

Trinity House Care Limited

Trinity House Care Centre

Inspection report

Mace Street
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West Midlands
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Tel: 01384634350

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

About the service

Trinity House Care Centre is a residential care home providing personal and nursing care to nine people aged 65 and over at the time of the inspection. The service can support up to 35 people.

People's experience of using this service and what we found

Although work had been completed on the quality of monitoring systems, these were still not completed consistently. The provider had not consistently ensured a positive working relationship with external organisations to ensure the safe transfer of people moving to alternative accommodation. People spoke positively about the management in place and staff told us they felt supported.

People felt safe and staff knew how to report concerns of abuse. Risks to people's safety and well being were being assessed. There were sufficient numbers of staff to meet people's needs. There were effective infection control practices in place. Medicines were managed in a safe way.

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

Rating at last inspection (and update)

The last rating for this service was requires improvement (published 26 September 2019). At the last inspection, breaches of regulation were found. At this inspection enough improvement had not been sustained and the provider was still in breach of some regulations. The service remains rated as requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected

We received concerns in relation to the provider not working in partnership with external agencies to ensure a safe transition to new services for people who were moving home. 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..

We have found evidence that the provider needs to make improvement. Please see the Well Led key question. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Trinity House Care Centre on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to the management of the service 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 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?

The service was safe.

Details are in our safe findings below.

Good ●

Is the service well-led?

The service was not always well-led.

Details are in our well led findings below.

Requires Improvement ●

Trinity House Care Centre

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 Care Act 2014.

Inspection team

The inspection was completed by an inspector and an assistant inspector.

Service and service type

Trinity House Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. 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

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 feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection-

We spoke with five people who use the service and one relative. We also spoke with five members of care staff, the nurse, a member of domestic staff as well as the assistant manager, deputy manager and nominated individual.

We reviewed a range of records. This included five people's care records and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

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 Requires Improvement. At this inspection this key question has improved to good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe at the service. Staff we spoke with knew how to identify types of abuse and the action they should take if they had concerns of abuse. One member of staff told us, "I would tell the manager [if I was concerned] and they would act on it."
- Although the provider had not raised any safeguarding concerns since the last inspection, the assistant manager was aware of what would require reporting to both CQC and external agencies.

Assessing risk, safety monitoring and management

- At the last inspection, we found the risks to people's safety were not always clearly recorded and staff had not consistently followed risk assessments where these were in place. At this inspection, we found the provider was working to improve the risk assessments in place.
- Where there were risks to people's safety and well being, these were assessed and staff were aware of how to keep people safe. For example, we saw where people had conditions such as epilepsy, records clearly described how staff should support to keep the person safe. Staff knowledge reflected what was in the risk assessment.
- At the last inspection, we found the provider had not always ensured the safety of the premises. At this inspection, the areas of concern had been addressed. Although there continued to be some issues with water temperatures, the maintenance staff member was aware of these and had been monitoring this and seeking external support where needed.

Staffing and recruitment

- People told us there were sufficient numbers of staff to support them. One person told us, "If you are in your room, you only need to press the button and the staff are right up the stairs. At night, there are three staff and they pop in and make sure you are ok."
- Since the last inspection, a number of people had left the service. Although the number of people had reduced, staffing levels had remained the same. Staff spoke about the positive impact this had on their work. One member of staff explained, "We have been having more time to spend with people because of reduced numbers. We all join in the bingo now. It's been nice."
- Staff told us recruitment checks had been completed prior to them starting work including providing references from previous employers and completing a check with the disclosure and barring service.

Using medicines safely

- Medicines had been managed safely. We found medicines were stored correctly and medication administration records (MARS) indicated people had received their medicine as required.

- We observed staff supporting people to take their medicine and this was done safely. The staff member was seen to explain to the person that it was time to take their medication and stayed with them while they took this.

Preventing and controlling infection

- There were effective systems in place to prevent and control the spread of infection. The home was clean, tidy and odourless. Staff were seen to wear personal protective equipment where needed.

Learning lessons when things go wrong

- The provider had demonstrated they would learn lessons where things had gone wrong. Since the last inspection, the provider had acted to improve the risk assessments in place and ensure the premises were safe. However, the work completed had been impacted by a number of people leaving the service since the last inspection, and further work was required to ensure these standards remained as occupancy levels changed.

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 this key question was rated as Inadequate. At this inspection this key question has improved to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Working in partnership with others

- Prior to the inspection we received information the provider had not been working in partnership with the local authority to address concerns raised and support people in moving to other services. At this inspection, we found this to be the case. It was clear the provider was in a dispute with the authorities who fund people's care, and this had led to people receiving conflicting information about their future accommodation. We spoke with the provider about this, who advised he was keen to resolve the issues. We will continue to monitor this situation to ensure that people who receive care from the provider are safe and supported to move where needed.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- At the last inspection, we found systems to monitor the quality of the service were not being completed consistently. At this inspection, this remained the case. Although the quality of audits completed had improved and were now more detailed, these were still not being completed consistently and we saw no audits had been completed in the previous two months. We raised this with the provider who acknowledged these audits had not been completed consistently as a result of the management team addressing the more serious concerns arising from the last inspection. The provider informed us they were aware of the importance of consistent quality monitoring and would address this.

Continuous learning and improving care

- Although some improvements were seen at this inspection and the provider had started to address the areas of concern found at the last inspection, there remained areas for improvement that had not yet been acted upon. The provider continues to not meet regulation in relation to governance systems and concerns were raised with us about the provider's willingness to work with external agencies to improve the care provided.

The failure to work in partnership with external agencies and ensure that systems to monitor quality were implemented is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At the last inspection, we found the provider did not always ensure an open or inclusive culture and staff felt unsupported in their work. At this inspection, we found this had improved and feedback received from staff was positive.

- People told us they knew who the registered manager and provider was and felt supported by them. Comments made included, "The managers are alright, I have no problem with them. They are good as gold" and, "They have always looked after [person] and I know that he is safe here and happy." Although the registered manager was away during the inspection, we saw the assistant and deputy managers had a visible presence around the home and people appeared comfortable with them.

- Staff told us they felt better supported by the provider. One member of staff told us, "The managers have been really open, there's no keeping secrets and they keep us up to date on everything."

- Since the last inspection, a number of people have moved out of the service due to the concerns raised. The management team and staff had identified the impact this had on people remaining at the service and had worked to ensure minimal distress for people. One member of staff told us, "We are trying to keep everyone's mood up, we try to keep morale up by sitting and talking with people."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they felt more engaged with the service since the last inspection and felt their feedback was acted upon. One person told us, "They asked me if I had any ideas. I did have a suggestion and they are actually looking into it for me." We saw meetings had been completed with people to discuss the changes occurring at the service with people moving out, however we were unable to view outcomes from these due to the minutes not being typed up or available.

- Staff told us they felt better listened too since the last inspection. One member of staff told us, "We have flash meetings and more formalised meetings. The management are more than happy to get feedback from us."

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

- Although there had been no reportable incidents raised with us by the provider since the last inspection, the management team were aware of the importance of duty of candour and demonstrated how they would meet this.

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to monitor the quality of care were not being used consistently. There were periods where no quality monitoring had taken place by the provider.