattresses were found to have stains on them which appeared to be caused by faeces or urine. Beds had been made in some rooms without domestic staff first cleaning the stains from the mattresses. The previous manager had reminded staff to wipe the beds with an antibacterial before placing clean bedding onto them, at a staff meeting in September 2016. A cleaning schedule was in place but it did not include the mattresses. The manager instructed cleaning staff to strip all the beds and disinfect every mattress in the early morning of the second day of our inspection and replaced some mattresses. Domestic staff told us "There's just not enough of us-there's so much to do and we can't manage". Although the odour in the service was less noticeable since our last inspection, there were still some areas where it remained, such as the downstairs corridor.

People were not provided with a clean environment in which to live in. Two toilets contained faeces on the floor and therefore were not fit for purpose. Dried faeces were also seen on the frame and seat of a commode chair. Cleaning schedules did not include commodes, although some were in use in the service. This created the potential for them to be overlooked when carrying out the cleaning of the service. Dried faeces was identified by the front door. A member of staff had picked up the newspaper beside the faeces and had not taken any action. It was only when the inspector drew the manager's attention to it that they were disposed of and the area cleaned. The staff said they did not know how this occurred and were unaware of the issue. At a staff meeting on 14 September 2016 the previous manager had stated that a contractor had refused to collect hazardous waste from the service the previous week because of the faecal matter at the bottom of the bin.

The premises were not managed so that facilities enabled the prevention and control of infections. On two occasions during the inspection two different care staff directed the inspector to walk through the kitchen where food was being prepared, to get to the manager's office. The area manager directed the inspector to their office through the garden. They stated all staff had been advised to take this route when accessing their office or the staff room, in line with infection control procedures at the service.

Cleaning staff described to us how they cleaned the toilet, then the sink and then made the person's bed whilst wearing the same pair of latex gloves. This posed a risk of cross-contamination between areas. When faecal matter was found on some floors at the service, the manager had to direct cleaners to use gloves and aprons to clean it and to disinfect the floor. Laundry staff used household kitchen gloves to sort washing instead of disposable gloves, which posed the risk of germs being transferred between items. Staff told us they had always used this type of glove. The manager said that latex gloves must be worn so that they could be thrown away between tasks. A senior staff member of staff had to be reminded by the manager to wear an apron and gloves when empting one person's catheter bag.

People had not been allocated an individual sling which they were required to use when being moved by hoisting equipment. Instead people shared slings which posed a risk of cross-contamination. The area manager told us that there was no cleaning schedule in place to show when these slings had been laundered. One sling was found to be ripped and with the foam inner exposed. The manager disposed of this sling during the inspection. This posed a risk of infection and also failure of the sling should it have been used.

The failure to assess, prevent and the control the spread of infections is a breach of Regulation 12 (1)(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in June 2016 the management of medicines was unsafe. Medicines were not stored appropriately and staff did not always check to ensure people had taken their medicines. At this inspection there had been no improvements. There were a number of gaps on medicine administration records (MAR)

for the month of January. The service had not carried out checks to ensure if people had been given their medicines as prescribed by their doctor, or if staff had omitted to record when they had given people their medicines.

Medicines were not stored appropriately and there was not a clear audit trail of medicines entering and leaving the service. People were placed at risk of not receiving their medicines as prescribed. The medicines room contained a box of medicines due to be returned to the pharmacy, but there was no record of the amounts of each medicines being disposed of. The area manager told us that some of these medicines were still in current use for people. One person had missed a dose of their anxiety medicine as it had been placed in the returns box. Guidance for staff about where to safely keep people's creams was in place, but not always followed. For example, a pain-relieving gel and steroid cream was stored in an unlocked medicines cabinet in two people's rooms. Another person's room contained a prescription medicine that had been prescribed for another person. There was a risk that some people may not know what the cream was for and it maybe inappropriately used. Creams prescribed for other people may not be safe to use on others and is not best practice. Medicines prescribed for an individual should not be used for anyone other than the person for whom it is prescribed.

The recording for controlled drugs, medicines which are at a higher risk of misuse and therefore need closed monitoring, was not accurate. One person had been prescribed strong medicine for pain relief once a week. However, records showed that they had received two per week on two separate occasions. We brought this to the immediate attention of the area manager. The area manager concurred with our findings and was unable to offer an explanation for the anomaly. They did not inform us during the inspection of any additional measures they had put in place to minimise any reoccurrence.

People's creams had not been applied as prescribed. For example, one person had been prescribed several creams. On three days before the inspection records showed that no creams had been applied and on two days one cream for a skin condition had only been applied once, rather than twice a day. Another person had a cream for a skin condition requiring application twice daily but there were only two documented applications in the week prior to the inspection. There were no body maps in place to guide staff to which part of a person's body a prescribed cream should be applied. The provider was not ensuring that best practice guidance was being followed as advised by the Royal Pharmaceutical Society and placing people at risk of harm.

Information on three people's MAR did not contain essential information about their known allergies to medicines. In each person's section on allergies it was recorded as 'None known'. However, one person had an allergy to penicillin, another person to codeine and two other medicines and a third person to three medicines. There was a risk that people might be given medicines which could cause adverse side-effects because these details were not consistently recorded.

The provider had not ensured the safe management and administration of medicines. This is a continued breach of Regulation 12(1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection in June 2016, people were not protected from abuse as there was not a robust system in place for raising safeguarding alerts with the local authority. At this inspection, the service had informed us of safeguarding incidents and the action they had taken to help keep people safe, such as seeking advice from relevant professionals. Staff had received training in how to recognise and report different types of abuse. They said any changes in a person's behaviour or body language could be an indication that something was not right with the person which they would report to a more senior member of staff. They

also knew to report other concerns about people's safety, such as if a person had fallen. After a fall, the manager completed checks to ensure that the person had recovered well and to assess if any further action could be taken to prevent any further occurrences where possible. Staff knew how to "blow the whistle" and would follow the provider's policy. They felt confident if they raised a concern they would be listened to by the area or home manager. However, if their concerns were not taken seriously, they said they would contact the provider, local authority or Care Quality Commission.

At our last inspection in June 2016, actions to minimise identified risks to people had not always been carried out. At this inspection there had been not been sufficient improvement. For example, one person had risk assessments in place about their behaviour which could sometimes be challenging to themselves or other people. Their plan gave guidance to staff that specific triggers, such as noises or waiting for things to happen could unsettle them leading to them exhibiting or escalating these identified behaviours. On the first day of our visit this person waited 15 minutes for their pudding before being guided to the noisy lounge where the cleaners were vacuuming the room and the TV was switch up loudly. This caused the person to become aggressive and subsequently injured a member of staff. The staff had failed to spot the triggers to prevent the incident from occurring.

Equipment people used to help prevent pressure wounds from developing and to maintain healthy skin had not been set at the correct levels for people's weights. For example, one person's cushion was correctly set for their weight, which was 43.8kgs, but their mattress was set to 85kgs placing them at risk. Another person weighed 47.3kgs but their cushion was set at 80kgs. This meant people were placed at risk of skin damage due to incorrect setting of their pressure relieving equipment.

The failure to take actions to minimise identified risks to people is a breach of Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A number of checks were carried out on potential applicants to ensure they were suitable for the role. This included obtaining a person's work and/or character references, their employment history, and Disclosure and Barring Service (DBS) check. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff files now contained a current photograph as recommended at the last inspection in June 2016. The provider operated safe recruitment practices in line with best practice.

Regular checks of equipment and services took place to ensure the environment was safe for the people who lived and worked at the service. This included safety checks on the supply of gas and electricity. Visual checks and servicing had been undertaken of fire-fighting equipment to ensure it was fit for purpose. It had been identified that some emergency lighting needed to be replaced and new ones had been delivered to be installed.

A fire drill had taken place using a scenario where the main exit route was blocked so staff had to move people away from the area of danger. Further drills were planned to ensure all staff knew what to do if a fire occurred. Each person had a personal emergency evacuation plan (PEEP). PEEPs set out the specific requirements that each person had, such as staff support or specialist equipment, to ensure they could be evacuated safely in the event of a fire.

Inadequate

Is the service effective?

Our findings

At our last inspection in June 2016 people's nutritional needs had not been consistently met. When people had lost weight, although the advice of a dietician had been sought, it had not always been accurately followed. At this inspection there had been no improvements. In December 2016 one person had lost weight. It was recommended they should be given a high calorie diet consisting of milky drinks with milk powder twice a day and cream added to their food. This information was not kept in the person's care plan where it was accessible to staff, but in a separate file held in the manager's office. Staff knew this person required cream in their food such as in their porridge, but did not know they also required milky drinks. Staff did not understand the reasons why this person required these high calorie foods and therefore, may not know what action to take if the person refused these foods or drinks.

People were not monitored effectively to ensure they received sufficient amounts of food and drink. One person, their care plan stated they should be supported to 'drink plenty' but a description of how much plenty was, had not been included. It had been assessed that this person was at risk of malnutrition and therefore a food and fluid chart had been put in place. However, the chart only included what the person had been offered not what they had eaten and so was not an accurate record. Staff completed records of what people had eaten for lunch in the middle of the afternoon. It was clear from their discussion that staff could not clearly recall what people had eaten or drunk. Therefore, records were not an effective tool in assessing whether people had eaten and drunk sufficient to keep them healthy.

On the first day of the inspection lunchtime was chaotic and people were rushed. People did not always receive the support they needed to eat and drink. One person ate using only one hand in which they held a knife. Their plate slipped on the table as they ate and most of their lunch was pushed off the plate and onto the table or floor. Therefore they ate very little of their lunch. They had lost around 12kgs in the last year and had consistent recent weight losses. However, their care plan said that they 'continued to eat well'. The plan also stated they should be offered encouragement and prompting to eat but this did not happen on the first day of the inspection. The inspectors highlighted these issues and on the second day of the inspection the person was supported to eat and referred to a dietician for advice about their weight loss. Action would not have taken place to improve this person's well-being, without the input of the inspection team.

We found during our inspection that people were not supported consistently. For example at a team meeting in December 2016 staff had been advised who required specialist cutlery to assist them to eat independently. On the first day of the inspection one of these people used special cutlery but on the second day they used standard cutlery. Another person was given very large pieces of meat which they were unable to manage. Therefore, people were not given the appropriate and consistent support they required at mealtimes.

The provider failed to ensure that people received adequate diet and fluids to maintain their health and well-being. This is a breach of Regulation 9 (3) (i) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

A relative told us, "The Food is really good and my family member can have more if they want". There was a four weekly rolling menu with two options at lunchtime and a hot or cold option at tea time. Staff used photographs of each meal to help people choose what they wanted to eat. The cook held information about each person's likes and dislikes and special requirements such as if they were diabetic or required a soft diet. The menu displayed in the quiet lounge was difficult to read as it was placed high up on the wall and in small print. It also did not accurately display what was on offer on the first day of the inspection.

On the second day of the inspection the mealtime was calmer as additional staff were available to support people. Staff explained to people what they had to eat, asked if they had had enough or if they wanted more to eat and encouraged people to eat. For example, for one person with a visual impairment staff guided their hands to feel where the salt and pepper were and to safely take their drink. Another person left the table to go to the toilet and staff reheated their meal so it was hot on their return.

At our last inspection in June 2016, staff had received training, but it had not always been effective. Medicines administration had not always carried out safely, people had not been consistently assisted to move in ways which met best practice guidelines and poor Mental Capacity Act (MCA) understanding had led to consent being inappropriately sought from people. At this inspection people were not consistently assisted to move in ways which met best practice guidelines. One staff member attempted to assist a person to their feet by pulling on both of their hands, but this person resisted. Another member of staff attempted to guide a person by holding both of their hands whilst walking backwards. This person said they did not feel comfortable being supported in this way so the member of staff then supported them in a safe way.

Domestic and most care staff had received training in infection control but had not put these skills and knowledge into practice. None of the staff team had received training in nutrition as recommended at the last inspection. Staff had not received the training they required in a timely manner. Some people exhibited behaviours that challenged themselves and others. Only Seven out of 14 staff had undertaken training in this area. Although additional training had been planned for March, new staff had not received this essential training as part of their induction.

On the first day of the inspection one person became aggressive towards a member of staff and a member of care staff tried to intervene. As a result of their intervention and lack of training the member of staff sustained an injury. Staff were required to record what happened before, during and after such an event. This was to monitor any triggers to the person's behaviour and what interventions worked well in calming the person. Records were not always completed which meant there was an incomplete picture of the person. This resulted in ineffective actions being taken to minimise reoccurrence.

A training matrix was in place which identified when staff had received the training they required for their role and highlighted when it required to be refreshed. The service had identified that there were a number of gaps on the training rota. A series of training dates had been booked for January, February and March to ensure staff had the training they required for their role. We asked the provider to send us details of the qualifications of the company's quality assurance and policy manager who delivered training at the service. They provided us with certification that they were a train the trainer in fire, infection control, moving and handling and mental capacity. However, there were no processes in place to assess staff's skills and knowledge once they had completed any training, such as spot checks and competency assessments.

The failure to ensure staff had the necessary skills and experience to enable them to carry out their duties is a continued breach of Regulation 18 (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

New staff completed an in-house induction which included gaining knowledge about the service's policies and shadowing a senior staff member to gain more understanding and knowledge about their role and undertaking training in essential areas. If staff were new to care they commenced the Care Certificate through Skills for Care. The Care Certificate includes the standards people working in adult social care need to meet before they are assessed as being safe to work unsupervised.

Most staff, including domestic staff had undertaken specialist training in supporting people living with dementia. Three senior staff had had specific training in supporting people who had diabetes.
Five out of 14 care staff team completed a Qualification Credit Framework (QCF) level 2 or above and a further staff member was part way through the award. To achieve a QCF, staff must prove that they have the ability and competence to carry out their job to the required standard.

The area manager had reintroduced staff supervisions in December 2016. Some staff supervisions had been completed and a plan was in place to ensure all staff received regular supervision. The area manager said they would delegate this task to the manager, once they had settled into their new role. Staff told us they felt well supported by the area manager and that they were approachable.

At our last inspection in June 2016 people's health needs in relation to diabetes had not been consistently met. At this inspection there had been improvements in supporting people living with diabetes. Advice and guidance about suitable diets for people living with diabetes were contained in their care plans and staff followed this guidance. The drinks trolley contained two tins of biscuits, one for everyone and one with biscuits that were suitable for diabetics. At lunchtime staff gave different desserts to people they knew to require low sugar options.

People's health care needs were assessed and specialist tools were used for assessing people's skin integrity. For example, there was a specific care plan in place for a person with a urinary catheter. This highlighted when the catheter bag should be changed and the signs that staff should look out for, which might indicate a urine infection. People's day to day health needs were managed by the staff team in partnership with a range of health care professionals including doctors, district nurses, and dietician. A doctor visited the service each week and told us they had developed a good working relationship with the manager. People attended regular appointments with chiropodists, opticians and dentists as necessary.

At the last inspection in June 2016 the service had not acted in accordance with the principles of The Mental Capacity Act 2005 (MCA). 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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

At this inspection staff understood the principles of the MCA and supported people to make everyday choices and decisions. This included what people wanted to wear, eat and drink. Staff sought people's consent when delivering care. For example, one staff said, "Is it ok if I cover your clothes up" before helping a person to use a food protector. Capacity assessments had been undertaken about each person's individual decisions, to determine whether people were able to make them on their own. For example, one person required bed rest due to their health needs, but often refused it. It was recorded that this person had the capacity to make this decision. Also that that staff should explain to the person the reason for the rest, so they could make an informed decision. Where people received medicines covertly, that is without their knowledge or consent, there were comprehensive records that demonstrated the person's mental capacity had been assessed and professional authority and advice sought and acted on. Best interest meetings had

been held with the person's family members and representatives, in order to make a decision for someone, who had been assessed as not having the capacity to make a specific decision.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The manager understood their responsibilities in respect of DoLs. A number of applications had been submitted to the local authority and authorisations had been received to ensure the service was was acting lawfully.

Requires Improvement

Is the service caring?

Our findings

Most people spoke positively about the caring nature of the staff team. One person described a member of staff as having, "Cold hands, but a very warm heart". Another person said about another member of staff, "She is good". A relative told us staff were kind and caring. "I wouldn't move my family member even if things were dreadful here", they told us, "My family member has been here too long to unsettle and they're happy". Staff interactions with people were mixed. Some ensured people were treated with kindness and compassion but others were disrespectful to people.

The culture of the service did not always ensure people were treated with dignity and respect or their independence was promoted. The previous manager had observed some members of the staff team did not value people, or one another. The minutes of the staff meeting in December 2016 commented on the, "Inappropriate use of language and swearing towards each other and service users". At this inspection, some members of staff continued to act in a disrespectful way to people. Whilst standing beside a person, one staff member said to another, "She doesn't want to move". At lunchtime a staff member said, "It's better not to give him his pudding yet" and another member of staff said, "This one isn't done" inferring that one person had not finished their lunch. This staff approach showed a lack of respect for the people as staff spoke about people as though they were not present and did not involve them in conversations about their needs.

Another person's fingernails looked uncared for as they were long, chipped and dirty. The manager told us they had asked staff to attend to this person's nails the previous week. However, staff had not cut this person's nails, which showed they did not feel this was important to the person's self-esteem and well-being.

Some staff missed opportunities available to them to engage with people throughout the inspection. Staff sitting in the lounge did not always attempt to communicate with people. One member of staff appeared to be bored and swung their handheld recording tool in their hand. At lunchtime another member of staff walked around the dining room, with their arms crossed, not attempting to speak to anyone. There had been a lack of continuity in the staff team and the use of agency staff, which meant that some staff were not familiar with the people they were caring for.

Staff responsible for domestic duties did not always consider peoples thoughts and feelings. These staff had undertaken training in supporting people living with dementia, but they were task- driven. One member of staff was hoovering in the lounge where people were relaxing. One person made it very clear to the staff member they were upset with the noise. The staff member responded loudly, "Well, I have to Hoover", and continued to do so until another member of staff intervened. An hour after lunch had started a team of staff entered the dining room to clean. However, a few people were still seated at the table. A member of staff cleaned the floor under the table where one person was sitting without letting either person know they were going to do so.

Staff did not always uphold people's confidentiality. Two members of staff supported a person in their

bedroom. Whilst doing so they had a conversation about other people who used the service, referring to them by name. This conversation could be heard by the person in their room and also in the outside corridor, so anyone walking past the room could hear the content. This was unprofessional and did not treat people's private information confidentially.

Staff and people's written records sometimes used labels as the main way to describe a person. One person's care plan stated they were, 'Acting up', when detailing information and guidance about the behaviours they presented. One staff member said to another member of staff that a person was, "On one today". This was an unprofessional and disrespectful use of language which did not value the person as an individual.

The failure to consistently treat people with dignity and respect is a breach of Regulation 10 (1) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection a recommendation was made to consider providing end of life care training to ensure people received the best experience and support in their last days. However, staff had not been provided with this training. A health care professional told us the service had not acted on people's wishes and choices at the end of their lives. They explained that one person had made their views known they wished to end their days at the service. The professional told us the previous manager ignored their wishes and attempted to make arrangements so they could die in hospital. Health professionals involved in this person's care ensured this person ended their days at the service, in accordance with their wishes. Although there was no one receiving end of life care at the time of the inspection, end of life plans did not contain detailed information about people's wishes. They focused on what would happen after their death, such as funeral arrangements, rather than how people wanted to be supported whilst at the service. Therefore, it could not be assured that people would receive support, according to their preferences at the end of their lives.

The failure to take people's preferences into consideration when planning care and treatment is a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014

There were times when we observed that people were treated with kindness and compassion. One person had limited vision. Staff positioned themselves so they were on the same level as them and the person could see their face when speaking to them. Another person got upset and started to cry. A staff member directed this person's attention away from what was concerning them and spoke to them about the visit from the music man that was taking place that afternoon. One staff member gently reminded a person that their slippers had come undone and helped them to tighten the fastening. Staff had been complimented for caring and for their kindness. Thank you cards received included the comments, "Thank you to you and your caring staff at Tralee", and "Thanks for your first class dedication".

Staff helped to make people feel they were valued. A member of staff was supporting a person to walk from the dining room to the lounge. This person said to the member of staff, "I'm not a quick mover". The staff member responded, "That's fine. I'll go at your pace". They reassured and spoke to the person whilst supporting them. One person was celebrating a birthday. Staff sang 'Happy Birthday' to them and arranged for their choice of special meal to be provided.

Positive relationships had developed between people and some staff. Staff used appropriate touch to show affection when talking to people, such as gently placing their arm on a person's shoulder. Some staff chatted with people in a relaxed manner and the conversations involved exchanges of laughter. One person gave a member of staff a kiss to show their affection. Another person's face lit up every time a member of

staff spoke with them.

There had been some adaptations to the service to help people living with dementia. There were picture signs to identify the lounge, dining room and toilets. Toilet seats were a bright colour so that people would be reminded of their location. People had their names and a picture on their bedroom doors if this was helpful to them. A notice board showed the date and what was available for lunch in photographs so it was easier to understand.

Requires Improvement

Is the service responsive?

Our findings

A relative told us that if they had any concerns or complaints about the service, they would speak to the manager. They said a new activities coordinator had been employed who engaged people with, "Better activities". There was a lack of consistency in how well the service responded to people's care, treatment and support.

At the last inspection in June 2016, people's care was not delivered according to guidance in their care plan. At this inspection no one had moved to the service, so initial assessments of people's needs had not been carried out. People's care plans had been reviewed and updated but people and/or their relatives had not always been involved in this process. People did not always receive the care as set out in their plans of care. One person told us they had been waiting, "For ages" for staff to come and empty their bag as it was very full. They said it was important staff emptied it before it became too full otherwise it gave them a stomach pain. Staff had not followed the guidance in their care plan about catheter care. Another person's plan advised that when they banged their cutlery at mealtimes, they should be given plastic utensils and a staff member sit next to them to calm them. Staff spoke to this person at lunchtime and they calmed, however, as soon as they left the person continued to bang their cutlery. This person remained agitated throughout most of the meal and staff did not follow their plan of care and sit with them throughout the meal. Guidance in people's care plans had not been followed to ensure they maintained healthy skin or received adequate nutrition.

The failure to ensure that care was delivered in line with care plans is a breach of Regulation 9 (1) (a) (b) (c) (3) (a) (b) 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. The activity coordinator had obtained information from people and their family members about each person's life history. This included past events and achievements which together gave a clear pen picture of each person and their personality. Life history's provided staff with an overview of each individual so they knew how to engage them in conversation that was meaningful. However, the files were not readily accessible to staff as they were locked in the medicines room to which only senior staff who administered medicines had access.

There was not a robust system in place for managing complaints. Details of how to make a complaint about the service were displayed in the entrance hall. However, there were no formal, regular opportunities for people or their relatives to raise any concerns or complaints, such as at resident or relative meetings. Therefore, the service did not actively encourage people to share their experiences. The service's complaints policy stated that a written record should be made of all concerns raised. However, the complaints log was not available at the service. The provider told us that some paperwork, including the complaints log had, "Gone missing". The area manager said that they had received some concerns from relatives, but these had not been logged onto a complaints form in line with the service's complaints policy. Therefore, there was no evidence to show how the service had investigated and responded to any complaints. The area manager contacted us a week after the inspection to say that the complaints log had

been found and that there had been one complaint since the last inspection.

The failure to establish and operate an effective process for managing complaints is a breach of Regulation 16 (1) (2) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

An activity coordinator was available to engage people in activities from 10am to 3pm each week day. The weekly programme of activities was displayed in the lounge in words and pictures so it was easier for people to understand. The coordinator explained that this programme was flexible and could be changed if people wanted to do something else on the day. The programme included pampering, book club, fun and games, art and craft, film, sing along, reminiscing and ball games. Each person had an individual activities record that showed the things they liked to do and documented those events in which they had taken part. People were also offered one to one activities, particularly those people who did not enjoy group events. These varied according to people's preferences. A musical entertainer visited the service on the afternoon of the first day of the inspection. People sang along and one person, who usually preferred to spend time in their room, came to join the experience. A valentine themed event had been planned and the service was on the waiting list for 'Pets as Therapy' (PAT). PAT aims to improve the lives of people, including those living with dementia, by including animal assisted interventions as part of a holistic approach to treatment. Therefore, people were given opportunities to engage in a range of group and one to one activities.

One person had lived at the service for over a year, but their religious beliefs had only just been responded to. The activity coordinator had discovered in the three months they had been working at the service that they were not able to travel to a place of worship to practice their religion. They contacted a local church which practiced their faith and made arrangements for them to be visited by one of its members each week. This person also played the organ, which they kept in their room. The activity person played their saxophone whilst this person played the organ. They and other people at the service had enjoyed the experience. "I feel if I go home having made a difference to people, then I have done my job", the activity coordinator told us.

Inadequate

Is the service well-led?

Our findings

One person said about the new manager, "They are here to sort everything out". A relative told us, "Things are better now. You have to give staff the benefit of the doubt. It takes time to get things right".

Following our last inspection in June 2016, significant shortfalls were found in the governance of the service. The issues related to the management of medicines, unclean equipment and environment, lack of staffing, some staff training not being effective, people's health and nutrition needs not being consistently met, care plan guidance not being followed, risks to people not always minimised, people's dignity not always respected and people's rights not being protected by the Mental Capacity Act (MCA) 2005. We took enforcement action in the form of imposing conditions on the provider's registration. These were not to admit any person to the service without the Commission's prior written agreement; and to send monthly audits of care plans and risk assessments, mattresses and air pump settings. The report the provider sent us in January 2017 stated that care plans had been reviewed, medicines audits were undertaken three monthly, pressure relieving equipment and bedrooms were checked daily and listed any actions taken to address any areas of concerns highlighted. At this inspection although we found that staff now understood how to follow the principles of the MCA, improvements had not taken place in any of the identified areas and therefore people continued to be placed a risk of harm. The actions the provider told us they had taken were not effective at improving the safety and quality of care people received.

At the last inspection in June 2016 auditing processes in place to assess, monitor and improve the quality and safety of the service were not robust. At this inspection there had been no improvement. There were a number of audits in place with regards to mattresses, cleaning schedules, bedroom checks and medicines but they had not picked up the shortfalls found at this inspection. For example, mattresses had been checked as part of an audit process on 4 November 2016 and infection control rated as 'acceptable'. Mattresses were checked again on 18 January 2017 and been found to be in a good state of repair. However, soiled and urine stained mattresses had been identified at this inspection. The auditing process for the service had therefore failed to identify the issues we found during the inspection.

The provider had failed to ensure that their systems and processes in place were operated effectively to ensure compliance with the regulations and improve the experiences of people. This is a breach of Regulation 17 (1) (2) (a) (b) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

At the last inspection in June 2016, there was not an effective process for seeking people's feedback. At this inspection there had been no improvement. There were no formal systems in place such as resident meetings or keyworker meetings for people to express their views of the service or the care they received. The last time people had been asked for their views was in May 2016 when they completed a survey. Although the results were positive, it was highlighted that a more 'Dementia-friendly' format was needed for the results to be wholly reliable. An open day had been held for relatives on 6 August 2016 where the management of the service was discussed. The manager said they intended to hold regular resident and relative meetings, but had only been in post for three weeks and therefore, had not had sufficient time to do so.

The failure to operate an effective process for seeking people's feedback is a breach of Regulation 17 (1) (2) (e) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Some records relating to people's care and treatment were not fit for purpose or easily accessible. People's food records included what the person had been offered rather than what they had actually eaten and so was not an accurate record. Care plans were not always accurate. One person's plan stated they eat well, but they had lost weight. The complaints log could not be found until a week after the inspection. One person's 'Do not attempt resuscitation (DNAR) form was not valid as their name had been crossed out and rewritten and the date of issue was not clear. A DNAR form is a document issued and signed by a doctor, which tells the medical team not to attempt cardiopulmonary resuscitation (CPR). The manager contacted the person's doctor during the inspection to complete another DNAR form. Information about people's life history was kept in locked in the medicines room and only accessible to senior staff. Accident reports were filed separately from follow up reports, which detailed the actions taken to prevent any reoccurrences.

The lack of accurate and accessible records is a breach of Regulation 17(1) (2) (c) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Since our last inspection in June 2016, the registered manager had left the service and so had their replacement. There was a new manager at the service at the time of the inspection who had only been in post for three weeks. This manager was not registered with the Commission. Therefore, there had been inconsistent leadership at the service. The new manager was still settling into the role. They had held a staff meeting to introduced themselves and give guidance about managing infection control. Changes had been made to the housekeeping role and a new menu had been implemented. They were supported by the area manager whose role was to monitor the quality of care of this service and the providers four other care homes. However, they had moved their work base to the service to offer the new manager support. The area manager told us the provider visited the service on a regular basis, but they did not make a record of their visit. The manager and area manager knew improvements were required at the service and told us they had started to address them. The provider had been submitting action plans to CQC but these were not effective and did not demonstrate a clear plan for improvement.

There had been a significant turnover of staff since the last inspection in June 2016. The head of care and a number of care staff had left the service due to the change in management of the service. These staff had worked at the service for a number of years and therefore had a working knowledge of the running of the service and knew people well. The staff vacancies had been filled by agency staff. The area manager told us that they were regular agency staff. However, one agency staff told us they had worked at the home for a month and the other agency staff that this was their first shift at the service.

The management team had reviewed the structure of the service and were recruiting to vacant posts, but there were still not enough staff to meet people's needs. Recruitment to replace staff who had left the service before the current manager had taken post had been successful. Four new staff, in a range of care roles, had started work at the service and a further six had been recruited to start work, when their checks were satisfactory and completed. Staff roles and responsibilities within the service had not been fully developed. On the first day of the inspection the area manager told us there were five senior staff. Four senior staff worked days and one senior staff worked at night time. One senior member of staff told us they were trying out the role to see if they were suitable. On the second day of the inspection the area manager told us there were only four senior staff. The management and leadership of the service needed to be reviewed to ensure all staff had an understanding of their roles and responsibilities.
A statement of the vision and values of the service were on the company website. "Our priority is to provide a supportive and welcoming environment for our residents and relatives whilst maintaining the respect and

dignity that they deserve. Valuing the contribution that each and every person can make in meeting and going beyond the changing demands of our community and regulators". However, the provider had not developed the staff team to make sure they displayed these values and behaviours towards people. People were not consistently treated with dignity, nor were their thoughts and feelings always considered when providing support. Staff did not always involve people in day to day decisions or uphold their confidentiality. As evidenced in this report, the service had not met the needs of people, upheld their rights and the Health and Social Care Act (Regulated Activities) Regulations 2014 were not being met.
Staff meetings had focused on negative feedback from the previous manager and staff had not been consulted about how to improve the service. The provider attended one of the meetings and thanked staff for supporting the service and reassured all staff the present situation in the service would improve. Staff told us the current management team were approachable and offered help and support when they needed it. They said that staff morale had been low, but that it had improved with the employment of the new manager and in the knowledge that new, permanent staff had been recruited.

At the last inspection in June 2016, statutory notifications had not been submitted to the Commission to tell us about incidents that we needed to be aware of. The service had made us aware of important events since this inspection in June 2016. At the last inspection the provider had displayed the rating of their CQC inspection at the service but not on the company's website. The service's inspection rating was now posted on the provider's website.