Trafalgar Care Limited

Trafalgar Care Home

Inspection report

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Date of inspection visit:
25 February 2021

Date of publication:
08 April 2021

Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Trafalgar Care Home is a residential care home. The home is registered to accommodate up to 29 older people in one adapted building. Nursing care is not provided by staff in the home. This type of care is provided by the community nursing service. At the time of this inspection there were 22 people living in the home.

People's experience of using this service and what we found
There was a Covid-19 outbreak at the service that resulted in the majority of the permanent staff team being unable to work. During this time, we received concerning information about the ability of staff working in the home to manage the risks people faced in relation to eating and drinking enough and keeping their skin healthy. We also received concerns about poor infection prevention and control (IPC) practices at Trafalgar Care Home. This information was initially followed up with an IPC visit on 19 February 2021 by staff from the Dorset NHS Clinical Commissioning Group (CCG) Quality Improvement Team. They made some recommendations to improve IPC within the home.

At the inspection, we noted that some improvements had been made following the CCG visit, such as some new chairs in communal areas. However, other concerns were highlighted, particularly the incorrect use of PPE by some staff members, a lack of robust oversight of cleaning and unsafe management of infectious waste.

The inspection also identified concerns about how the risks some people faced were being managed. For example, the registered manager and a senior member of the team told us that people did not appear to have been well hydrated during a period when the majority of the home's permanent team were not working due to an outbreak of Covid-19 in the home. Records did not reflect that an immediate improvement had happened since they identified this concern and records were not always accurate.

Staff reported people were in improving spirits despite the current restrictions of being cared for in their rooms. People were supported to keep in touch with loved ones via telephone, mobile phone and via the internet.

Staff had received training on how to keep people safe during the Covid-19 pandemic and had plentiful supplies of personal protective equipment. Due to concerns identified, staff were provided with refresher training following our visit.

Staff and people were regularly tested in line with the government's current testing programme. The size of the home and variety of spaces meant there were well ventilated spaces people who could not stay isolated in their rooms could spend time. This helped promote social distancing.

Why we inspected

We undertook this targeted inspection to follow up on specific concerns we had received about risk management and infection prevention and control measures at the service. A decision was made for us to visit to look at these risks.

CQC have introduced targeted inspections to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.
We have found evidence that the provider needs to make improvements. Please see the Safe sections of this full report
Since our inspection visit, the provider reported that they have taken action to improve infection prevention and control measures.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so. We have identified breaches of regulation in relation to the safe care of people living in the home at this inspection.

Please see the action we have told the provider to take at the end of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Trafalgar Care Home on our website at www.cqc.org.uk.
Follow up
We requested assurances from the provider regarding the changes they had made following our inspection visit. They told us they would send us photographic evidence of these changes by 5 March 2021. We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

At our last inspection we rated this key question Good. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

Trafalgar Care 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.

The inspection
This was a targeted inspection to check on a specific concern we had about the management of risk and infection prevention and control. We will assess all of the key question at the next comprehensive inspection of the service.

Inspection team
Two inspectors visited Trafalgar Care Home.

Service and service type
Trafalgar Care Home is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
The inspection visit took place on 25 February 2021 and was announced just before our arrival.

What we did before the inspection
We received feedback from an infection control visit carried out by staff from the Dorset NHS Clinical Commissioning Group (CCG) Quality Improvement Team on 19 February 2021. We reviewed information provided by the registered manager about the needs of people living in the home.

We reviewed information we had received about the service since the last inspection. We used this information to plan our inspection.

During the inspection
We followed up what actions had been taken to improve infection control systems.

Most people living in the home did not use words as their main form of communication. We spoke with three people who were able to tell us about their day. We also spoke with registered manager and six members of staff including care and housekeeping staff. We reviewed records related to the management of risks for seven people. We also reviewed infection control policies and procedures, cleaning records, a Covid-19 risk assessment and the findings of an infection control audit and the business continuity plan.

We continued to receive information and speak with staff through arranged telephone calls until 4 March 2021.

Inspected but not rated

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

Assessing risk, safety monitoring and management

● Following their period of isolation due to Covid-19, the registered manager and a senior member of the team had identified issues with people's intake of food and drinks when they returned to work. Their isolation period had coincided with the majority of the staff team being unable to work due to the outbreak in the home. They both told us that they had found this upsetting and that people were starting to look better now more permanent staff were returning. The registered manager and a representative of the provider told us that the importance of ensuring safe support with food and drinks was highlighted to staff on 12, 17 and 18 February 2021.

● People had drinks available in their rooms when we visited, but the system of monitoring people's food and drink intake was not effective. Records were not being used to ensure people that had been assessed at risk of dehydration and malnutrition had enough to eat and drink. One person did not have any drinks or food recorded after lunchtime on 19 February 2021. This meant the record had not informed their care and support during the remainder of the day and the night. We asked this person about their drink and they told us: "They do bring me drinks." Another person who had a risk assessment in place due to weight loss, had not had their fluid intake added up to check if they had received enough to drink on five consecutive days following the registered manager speaking to staff. The person had low fluid intake recorded on each of these days. This meant their records had not been used to inform their care and support. A senior care worker told us that everyone had been assisted with lunch at approximately 12:30 during our visit. Another member of staff explained that this person had refused their breakfast and lunch. Their food and fluid record had not been completed to indicate refusal or alternatives offered. Their daily notes referred to 'low intake'. The person's records were not sufficient to review how they had been supported.

● Records about people's diet and fluid intake were not always accurate. One person had duplicated diet and fluid intake records for the 20 and 21 February 2021. The duplicate records recorded different intake so it was not possible to review what they had eaten and drunk. Another person did not eat their main meal when we visited, and they were given a yoghurt. Their record for this meal did not indicate that they had not eaten their meal and it did not record that they were given a yoghurt. This meant that it was not possible to review what the person had eaten from the record put in place to monitor this.

● Care documentation about how to support people to keep their skin healthy did not outline clearly when people should be helped to move. The registered manager told us that unless there was a specific reason this help would be given every two to three hours. One person who could not move themselves and whose skin was at risk was not helped to move from their back for more than five hours on both the 23 and 24 February 2021. The record of their position was not used to inform their care during this time.

● Records related to creams being applied to protect people's skin could not be used to review or inform their care as they were not always completed. Staff told us they applied creams to protect people's skin, the

records did not reflect this.
● Care plans related to how to protect people's skin did not reflect people's preferences. We looked at four people's care plans outlining how they should be supported to protect their skin. These plans were identical and did not reflect their individual preferences. This meant important detail about how to keep them safe was not included.
● Oversight during the time when the registered manager was off and just after their return was not sufficient to ensure processes were followed. The business continuity plan outlined that senior management could have been present in the home. Whilst this was impacted by the Covid-19 outbreak the issues around risk management were not resolved through remote oversight. An incident of unexplained bruising was not appropriately reported, and improvements in the monitoring of food and fluids were not sufficient or sustained. This meant people were at risk of receiving unsafe care.

This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and three staff all told us that people were drinking and eating more now the team were starting to return. They told us recording was also improving. We have not yet been able to review the sustainability of any improvement.

●The provider held regular meetings for the managers of their homes to share information and support each other. These meetings included information about risk management, the registered manager described an example of learning being shared between the homes.

Preventing and controlling infection
● Staff did not always use PPE safely. One staff member was observed wearing their mask under their chin during a break and then not replacing it on return to work. Another member of staff was seen to put their mask under their nose whilst working and without changing their apron and gloves between the rooms of people who were positive with Covid-19 and those that weren't. Another member of staff also left the room of a person who had tested positive for Covid-19 without removing their apron. This put people and staff at an increased risk of transmission.
● The management of infectious waste was not carried out in line with current government guidance. There were clinical waste bags available in people's rooms. These were removed and put straight in the clinical waste bin during our visit. These bags should be stored securely for 72 hours if a person has tested positive for Covid-19, or the waste should be placed in an infectious waste bag. This put people involved in waste management at risk of transmission.
● Staff were not always taking off their PPE in a safe way. One person who had tested positive and was isolating in their room was sat by their door. Staff were removing their PPE in the person's bathroom before walking through the room and past the person. The person's bedroom door was open onto the corridor. These environmental factors increased the risk of transmission.
● The registered manager told us that cleaning was being done in bedrooms when it was necessary. Cleaning records were not available during our visit. This meant the oversight of cleaning was not robust at a time when the home was managing an outbreak.
● Actions identified by the CCG during their visit on 19 February 2021 had not all been actioned. Whilst some new chairs had been delivered other changes had not been made. Bins and toilet roll holders had not yet been ordered and staff members still hung their coats so that they touched other staff coats. The coats touching increased the risks of transmission.

This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Following our visit the registered manager explained the actions that they had taken to improve IPC in the home and assured us that they would send evidence of changes by 5 March 2021. We have not been able to check the sustainability of these changes.

● There was signage in place to remind people to maintain distance and some furniture had been moved to encourage this. Plans to improve the environment were in place and we received assurances about changes to handwashing facilities in the sluice room.
● A member of staff had been designated as an infection prevention and control lead. They had a folder which contained information about their role and responsibilities.
● Regular Covid-19 testing of people and staff was carried out at the service. This enabled the service to identify if people or staff needed to isolate to prevent the further spread of infection.
● The layout of the home and garden meant there were well ventilated spaces where people who could not stay isolated in their rooms could spend time. This helped promote social distancing.
● Staff reported that people were in improving spirits as their regular staff team returned. Following our visit we heard that people were enjoying returning to communal living as their isolation periods ended.
● The provider was working with the local infection prevention and control team to make further improvements. We have also signposted the provider to other relevant resources to develop their approach.
● Staff had undertaken IPC and Covid-19 training. Refresher training was provided following our visit.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from the risks associated with the transmission of infection.

The enforcement action we took:

A warning notice was served requiring the provider to meet the requirements of the regulation by 20 April 2021.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Records were not sufficient to ensure that risks could be managed effectively. Systems and processes were not operated effectively to ensure people's safety.

The enforcement action we took:

A warning notice was served requiring the provider to meet the requirements of the regulation by 20 April 2021.