Trafalgar Care Limited

Trafalgar Care Home

Inspection report

207 Dorchester Road
Weymouth
Dorset
DT4 7LF

Tel: 08000121247
Website: www.agincare.com/care-homes/dorset/trafalgar-care-home-weymouth

Date of inspection visit:
09 August 2021
11 August 2021

Date of publication:
18 October 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

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

People told us the staff were kind and we saw this was the case, however, staff were not deployed in a way that met people's needs. People waited for support in unsupervised communal areas and people's care plans related to safe eating and drinking and skin care were not followed.

People were not protected from the risks of cross infection because staff did not wear their PPE in line with guidance.

Environmental risks were not always well managed. A fire alarm system was silenced when damaged and this meant that when a fire started the alarms did not sound and some bedroom doors did not automatically close. Whilst no one was injured in this fire, safe practices were not followed.

Staff told us they did not always feel well supported and that their training and supervision sessions were not up to date. This meant they were not confident they had the skills and knowledge they needed. Training related to health and safety had not been delivered in line with the provider's policy.

People were supported by staff who understood how to report safeguarding concerns.

Most people received their medicines as prescribed. The provider had identified that some pain relief was not being given as prescribed in the week prior to our visits. This had not been addressed when we visited.

The oversight of the service was not sufficiently robust to ensure improvements. There had been a delay in carrying out some audits. This meant actions such as ensuring flooring did not present a trip hazard and pain relief being given as prescribed had been delayed. Actions identified by the provider had not been acted upon in the home. This meant issues related to the oversight of deprivation of liberty safeguards and safe care and treatment had not been addressed in a timely manner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
We did not rate this service at our last inspection (published 27 April 2021).

The last rating inspection for this service was Good (published 25 June 2019).
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.

Why we inspected □
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We received concerns in relation to the oversight of the home, fire safety and staffing. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led key question sections of this full report.

The provider has been responsive in ensuring additional oversight and support for staff. We have not been able to review the sustainability of these changes.

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.

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 in relation to risk management, the deployment of staffing and the oversight of the home at this inspection.

We have taken enforcement action in relation to risk management and the oversight of the home.

Follow up
We will request an action plan for 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Trafalgar Care Home

Detailed findings

Background to this inspection

The 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Three 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 site visits took place on 9 and 11 August 2021. The visit on 9 August 2021 was unannounced.

What we did before the inspection
We reviewed information we had received from, and about, the service since our last inspection. This included feedback from the fire service, the local authority safeguarding team and the local authority quality improvement team. We also gathered information from the provider related to risk management. We used this information to plan our inspection.

During the inspection

During our visit to the home we observed the care and support people received. Most people living in the home did not use words as their main form of communication. We spoke with four people who were able to tell us about their experience of care. We also spoke with the registered manager, three representatives from the provider organisation and three members of staff. We asked the registered manager to invite all staff and the friends and relatives of the home to share their experiences. We did not receive any comments. We reviewed records related to the care and support of 11 people. We also reviewed training records, meeting minutes and documents related to the oversight of the home. We spoke with two health professionals who had contact with the home. We afforded the registered manager the opportunity to share examples of good care and support we had not seen. We did not receive anything.

Inadequate

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 that resulted in a rating this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not always supported to minimise the risk of pressure damage to their skin or to promote their well-being. We saw that some people sat in the same position throughout the day. We checked the records of one of these people; records indicated they had not moved, or been offered to move, from when they got up and sat in the chair to when they were supported to bed at the end of the day on both days we visited.
- Four people received all their care and support in bed and needed staff to help them move to protect their skin. One of these people did not like to change their position and this was recorded. The other three people had care plans indicating how often they should be helped. Two of these people were not supported as their care plans described and remained in the same position when records said they had been moved.
- One person was at risk of malnutrition and their care plan indicated they should be weighed weekly. They were being weighed monthly and records related to their food intake were not accurate. This meant the person was not being supported to reduce the risks associated with insufficient nutrition.
- Environmental risks were not managed effectively. A person, who could not safely leave the building alone, had worked out how to open door in May 2021. An alarm was not added to this door until August 2021. The person continued to have access to this door during this time period.
- The fire alarm was silenced after an incident. Approximately three hours later the fire brigade were called due to a small fire being located in the building. The company that maintains the fire alarms provide 24hour support and they were not contacted during this time. The decision to leave the fire alarm system disabled put people at high risk of harm. Robust measures were not put in place to check the building during this time.
- Fire drills had not taken place in line with the provider's policy. A fire drill that took place in March 2020 had not been successful and staff had refused to participate. There was a note on this drill saying it would be repeated. The next day time fire drill took place in January 2021. The manager who was present when the fire broke out had not taken part in a fire drill during the year prior to the incident.
- Fire training was not up to date for the majority of staff at the time when the home had a small fire.
- During the fire, the evacuation plan was not followed in line with the home's fire risk assessment.

This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- At our inspection in February 2021 the provider had failed to ensure that risks associated with infection

prevention and control were managed safely. There had been a breach of regulation and the Care Quality Commission took enforcement action. The home also received support and guidance from the clinical Commissioning Group (CCG). At our inspection in April 2021 improvements had been made and the requirements of the regulation were met. These improvements had not been sustained.

● People were placed at risk of infection because personal protective equipment (PPE) was not always worn appropriately. During the morning we saw a member of staff remove their face mask when sitting with people. The member of staff then used the face mask as a fan to cool themselves down. This member of staff also wore their face mask round their neck when serving meals. Although other staff were in the area no staff challenged these practices. We also observed staff placing their masks under their chins, whilst on breaks, and then placing them back over their mouth and nose without replacing them. Another staff member was not wearing an appropriate grade face mask.

● Staff were observed to be wearing jewellery and were not all bare below the elbows. This is not good practice as it increases the risk of spreading infection.

● Cleaning records had not been maintained since our last inspection, internal audits had identified this, but improvements had not been sustained.

● In February 2021 the laundry was untidy and items were stored in the ground making cleaning difficult. Work was done to address this, but it had not been maintained. On 9 August 2021 there was soiled laundry in open bags on the floor. The sink was not accessible for staff to wash their hands. This increased the risk of cross infection.

This is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the provider to revisit PPE requirements with the staff team as a matter of urgency. They assured us they had done this. We have also signposted the provider to resources to develop their approach. They assured us they had contacted the CCG for additional training.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Staffing and recruitment

● Staff were not deployed in a way that met people's needs. On the first day of our inspection we made a decision to come back on another day because there were not enough staff to meet people's needs and support an inspection. The registered manager was working on shift alongside two care staff due to short notice sickness absence. A manager from another care home was visiting to undertake an audit, they assisted with supporting people.

● The registered manager assured us that staffing levels were safe. The registered manager had attempted

to get agency support and support from the provider's other homes locally. This had not been possible. They had made their line manager aware of the situation.
● The lack of available staffing meant some people appeared unkempt with dirty clothing and nails and hair that was not brushed.
● On 11 August 2021 there were four care staff working. These staff were not deployed in a way that met people's needs. At lunch time we saw people did not receive support or encouragement to eat their meals whilst the meals were still hot. This led to several people not eating their main meal. A lounge upstairs was largely unsupervised.
● Staff were not always available to offer social stimulation to people or promote their safety. During the morning three people were sat in the upstairs lounge with very limited interaction from staff. This resulted in two people falling asleep. There was no accessible call bell in the room. We asked one person how they would get assistance if they needed it. They told us they would "Go to the top of the stairs and shout."
● Staff told us they did not always feel supported. Two staff told us they did not feel they had sufficient support to ensure they had appropriate training. They recognised some of their training had become overdue in line with the provider's policy.
● The majority of staff had not received supervision during 2021 and they told us that morale was low. The registered manager acknowledged that morale was low and that supervision sessions had not been offered. They told us this was because they did not have a deputy manager to support with this.

This is a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment practices had been improved by the provider across all their services to ensure that appropriate checks and risk assessments were carried out before new staff started work. A new member of staff described how their checks had been undertaken prior to starting in the role.
● The provider assured us that oversight of training and staffing would be put in place immediately. We have not been able to review the sustainability or impact of these measures.
● Representatives from the provider, told us that they had given a number of rewards to staff to show their appreciation of how difficult working had been through the pandemic. These included gifts at Christmas and medals for all staff.

Systems and processes to safeguard people from the risk of abuse
● Two people living in the home told us they did not want to be there and asked to leave. There were records related to one of these people and another person that indicated they had been upset and tried to leave the building. Whilst the local authority team that oversees Deprivation of Liberty Safeguards had received applications related to these people, they had not been informed that they were actively stating, or displaying, that they wanted to leave. This means these people were not being protected by the statutory framework that safeguards people from being deprived of their liberty unlawfully or inappropriately. A representative of the provider assured us this would be addressed urgently.
● People told us they felt safe at the home and with the staff who supported them. One person said, "Feel safe. You can walk round safely day and night." Another person said, "I Feel safe – doors are always locked."
● People told us staff were always kind. We observed that people appeared comfortable when staff approached them.
● People were supported by staff who knew how to report safeguarding concerns.

Using medicines safely

● Not all medicines were being administered in accordance with the prescription. We saw that some pain relief was prescribed to be given four times a day, but staff were administering this on an as required basis. This meant people were not receiving medicines consistently to ensure their comfort. This had been identified by an internal audit the week before our visit and the provider assured us that actions would be taken to address this.

● Where people were being given medicines without their knowledge there was information to show this had been decided in their best interests. The decision had been taken by personal and professional representatives who knew the person well. However, the assessment did not detail which medicines should be given in this way, or if pharmacy advice had been sought. This could result in medicines being administered in an inappropriate way and reduce their effectiveness. This had been identified by an internal audit the week before our visit and the provider assured us that actions would be taken to address this. However, we have not been able to assess the sustainability of this.

● People received their medicines safely from staff who had received specific training to carry out the task.

● Some people were prescribed medicines, such as pain relief, on an as required basis. There was guidance in place to help staff to administer these in line with people's needs.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection which resulted in a rating this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in the service's leadership. Leaders and the culture they created did not assure the delivery of high-quality care for people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- People did not live in a home where the quality of care and support was monitored in a way that led to improvement in the quality and safety of their care. The provider had identified shortfalls and was supporting the registered manager with audits and monitoring.
- This support had not led to action to improve people's experience. For example, spot checks on PPE to ensure that compliance was maintained had been identified as an action within a provider audit and within a response to a whistle blower in June 2021. This had not led to staff wearing their PPE appropriately. The oversight of Deprivation of Liberty Safeguards had been identified in an audit and this had not led to a check on whether necessary information had been shared with the local authority. It had been identified that a fire drill was required prior to the date of the fire but this drill had not happened. This meant people had remained at risk of harm and had not experienced good quality care.
- Some audits had not been carried out in line with organisational policy. These had been carried out the week before our visits and had identified issues that needed addressing such as people not receiving pain relief as prescribed and an area of uneven floor that presented a trip hazard. The delay in carrying out these audits had left people at risk of harm.
- Records necessary for the safe running of the home could not be located during our inspection. This included maintenance records and a record related to the deprivation of a person's liberty.
- At our last inspection in February 2021 the provider had failed to ensure that records related to the monitoring of risk were enough to support safe care. This was a breach of regulation. In April 2021 actions had been taken to improve this but these actions had not been sustained. The provider offered assurances following a whistle blower in June 2021 that checks were being made, and support was being provided to staff to ensure they understood how to record food and fluid intake appropriately. During the inspection we noted four occasions where people did not eat the food they were recorded as eating. One of these people was at risk of malnutrition.
- Oversight had not led to an improvement in people's experience of mealtimes. The provider had shared information about supporting people with dementia during a manager's call, this had not led to changes in the mealtime experience for people in the home. We observed missed opportunities for social interaction and choice and people not receiving support when they needed it.

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

●The provider held regular meetings for the managers of their homes to share information and support each other. These meetings included information about positive risk management.
● Following our visits, the provider enhanced their support to the home to ensure quality and safety issues could be addressed. We have not been able to review the impact and sustainability of these actions.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● An inclusive and empowering culture had not been promoted in the home. People were not always offered choices. For example, at lunch time people were served plated meals which did not give them an opportunity to choose portion sizes, or accompaniments to their meal. People were not offered the chance to move between different parts of the home and spent long periods of time without the opportunity to influence their day. We spoke with the registered manager and a provider representative about people remaining seated in one place for a long time and the registered manager commented that people were helped to go to the toilet. Records did not indicate that this was the case.
● People lived in a home where staff provided care in a task led way. Although some staff appeared to know people well on the days of the inspection, they were focussed on providing physical care for people. This had an impact on interactions. For example, staff were largely absent in the upstairs lounge but occasionally walked through it as a corridor. We observed a person ask for some assistance from a member of staff who walked through whilst carrying out a task. They were kind in their response but did not come back to the person. They did not get the help they had requested for a further three hours when we highlighted this to a member of staff.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a clear policy in place regarding duty of candour. It was not, however, clear that people and their loved ones had been told when things had gone wrong.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although some people said they had choice about their day to day lives, systems, such as observation, were not in place to regularly seek the views of people who were unable to say what they wanted.
● The registered manager told us they had not held resident's meetings but planned to start this soon.
● The provider had provided tailored equality and diversity training to the staff in the home.
● One person told us they would feel comfortable to ask staff for help and that if something was not done, they would go to the registered manager.

Working in partnership with others
● We received positive feedback about the dedication of the registered manager from external professionals who acknowledged the difficult year the home had experienced.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing People were not supported and cared for by staff who were adequately trained and supported to meet their needs. The deployment of staff did not ensure their needs were met.

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 did not receive safe care and treatment. The risks people faced were not managed effectively. Staff did not follow infection control guidance. Staff had not received appropriate training to maintain safety.

The enforcement action we took:

We served a warning notice on 3 September 2021. The provider must be fully compliant with the regulation by 28 February 2022.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from unsafe care by governance. Monitoring and oversight had not led to improvements in quality. Records were not accurate.

The enforcement action we took:

We served a warning notice on 3 September 2021. The provider must be fully compliant with the regulation by 28 February 2022.