Tralee Ltd

Tralee Rest Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Tralee Rest Home is a residential care home providing accommodation and personal care to up to 36 people. The service provides support to older people and people living with dementia. At the time of our inspection there were 32 people using the service. The service was being provided in an adapted building based in a residential area of Whitstable.

People's experience of using this service and what we found
People and their relatives were positive about the staff who provided support to them. People were happy in the company of staff. Staff spoke to people in a kind and caring way. However, there were concerns about the governance of the service and the support provided to people.

People were not always kept safe where there were risks from their health conditions. For example, risk assessments were not always in place and guidance from health care professionals had not always been followed. Care plans were not up to date and did not include the guidance staff needed to ensure they knew how to safely and effectively support people. There were significant risks from the environment which had not been identified and addressed prior to the inspection. For example, risks from fire and from hazards that could increase the risk from falls. Medicines had not always been stored at the correct temperature increasing the risk they were not effective. There were risks from cross contamination increasing the risk of the spread of infection.

The provider addressed the serious concerns identified at the inspection. However, governance systems in place at the service had not always identified these concerns prior to the inspection and were not effective at improving and maintaining safety and quality. Staff understood how to raise a safeguarding if concerns arose about abuse. However, the provider and register manager had failed to act to protect people from risk The registered manager had raised some issues with the provider; however, the provider had not always acted to address these.

There were gaps in care records which meant that the care provided to people could not always be effectively monitored to ensure people were getting the right support.

There were enough staff to support people and staff were recruited safely. The registered manager understood their responsibility under duty of candour. There were opportunities to feedback their views.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. People were offered day to day choices and staff knew how to support people to make decision as appropriate.

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

Rating at last inspection
The last rating for this service was good (published 16 December 2021)

Why we inspected
The inspection was prompted in part due to concerns about managing risks for people and fire safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Tralee Rest Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to good governance at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Tralee Rest 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under 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
The inspection was carried out by one inspector.

Service and service type
Tralee Rest Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Tralee Rest Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought and received feedback from health and social care professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 4 people who used the service and 4 relatives/friends or people who used the service. Some people were not able to express their views. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 10 members of staff including the providers, the registered manager, the head of care, senior care staff and care staff. We also received written feedback from some staff. We reviewed a range of records. This included all or parts of 6 people's care records and multiple medication records. We looked at 2 staff files in relation to recruitment. A variety of records relating to the management of the service, including audits, training records and procedures were reviewed.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- The risk from fire had not been well managed. For example, the equipment used to evacuate people in the event of a fire had been removed from the service by the provider and not replaced. The registered manager had not been informed of this. If there had been a fire, staff would not have the equipment they needed to move people to safety. Fire drills had not been undertaken. We raised this with the provider who addressed the concern during the inspection.
- Risks from the environment had not been well managed. For example, gates had been put at the top of stairs to reduce the risk of people falling down the stairs. These were of a type normally used for small children and were not suitable for use with adults. If pushed the gates gave way and they could be climbed over and under. We raised this with the provider who addressed the concern during the inspection.
- One person was at risk from choking. Health care professionals had assessed that the person needed a modified diet to remain safe. Staff were not following this modified diet and the kitchen staff were not aware that the person needed a special diet. A risk assessment was not in place. We raised this with the registered manager who ensured all staff were informed of the person's dietary needs.
- One person was at risk from diabetes. They had times when their blood sugar readings were high. The registered manager had referred the person to a visiting health care professional to review this. However, there was no evidence staff were taking immediate action when the person's blood sugar was high and re-testing blood sugars to ensure they had come down. There was a lack of guidance in place for staff about the person's diabetes and staff had not undertaken training in diabetic care. We raised this with the registered manager who put new processes in place to reduce this risk.

Using medicines safely

- Medicines had not always been managed safely. Some medicines need to be stored at below 25 degrees to ensure they remain effective. During the hot weather the medicines room temperature had been recorded over 25 degrees on multiple days and had remained that way throughout the day. There was an aircon unit in place. However, this had either not been correctly adjusted or was not effective at bringing the temperature down.
- Some people needed as and when required (PRN) medicines and PRN guidance was not always in place. PRN guidance includes information such as when the person might need the medicine, the maximum dosage that can be given, safe intervals between doses and what to do if the medicine did not have the expected effect. We raised this with the registered manager who addressed the concern during the inspection.

The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to

people. Medicines were not safely managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Creams and bottles of liquids were dated so staff knew when they should no longer be used, as some creams and liquids only remain effective for period of time after they are opened.
● Medicine administration records (MARs). Where complete and accurate. For example, the count of medicines in the records matched the number of medicines in stock.

Systems and processes to safeguard people from the risk of abuse
● Staff were knowledgeable about safeguarding adults and were able to tell us how to identify and respond to allegations of abuse. However, the providers and register managers' understanding of safeguarding fell short as there had been a failure to act to protect people from risk. We have identified this as an area for improvement
● Staff had undertaken safeguarding training and were confident any concerns raised would be acted upon and reported. The registered manager knew how to report concerns and was aware of the local safeguarding procedures.

Preventing and controlling infection
● We were not assured that the provider was always supporting people living at the service to minimise the spread of infection. People were sharing some manual handling equipment and these items were also stored together on coat hooks. This increased the risk of any infection spreading between people. We raised this with the provider who purchased new equipment to reduce this risk.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Visiting in care homes
People's friends and relatives were able to visit in line with government guidance in place at the time of the inspection. Relatives were positive about how visiting was supported. One relative said, "There are no issues visiting. The staff are very welcoming"

Staffing and recruitment
● There was enough staff to provide support to people. One relative said, "There is always enough staff around." Staff responded to people's requests for assistance in a timely way during the inspection.
● There was a dependency tool in place which helped the registered manager to assess what staff hours were needed to provide support to people. However, prior to the inspection a fire drill had not been completed to assess if there was enough staff to support people to evacuate in the event of a fire. This was addressed during the inspection.
● Staff had been recruited safely. Recruitment checks continued to be carried out centrally by the provider to ensure that staff were recruited safely. For example, to make sure disclosure and Barring service (DBS)

checks had been completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Learning lessons when things go wrong
● Staff knew how to report incidents and accidents. When these occurred, people were referred for appropriate medical help when this was needed.
● Action was taken following incidents. However, we did raise concerns about the gates put in place to reduce the risk of injury from falls on the stairs.
● There was some analysis of incidents and accidents. However, this needed to be improved to fully assess if there were trends. Information about incidents was recorded, however there was a lack of narrative to evidence that the information had been analysed to ensure opportunities were not missed to reduce risks to people. This is an area for improvement.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● Staff understood that some people needed support to make decisions and that some decisions needed to be made in people's best interests. Where people had capacity, staff understood they had the right to make choices they themselves might feel were unwise.

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Working in partnership with others; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Quality assurance systems needed improvement as some concerns had not been identified and mitigated. For example, systems had not led to identification and action when medicines storage temperatures were too high in the hotter weather. Care audits had not identified one person was not being supported to eat a safe modified diet. This led to a risk of potential harm for people.
● Management of equipment and the environment needed significant improvement. For example, we identified concerns in relation to fire equipment and stair gates. There were also a number of other issues such as flooring had been taken up in one person's room and put back down unevenly increasing the risk of falls for the person. Controls for 2 profiling beds were missing, meaning staff could not move the bed up and down to support the person with bed care or to adjust the height to assist them to get out of bed. A plug socket, which was in use, cover was broken and had a large hole in it. Whilst the provider and registered manager had been responsive and addressed the issues raised; they had failed to be proactive and had not identified these issues prior to the inspection.
● The provider had failed to learn lessons. For example, we found the same concerns about poor wheelchair maintenance and manual handling equipment at another service run by the same providers (although registered separately). The registered manager had requested more manual handling equipment was purchased in September 2022; however, the provider had failed to act. Staff also told us they had raised issues which had not been addressed or took a long time to address. One staff said, "I have raised several issues but nothing much has been done. Issues are resolved very slowly."
● Care records needed improvement to enable people's support to be monitored to ensure they were well supported. For example, records of peoples support with continence support were poor and there were significant gaps in records. There were no records of one person, who was doubly incontinent, being supported with continence from early in the morning to the evening, on multiple days.
● Risk assessments were not always in place when they needed to be. For example, one person had asthma, and, prior to the inspection, there was no risk assessment in place to provide guidance for staff to support the person safely with this health condition. Care plans needed improvement and the lack of information had led to increased risks for people and staff. For example, one person's mobility risk assessment lacked detail, and this had resulted in staff telling us they had not been providing the correct support.
● The service worked in partnership with health and social care professionals. However, guidance from

these professionals had not always been followed which put people at risk of potential harm. For example, one person's modified diet needs were not followed.
● Feedback about staff was positive. Comments included, "The staff are really friendly." And, "The staff are just lovely, they talk to him and know [my relative].' However, the provider had not invested in providing staff with a wide range of training appropriate to the role. For example, staff had not completed training in catheter care and provided this support. Some staff had not undertaken training in choking and aspiration and supported people with this risk.

The provider had failed to establish effectively operated systems or processes to assess, monitor and improve the quality and safety of the services provided; or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● There were systems in place for residents and relatives to provide feedback on the service. A survey for feedback from people and their relatives had not been completed since the last inspection, however, one was being undertaken at the time of the inspection.
● There were regular meetings for relatives where people discussed issues such as what food they wanted on the menu and activities.
● There was a social media group for relatives and relatives told us they felt well informed. Relatives were also positive about the registered manager and told us they listened to them if they raised issues or had feedback.

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 registered manager understood their responsibilities in relation to duty of candour. A duty of candour incident is where an unintended or unexpected incident occurs which resulted in the death of a service user, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure they were doing all that is reasonably practicable to mitigate risks to people. Medicines were not safely managed.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish effectively operated systems or processes to assess, monitor and improve the quality and safety of the services provided; or assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. The provider had failed to maintain accurate, complete and contemporaneous records in respect of each service user.

The enforcement action we took:

We took enforcement action against the provider