Trinity Carestaff Solutions Limited

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Inspection report

Manchester House
113 Northgate Street
Bury St Edmunds
Suffolk
IP33 1HP

Tel: 01284701944
Website: www.trinitycarestaff.co.uk

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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
Trinity Carestaff Solutions is a domiciliary care agency, providing personal care to people living in their own homes. There were 153 people receiving personal care at the time of the inspection. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
Staff were not always recruited safely and the provider did not always follow its recruitment policies and procedures.

It was unclear if staff had received adequate training for their roles. Dates recorded on the provider's staff training matrix records did not match training certificates. There was a lack of regular, planned supervision, staff meetings, spot checks and competency assessment to ensure staff received support and their performance monitored.

Care records did not always contain sufficient information and guidance to enable staff to support people in a safe way. Risk management was not always in place for falls, dementia care, care of people with diabetes, Parkinson's disease and risks of choking.

People were not always protected because records did not reflect safe administration and monitoring of medicines errors. Staff competency had not always been assessed prior to staff administering medicines. A lack of medicines audits meant any medicines errors could not identified.

People told us they did not receive prior notice of what staff would support them with the timings of calls. They also told us they were not provided with any care plan to review and confirm their agreement with.

Governance arrangements did not provide assurance that the service was well-led. The provider had not ensured that their systems and processes to monitor the quality and safety of care was effective.

There was a lack of analysis of incidents and it was not clear that lessons were learnt with actions taken to ensure improvements were made when things went wrong. For example, in relation to late or missed calls.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
The last rating for this service was Good [published 12 September 2018].

Why we inspected
We received concerns in relation to the management of risk, reporting of incidents and staff training and recruitment processes. A decision was made for us to inspect and examine those areas of risk. As a result, we

undertook a focused inspection to review the key questions of safe and well-led only.

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

You can see what action we have asked the provider to take at the end of this full report.

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 have identified continued breaches in relation to safe care and treatment, recruitment, governance and failure to notify. Immediately after the inspection we wrote to the provider and requested they provide us with urgent information telling us what they were going to do regarding safe care, the management of risks, infection control and ineffective government arrangements.

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 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 means 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 of 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.

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.

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.

Trinity Carestaff Solutions Limited

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 team consisted of two inspectors on site and an Expert by Experience made telephone calls to people who used the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own homes.

The service did not have a manager registered with the Care Quality Commission. A registered manager is legally responsible for how the service is run and for the quality and safety of the care provided. The previous registered manager left their employment in April 2020.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because the service was being managed remotely and we wanted to be sure the manager would be in the office to support the inspection. We also requested the provider send us documents prior to and following the inspection.

What we did before the inspection
We reviewed any information we had received from the service since the last inspection. We sought feedback from two local authorities. 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 seven people who used the service and eight relatives about their experience of the care provided. We spoke with 10 members of staff including the provider, manager, care coordinator and training manager.

We reviewed a range of records. This included eight people's care records including risk management plans, and multiple medication records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including audits, policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 this key question was rated as Good. At this inspection this key question has deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Staff had not received adequate training in key areas such as medicines, emergency treatment and safeguarding. Where staff supported people with a 'percutaneous endoscopic gastronomy' (PEG) in place, the manager was unable to provide evidence that staff had been trained and their competency regularly assessed. A PEG is equipment used to introduce food, fluid and medicines via a tube directly through the skin into the stomach. This put people at risk as staff did not always have the skills and competency to deliver care safely.
- When staff were asked how they would support people to access emergency treatment, two staff were unable to tell us how they would call 999 for an ambulance, quoting instead a number to access emergency treatment used in another country.
- There was not always guidance for staff in care records with steps they should take to support people safely with their equipment, such as mobility aids, hoists, commodes and care of conditions such as diabetes, Parkinson's disease and dementia.
- Care records contained conflicting information. For example, two people's pre-admission assessments stated they had a diagnoses of dementia and at risk of choking, but in the risk management section of their care plan it stated they did not have these diagnoses. This meant guidance for staff had not been provided to meet assessed needs and to prevent the risk of harm.
- Risks to people's health and safety from the COVID-19 infection had not been assessed and care planning guidance provided for staff. For example, risk management guidance for people clinically vulnerable.
- People and their relatives told us care and support was not always delivered on time. One person said, "We don't know who is coming and what time they will come. They are often late and don't always turn up. There have been two occasions recently when we have had to intervene and help [person's relative] to get out of bed, wash and dress. What would happen to people without relatives? They would be left in bed with no food or drink. It's very worrying."
- All of the people we spoke with told us they did not receive prior notice of what staff would support them with the timings of calls. They also told us they were not provided with any care plan to review and confirm their agreement with.
- People did not always receive support at their assessed time of need. This meant people had to wait for continence care, medicines and meals, putting them at risk of harm. One relative told us, "Staff turned up recently at 6pm to put [relative] to bed. The agency knows this time is too early. [Person's relative] told the staff at the time they did not want to go to bed that early and the staff left them in a chair knowing they would not be able to go to bed without support. Luckily [relative] phoned and we went over, otherwise they would have been left to sit up all night in a chair."
- Daily records were task focused. For example, records included; 'washed', 'food given', 'drink given', 'put on commode'. There was no detail as to what food and drink was provided and neither a record of any

social interaction or record of person's emotional wellbeing.

Using medicines safely
● Systems to plan, support and administer medicines were not always safe. There was limited evidence to demonstrate staff had all been trained in medicine administration and competency assessed prior to their administering people's medicines.
● A document was in place to assess staff competency in medicine administration. This was brief in detail with no comments, only tick boxes with a lack of information as to what was observed. Assessments had not been completed for all staff who administered medicines. This meant staff had not received appropriate training and assessment to ensure they administered people's medicines safely.
● There was a lack of systems to ensure medication audits were carried out which would include stock checks against administration records. There was no system for identifying medicines administration errors and ensure investigations were carried out. This meant we were not assured medicines errors would be identified and steps taken to check people received their medicines as prescribed.

Systems were either not in place or robust enough to demonstrate steps had been taken to provide safe care and treatment. The failure to robustly assess risks relating to the health safety and welfare of people demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and processes were not established and operating effectively to prevent potential abuse, and learning lessons when things went wrong. This placed people at risk of harm.
● Staff, including senior members of staff, did not demonstrate an awareness of safeguarding processes or how to escalate and consult local authority safeguarding teams.
● Complaints recorded which included safeguarding concerns were not reported as such.
● The provider had not considered the risks posed to and by staff who were related working together unsupervised.
● Two people who used the service told us, "I am only supposed to have one carer, but sometimes there are two turn up and I don't understand why. One just stands there not doing anything. They say they are related." Another said, "My regular carer used to bring a man with her. I think he worked for the agency but I didn't know why he was here." There were no risk assessments or policy which monitored this practice by recognising risks and mitigating them. One staff member told us, "There are lots of people who are related or live together who work together and this causes problems sometimes."
● Where electronic systems were not being used effectively, a staff member told us that the service could only identify missed visits if people called to complain.
● We noted a number of missed calls where staff did not turn up to provide people with the care and support needed. For example, we noted eight missed calls in October 2020 where people did not receive the care and support needed. One person did not receive a call for both the morning and lunch time. This meant they did not all receive support with personal care, medicines administration, food and drink. The local authority told us these incidents had not been reported as safeguarding concerns as required.
● People did not always receive their calls in full or on time. Staffing rotas had no travel time and no breaks Included. People told us call time allocated was often cut short to enable staff travel time between one call to another. One carer told us, "I move things around so that by the end of the day I have made up enough travel time. Yes, this does mean people do not always have their full time, but we do what needs doing." No risks had been considered on what impact this may have for people's assessed care needs and relied on care staff making their own ad-hoc decisions about who to visit and when
● Eight of the 15 people we spoke with told us they had experienced late or missed calls.

● Relatives told us and a review of complaints records confirmed, where people lodged a complaint with the provider this was not always investigated with outcomes which would demonstrate learning from incidents and feedback.
● We were provided with the manager's fall and incident analysis. This was brief in detail and did not identify trends with action described as to steps to reduce the risk to people from falls, skin tears, infections and neglect of care following missed calls.
● Following incidents where people sustained injuries from falls, we were not assured the provider had taken action to fully explore all safeguarding concerns in order to implement required learning.
● The management team could not demonstrate how they looked for themes and trends in safeguarding incidents and the management of complaints. This meant people could not be assured the provider took action to reduce the risk of re-occurrence where possible.

Systems and processes were not established and operating effectively to prevent potential abuse, placing people at risk of harm. This demonstrated a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were not recruited safely. Recruitment checks were not always conducted in line with legal requirements or in line with the provider's policy. Shortfalls in recruiting staff safely had been highlighted to the provider in recent quality audit inspections carried out by the local authority. This had resulted in some improvements, but further work was needed.
● Staff did not always have an enhanced Disclosure and Barring Service check (DBS) completed before commencing employment as legally required. A DBS helps to prevent unsuitable people from working with vulnerable groups by checking police records and barred lists. For example, we found staff with only a basic DBS and not the enhanced check required for staff working with vulnerable adults.
● Where recruitment application forms had not been fully completed, further information was not always obtained. For example, action had not been taken to identify gaps in employment history as legally required.
● The provider's policy stated, 'where verbal references are sought these will be recorded and held on file until receipt of written references; any discrepancies will be investigated and recorded.' However, we found only telephone references had been obtained without evidence of any written references including any obtained from the most recent employer.
● There were no records of any pre-employment interview. Records of this are important to assess the accuracy of the staff member's application form. For example, in regard to past employment, qualifications or gaps in employment history.
● There was no system and process in place to ensure regular audit of recruitment files to identify any shortfalls and ensure processes for the recruitment of staff were safe and in line with the provider's policy and legal requirements.
● All of the above put people at risk as checks had not been undertaken to ensure staff were safe and suitable for the role employed.

Recruitment procedures were not established or operated effectively to ensure that staff recruited were able to provide care and treatment appropriate to their role. This demonstrated a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● Care staff told us they were provided with on-line infection control training and they were supplied with plenty of personal protective equipment [PPE].

● People using the service and their relatives told us staff always wore PPE when undertaking visits.
● When inspectors arrived at Trinity Carestaff Solutions office there was a sign-in book for track and trace purposes, a questionnaire and temperatures were taken.

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 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 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

- The previous registered manager had de-registered in October 2020 but had left in April 2020. The current manager had not yet registered with the Commission. The manager demonstrated a lack of understanding of fundamental standards and the principles of good quality assurance and planning for improvement.
- Leadership of the service was inconsistent, and the management team were not clear about their responsibilities. There had been three changes of manager in the last nine months.
- There was a lack of systems in place to ensure effective oversight and governance of the service. This meant shortfalls we identified at this inspection were not always identified and improvements were not made. This did not ensure consistent delivery of quality and safe care.
- The lack of oversight meant people were put at risk from unsafe recruitment, untrained staff, inadequate care planning, including guidance and management of risks to people's welfare and safety.
- Monitoring systems had not ensured concerns about people's care and exposure to the risk of harm were responded to. Failure to have effective systems to respond to feedback prevented prompt, effective action and improvements being made as to how the service was run and the quality of care people received.
- Reporting of incidents and concerns was inconsistent. There was a lack of analysis of missed calls and medicines errors. This meant there was no opportunity to identify improvements and learn from these and reduce reoccurrence.
- Records reviewed showed the provider had failed to inform the local authority and raise a safeguarding referral as required following incidents of missed calls. These were incidents where people did not receive care to meet their assessed needs.
- The provider had not ensured staff were suitably trained, skilled and competent in their role to deliver care safely. We found training certificates belonging to one member of staff found on several other staff files. Dates on the staff training matrix confirming staff had received training conflicted with dates on training certificates.
- Certificates reviewed in staff files showed some staff had attended one mandatory training day delivered by one training manager. This included 18 modules in areas such as basic life support, food hygiene, manual handling, safeguarding, health and safety and fire safety. The manager was unable to demonstrate how all these areas were sufficiently covered within the timeframe.
- People who used the service told us new staff were deployed to provide their care without shadow opportunities. One person told us, "I have to tell them [care staff] what to do. one week I had that many new

staff turn up, none of them knew what to do." A relative told us, "I did not think it was my job to tell staff what to do and how to do it. The regular carers know what to do but when they send cover for holidays it all goes wrong. They clearly haven't been trained in using the equipment before they arrive."

Continuous learning and improving care; Working in partnership with others

● Despite support from the local authority the provider has failed to learn and put effective measures in place to regularly monitor the quality and safety of the service.

● As described in the 'Safe' section of this report, there was evidence to demonstrate a failure by the management team to ensure people using the service were safeguarded against the risk of harm.

● The provider was aware that changes needed to be made at the service and had previously received support from a local authority quality team. Whilst we found some steps had been taken to improve staff training and safe recruitment, more work was needed to ensure quality and safety of the service.

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

● Systems were not managed effectively to ensure people and relevant others were engaged in the service. Opportunities for feedback were minimal.

● People were not kept informed in areas important to their care and issues raised were not successfully addressed through robust and effective complaints handling. Where people told us, they had experienced poor communication, missed or late calls, these had not always been recorded and responded to with actions taken to mitigate further risk of their care needs not being met. A lack of oversight and learning following incidents meant people were at risk of avoidable harm.

● People and relevant others were not given adequate communications about important topics which impacted on their care and support. For example, there was no system in place to inform people of which staff would be providing their care and at what time. One relative told us, "The communication from the office is very poor. They don't tell you when your regular carer is not coming, if staff are going to be late or if they are not going to turn up at all." Another told us, "Trying to get a manager to answer your calls and complain to is challenging. I spent three days phoning trying to get someone to return my call and listen to my complaints before someone came back to me."

We found no evidence that people had been harmed however, systems were either not in place or robust enough to evidence effective oversight of the service and the fulfilment of regulatory requirements, placing people at risk of harm. This demonstrated a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014.

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
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk to people's health, welfare and safety had not always been assessed and action take to reduce risks.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to take action in reporting safeguarding incidents to relevant authorities

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems were either not in place or robust enough to evidence effective oversight of the service and the fulfilment of regulatory requirements, placing people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures were not established and operated effectively to ensure that staff recruited were able to provide care and treatment appropriate to their role.