Quantum Care Limited

Trefoil House

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?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Trefoil House is a residential care home providing accommodation for older people, who may be living with dementia or a physical disability, who require nursing or personal care. At the time of inspection 48 people were living at the care home.

Trefoil House is split in to four different 'units' across two floors and can support up to 70 people. The building has been designed and adapted to support people living with dementia. Facilities, such as a hair dressing room and social communal areas are available.

People's experience of using this service and what we found
Robust procedures to safeguard people from potential harm and abuse were not in place. The providers response to unexplained skin tears and bruises did not always identify their review, nor communication, with the local authority safeguarding team. This is the third inspection which has identified this shortfall.

Care plans and risk assessments were not always reflective of people's needs. Records provided conflictive guidance to staff; and relatives told us they had not always been involved in the care planning process. People were not always involved in their care and robust care plan auditing did not take place.

Medication processes and administration records did not always follow the providers procedures nor best practice requirements. Medication access was not securely restricted, and security measures relating to the storage of controlled drugs was reduced.

Staff deployment was not always effective to meet the needs of people and mitigate risk. We identified concerns relating to staff moving and handling practices due to reduced staff availability.

Training provided to staff did not include regular dementia training updates. Staff had not completed training in key areas such as positive response to behaviour which may challenge, or end of life care.

The providers quality assurance and governance systems had not identified our findings and did not always drive continuous improvements. Actions from a local authority visit in April 2021 had not been completed, and we did not see evidence of clear provider-led timescales in place.

Despite this, people said they felt safe and relatives told us staff were caring. Staff spoke to people in a dignified and personalised manner, and they told us they took pride in their roles. The home was clean, fresh and inviting. The housekeeping staff were diligent in their duties and reported having ample provisions to ensure the cleanliness of the home.

We had mixed feedback relating to communication. Relatives and staff told us communication could be variable, and concerns were not always followed up. However, we saw several different communication

methods during the inspection, and were told by some relatives that the registered manager had acted where shortfalls had been experienced.

Healthcare professionals told us staff were responsive to their advice, and followed their referral processes to ensure people had access to services. Several initiatives were planned at the care home to further increase support available, where a person may experience deteriorating health.

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 (inspection undertaken 09 April 2019; inspection report published 07 May 2019). We had identified a continued breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

The service remains rated as requires improvement and has been rated requires improvement for the last two consecutive inspections. We have identified further breaches of regulation which relate to safe care and treatment, staffing and good governance.

Why we inspected
We received anonymous concerns which related to safe staffing levels and the needs of people not being met. During our remote review of the service, we received further information which led us to enquire further about staffing levels and the needs of people. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

Having reviewed the information, we held about the care home, no areas of concern were identified in 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 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.

The overall rating for the service remains as requires improvement. 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 sections of this full report.

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 inspections, by selecting the 'all reports' link for Trefoil House 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 a continued breach in safeguarding people from harm and abuse, and further breaches relating to safe care and treatment, staffing, and good governance.

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

Follow up
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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Trefoil House

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.

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
This inspection was carried out by two inspectors.

Service and service type
Trefoil House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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 the information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

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.

During the inspection
We spoke with fourteen people who lived at the service about their experience of the care provided. We spoke with thirteen members of staff including the registered manager, regional manager, deputy manager, senior care workers, care workers and members of the housekeeping team.

We reviewed a range of records. This included recruitment documentation for staff and multiple medication records. We asked the registered manager to send us a range of records so that we could review these away from the care home. Records included care plans, risk assessments, accident and incident analysis, medication records and staff training and supervision documentation. Additionally, we requested some policies, the provider's statement of purpose and other records relating to the management and oversight of the service.

After the inspection
Following the visit, the inspection continued, and we reviewed the records which were sent to us. We received feedback from twelve relatives and five staff. We held a virtual call with the registered manager and regional manager. We also spoke with three healthcare professionals. Further clarification was sought from the registered manager so we could confirm the accuracy of the records provided.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. 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.

Systems and processes to safeguard people from the risk of abuse

At our previous two inspections the provider had failed to robustly review and report unexplained bruising or injuries. This was a breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13.

- The providers procedures did not evidence a robust system to investigate all injuries and incidents. This offered little protection for people and had been identified at previous inspections.
- The registered manager told us all incidents, accidents and injuries were investigated, however, records did not confirm this. Unexplained injuries, such as bruises and skin tears, were not always reported to the local authority safeguarding team.
- Relatives said they were informed if their family member experienced a fall or was admitted to hospital. However, wounds, marks and general health concerns were not always communicated.
- An incident occurred at the time of our visit, and we found the report was not reflective of circumstances. The incident was not reported to the safeguarding team without our prompt, and we further requested the completion of a CQC statutory notification form.

We found systems were either not in place or robust enough to demonstrate how unexplained injuries and incidents were investigated and reviewed. This placed people at risk of potential harm and abuse. This was a continued breach of regulation 13 (Safeguarding service users from abuse or improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded to our findings and told us a review would take place to strengthen systems at the home.

- Staff had completed safeguarding training and shared their knowledge of the types of abuse they may encounter. Staff told us they were confident to report any concerns to the management team.
- Information and processes were on display within the care home which offered guidance to staff. This information included the contact details of the local authority and CQC.

Assessing risk, safety monitoring and management; Using medicines safely; Learning lessons when things go

wrong

● Risks were not thoroughly assessed, and care plans were not always reflective of people's needs. Daily documentation provided little insight into the wellbeing, involvement and feelings of people.

● Records provided conflictive guidance to staff. For example, one person's care plan stated they needed two-hourly positional changes to promote skin integrity, and then stated this was required four-hourly. We saw the person had been assisted approximately two-hourly. Another person was unable to walk independently due to leg bandages; this was not reflected within their records. Staff were unable to confidently tell us about the individuals support needs which placed them at risk.

● People did not always have access to a call bell. We asked one person how they would call for staff if they needed assistance, they said they didn't know, but would likely shout. Alarmed sensor mats were not always located near to people who had an identified need for this equipment.

● People were at risk of dehydration. The hydration needs of people had not always been assessed and fluid intake targets for people were not available to guide staff. Responsive action was not documented following low intake recordings.

●The providers medication management procedures were not always followed. Medication access did not follow safety systems as described, and nominated key holders were not in place.

● Medication administration records did not always detail medication amounts carried over, and where handwritten records were in place these were not always double signed by staff.

● PRN medication (medications required on a 'when needed basis') protocols were in place, but staff were not confident in their whereabouts nor the guidance to follow. Medications were not always considered for administration where people's needs met the prescriber's instructions.

● Lessons were not always learnt when things went wrong. Some areas relating to safeguarding had been reviewed and improved upon since our last inspection, however, strong systems were not embedded into practice.

We found systems were either not in place or robust enough to demonstrate how safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded to the identified areas and updated their service improvement plan. Medication safety systems, PRN protocols and call bell allocations were reviewed. We were told that additional care plan training would be provided to staff.

● Despite our concerns relating to risk management people told us they felt safe. Many relatives told us they found staff provided a safe environment for their family member and reflected upon the additional pressures which had been faced during the COVID-19 pandemic.

● In the days prior to our inspection, staff had acted when risk arose in relation to the changing needs of one person. However, during our visit we found safety systems, personalisation and staff communication had not been fully considered. The registered manager, deputy manager and regional manager took prompt action to rectify these concerns.

● People's prescribed PRN medications were stored all together in a plastic container for each unit. This did not allow for prompt nor safe selection. The registered manager told us this would be reviewed.

● Two staff were observed administering timed medications to people. This was completed safely and in line with best practice requirements. Staff communication was individualised and supportive.

● Safety checks relating to moving and handing equipment, electrical testing and fire systems were conducted on a scheduled basis.

Staffing and recruitment

● Safe staffing levels were not robustly assessed or reviewed. The provider determined staffing levels using their electronic care planning system. Risks to people were not thoroughly assessed and records were not always reflective of people's needs.
● Staff moving and handling practices were not always safe nor in line with requirements. Staff told us staffing levels did not always reflect the needs of people. This placed people at risk of injury, avoidable harm, and did not evidence safe staffing numbers.
● Specific areas of the service, such as lounges, required staff presence when in use. This was to ensure people were safe, and staff were available to mitigate risk. At the time of our visit these areas were not always staffed, and an inspector sought staff support for one person following an incident.
● Of the staff and relatives, we spoke to, many told us they felt there was not enough staff to meet the needs of people. One person told us, "They really could do with more staff. When the weather is nice, I like to sit in the garden, they don't take me out anymore though". Other people told us staff were often busy and it was not unusual to wait for support.
● Staff told us they had little meaningful time to spend with people, and this was an area they would like to see improved. Engagement was often task based with little time available for social support and activities.

We found unreliable systems were in place to identify safe staffing levels and deployment within the care home. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and regional manager reviewed our concerns and findings in relation to staffing levels, staff deployment and moving and handling practice. They told us they were not aware of staffing pressures and were also unaware of the highlighted concerns surrounding moving and handling practices. The registered manager told us training and practices would be reviewed, and additional training and guidance will be provided to staff in relation to moving and handling.

● Staff were safely recruited in line with the providers procedures. Pre-employment checks were completed, and staff received induction training and support when taking up their roles.

Preventing and controlling infection
● The care home environment was clean and fresh. Relatives gave very positive feedback of the cleanliness of the care home. The housekeeping staff spoke positively of their line management and told us they had access to all they required to ensure the high standards of cleanliness at the care home.
● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● 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 were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- The findings of our inspection did not always evidence good outcomes for people. Risks had not always been thoroughly assessed and care plans were not always reflective of people's needs. There was limited personalised information within records which did not always evidence the involvement of people or their relatives.
- Quality assurance and governance systems were in place, but they had not identified our findings, nor did they always drive continuous improvement. The local authority undertook a quality monitoring visit in April 2021, and some actions remained outstanding with no clear provider-led timescales in place.
- The training needs of staff had not been fully reviewed to consider the needs of people. Some staff had not received dementia training for a significant period of time. Specific training relating to person centred care, responding to behaviour that may challenge and end of life care had not been completed by staff prior to our inspection.
- Some relatives told us when they enquire about their family member, very little information is shared with them. They told us this made them feel unaware of how their family member is and provides them with little reassurance. Relatives told us they were unaware of keyworkers, and their role, and found speaking with different staff did not always allow for positive outcomes.
- Some staff told us they did not always feel valued, nor did they feel there was an inclusive approach to staff meetings. Some staff told us they felt their concerns were not always acknowledged or reviewed in relation to safe staffing levels for people.
- We were not assured of the providers audit and documentation retrieval methods at the care home. The registered manager and regional manager were unable to provide us with historical documentation for one person, and said records were irretrievable for all people. Since the inspection, past documentation has become accessible, but this did not evidence good oversight of systems nor records.

We found systems were either not in place or robust enough to demonstrate the service was effectively managed, training needs of staff were reviewed and safe, and good communication systems were always in place for people and relatives. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had been appointed since our last inspection and was aware of some areas which required improvement. We saw action was taken in response to our findings and were told systems would be developed further to increase the safety outcomes for people.

● Despite our findings some relatives and staff told us that their experience of communication had been good. A relative told us despite distance and travel implications, the staff had maintained positive communication methods during the COVID-19 pandemic. Another relative told us how impressed they were with staff support and communication during a time of difficulty for their family member.
● The registered manager-maintained group communications with relatives by holding virtual meetings and provided further updates by email.
● Activity days, and celebrations, took place at the care home and photos were available for relatives to view. However, on the day of our visit there was little social interaction taking place.
● The provider undertook a range of quality assurance audits. Although they did not identify all our findings, we did evidence remedial action took place where areas for improvement were identified, and good practice was recognised.
● The registered manager was a mental health champion and we saw systems were available to support staff with their well-being.
● The registered manager had invited relatives to provide feedback on their experiences of the services at Trefoil House, and analysis of this was available. Continued quality assurance was planned to gain additional feedback from people and 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
● Some relatives told us of occasions where they had received positive contact and acknowledgement when things went wrong. We were given positive feedback relating to how this had been approached and handled by the registered manager.
● The registered manager was aware of their responsibilities to be open and honest. During the inspection process we noted that our findings were reviewed, and several areas were acted upon without delay.

Working in partnership with others
● We received feedback from three healthcare teams which provided support to people and the staff at Trefoil House. We were told the staff were proactive in their approach to referrals and additional training and support is available to staff where it may be required.
● The registered manager informed us of plans to implement clinical systems within the care home with the support of healthcare professionals. This would allow for prompt clinical assessment of people should their health decline or where staff are concerned for their wellbeing.

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 Effective care planning and risk assessment practices had not taken place to reduce risks to people. The hydration needs of people were not managed safely and call bell allocation and ongoing review processes required implementation. Medication management did not reflect the providers procedures. Regulation 12 (1) (2) (a) (b) (c) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not ensured that people were protected from potential risks of harm and abuse. Incidents such as unexplained injuries or bruising were not always thoroughly investigated or reported to the local authority safeguarding team. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were not effective in identifying, monitoring and improving quality and safety of care. Risks were not identified to be assessed and mitigated in all cases. People and their relatives had not always been involved in the

	care planning process. Staff training was not found to be reflective of peoples needs and communication systems were not always effective for relatives. Regulation 17 (1) (2) (a) (b) (c) (e) (f)
Regulated activity	**Regulation**
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Robust systems and reviews were not in place to ensure safe staffing levels were available and deployed within the care home. Staff practices did not always follow safe procedures in relation to training and responding to peoples needs. Regulation 18 (1) (2) a