Temple Mead Care Ltd

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Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This inspection took place on 1 and 17 September 2015 and was unannounced. The inspection was undertaken by two inspectors on 1 September 2015 and one inspector on 17 September 2015.

Temple Mead Care Ltd provides personal care to people in their own homes. At the time of our inspection there were 70 people who were receiving a service. This was the first inspection of the service since it's registration in July 2014 at this location.

There was a registered manager in post but due to personal reasons they were not available during the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Prior to our inspection we had received information indicating that people were not always getting their calls as planned, there were not always sufficient staff available and recruitment and training practices were lacking consistency.

Summary of findings

During our inspection we saw that people were not always protected from potential harm because the required recruitments checks were not carried out consistently to ensure that only suitable people were employed to support people.

People were not always supported by staff that had the skills and experience to support people safely. People's needs were not always met because staff had not attended the call or because staff had not attended the calls at the agreed times.

The provider did not have systems in place that ensured that they were able to assess and monitor the quality of the service to ensure that people received a good quality service.

This meant that the registered provider was not always meeting the law. You can see what action we told the provider to take at the back of the full version of the report.

People were not always protected from abuse because staff were able to recognise the signs of abuse and knew how to raise any concerns they had but there was a risk that not all safeguarding concerns were raised with the local authority by senior staff.

Plans were in place to manage and minimise the risks associated with the care and support people received. Staff were knowledgeable about what they should do in emergency situations but did not always follow them. This could leave people at risk of not having their needs met.

People were supported to take their medicines as required however, on occasions this did not happen because a call had not been attended.

Staff received training to equip them with the skills and knowledge that they required but the training was not always provided by a trained individual. Staff received some support to ensure that they provided good care through supervision sessions.

People were happy with their regular staff and had built up friendly relationships with them but were concerned that there was a lack of continuity of care with regular changes in the staff that supported them.

People were supported to make choices and involved in the care and support they received.

Privacy and dignity was maintained and people were supported to carry out tasks themselves so that they maintained their independence as long as possible.

People knew how to raise concerns about the service they received but were not always happy with the responses they received.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there

is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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 always safe.

People were protected from abuse because staff had the skills and knowledge to identify abuse and ensure that senior staff were made aware of their concerns.

The appropriate authorities were not always informed of concerns. Systems were in place to protect people from harm and injury but staff did not always follow procedures in emergency situations.

Some people experienced missed calls or late calls which affected how well their needs were met because the appropriate staff were not always available. People were supported to take their medicines.

Is the service effective?

Requires improvement

The service was not always effective.

People were happy with the care provided by their regular care staff but didn't like that there were a lot of staff changes.

Staff were not always provided with the skills and knowledge to provide people the support they needed.

People were supported to make choices and decisions about their care.

People were supported eat and drink and received medical support if needed.

Is the service caring?

Requires improvement

The service was not always caring.

People were sometimes left without the care they needed because of late and missed calls.

People were supported by staff that were nice and pleasant with them and supported them to make choices about the care they received.

People's privacy and dignity was maintained.

People's independence was promoted wherever possible.

Is the service responsive?

Requires improvement

The service was not always responsive.

People received care and support that was individualised to their needs because staff were aware of their needs.

People knew how to raise concerns about the service they had received but concerns were not always appropriately addressed.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well led.

People did not always receive a good quality service because the systems in place did not ensure that monitoring systems were sufficient to identify shortfalls and enable appropriate actions to be taken to address the shortfalls.

There were some systems in place to gather the views of people but these were not systematic and comprehensive.

Temple Mead Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1 and 17 September 2015 and was unannounced. The inspection team consisted of two inspectors on 1 September 2015 and one inspector on 17 September 2015.

In planning our inspection, we looked at the information we hold about the service. This included notifications received from the provider about deaths, accidents/ incidents and safeguarding alerts which they are required to send us by law. Before our inspection we had received some concerns and this information to inform our planning. We contacted the local authorities that purchase the care on behalf of people, to see what information they held about the service.

As part of our inspection we spoke with eight people that used the service, two relatives and eight staff including two care co-ordinators. During our visit to the service's office we looked at records that included the care records of four people that received a service, the recruitment and personnel records of nine staff to check that recruitment, training and support for staff was sufficient for them to provide good quality care. We also looked at other records relating to the monitoring of the quality of the service including complaints and audits by the registered provider.

Inadequate

Is the service safe?

Our findings

People were not always protected from potential harm because the required recruitment checks were not always carried out before people started their employment to ensure that only suitable people were employed. Staff spoken with told us that they had been interviewed and references and police checks had been carried out. When we checked the recruitment records we saw that for one person they had started working before their police check had been received, for another person there was no evidence of references on the file and for another person issues identified on a reference had not been followed up and no risk assessment had been put in place to show why they were suitable for employment. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not sufficient staff available to ensure that people always received the service they required. We had received information before our inspection that calls were sometimes not attended or not attended at the agreed times leaving people at risk of not having their needs met including not receiving their medicines and meals.. Most people spoken with during our inspection told us that they had had calls that were not attended at the agreed times but were often understanding of the reasons for this. One person told us, "Carers are late because they don't get travel time." Three people told us that they had had missed calls. One person told us they had made their own arrangements to ensure food was accessible to them in case their call was not attended. People spoken with told us that when they rang the office about a missed call they were sometimes told nothing could be done. Discussions with a care co-ordinator showed that on one occasion despite being informed that no one had attended a call no alternative provision had been made to attend the call so no call service was provided. The care co-ordinators were unable to say why this had occurred. Another person was left in a chair overnight due to a missed call. A person living with dementia attempted to prepare a meal independently because staff had not turned up and caused a fire in their home. This showed that people's needs were not being met and their health and welfare was put at risk. This is a breach of Regulation 9 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected from abuse because staff were knowledgeable about their responsibilities and were able to identify concerns. People spoken with told us that they felt safe with the staff that supported them. One person told us, "The staff are nice." Another person said, "I feel safe [with staff], they are friendly and talkative." Staff spoken with told us they had received training in how to recognise the signs of abuse. Staff were able to describe the signs that would alert them to take actions such as raising their concerns with the office staff so that the appropriate actions were taken to protect people.

People were not always protected from the risks of preventable injury. Risks associated with the care provided by the staff and the environment had been assessed and plans put in place to minimise them. One person spoken with told us care staff were able to access the property safely by the use of a key code box. Another person at risk of falls told us that they had a pendant to us in an emergency. Staff confirmed they had access to the risk assessments in people's homes and updates in any changes were passed on through email, text or verbally to them. Staff confirmed that they knew what to do in emergency situations such as when entry to a person's accommodation was not possible. However, we saw that staff did not always follow procedures and this left people at risk. For example, we saw evidence that one staff member had not been able to access a person's home but had not notified the office staff of this as required so that enquiries could be made about where the individual was. As a result the individual had not received their medicines and this could affect their health.

People were not always supported to receive their medicines as prescribed. Staff told us that they prompted people to take their medicines. [Prompted meant that staff reminded people to take their medication]. Staff spoken with during our inspection told us and records confirmed that if they needed to support someone with their medicines they [staff] had received training in how to support people with medicines. However, we had received concerns from whistle blowers stating that staff had not received training in the safe administration of medicines although they had been asked to administer medicines. We saw that risk assessments had been carried out that identified what support people needed with taking their medicines. We asked to see what monitoring there was in place to check if people had received their medicines. Records and systems seen showed there were not the

Inadequate

Is the service safe?

appropriate records in place to record the medicines that staff had supported people to take. Before and during our inspection we received concerns that some people had not received their medicines because calls had been missed and the medicines given were not appropriately recorded.

On the second day of inspection we saw a system was being put in place to ensure that checks were carried out in the future. This showed that the safeguards in place to ensure people received their medicines as prescribed were not robust and there was a potential risk to people's health.

Requires improvement

Is the service effective?

Our findings

People spoken with told us that they were happy with the care provided by their regular care staff. One person told us, "Depends who comes. Some are good, some not so great. There are lapses in attention. Some know what to do." Another person said, "They know what to do. They make sure I'm okay." Another person told us, "I get on well with the carers. No qualms about the carers. They know what to do or ask. There is a care plan available." Staff confirmed that they had access to the care plans to find out about people's needs. Staff told us that they asked people what help they wanted even though they knew what support they should be providing. Staff told us and records confirmed that some staff received supervisions so that they had an opportunity to discuss issues and further training.

People were not always supported by staff that had been provided with the skills, knowledge and support they needed. People were generally happy that their regular care staff knew how to support them but some replacement staff were not as well informed. Staff told us that if a call was new call to them they were sent information via text or email. This could mean that they received only limited information or had not looked at the information they had been sent. One person told us that they felt the staff knew what they were doing. Staff spoken with were knowledgeable about the needs of the people they supported. Most staff told us they had received training that included first aid, administration of medicines and moving and handling. Some staff told us they had not received all the training they required and that they would have benefitted from classroom based training. Staff confirmed that as part of their induction training they had spent some time working alongside experienced staff to build up their skills and knowledge. However, not all staff felt this had been sufficient. Training records looked at showed that the induction and shadowing carried out by some staff had not been completed as required by the provider. We saw that staff had not received training in moving and handling from a person that had been assessed as being competent to ensure that staff received training based on current best practices. This showed that training for staff was not sufficient and could not ensure that staff had been given the skills and knowledge they required to work to the standards required.

People were supported to make decisions about the care they received. People told us that they were involved in planning their care so that they received the support they wanted. One person told us, "Staff do what the care plan says. They ask if they can do anything else." Staff confirmed that they had regular calls and had got to know the people they supported. Relatives told us that they were able to have an input into planning for their relatives who were not able to make decisions for themselves. Staff told us how they involved people in their day to day choices for example in asking people what they wanted to eat and if people refused care this would be respected but this would be reported to the office staff.

We were told by a care co-ordinator that there was no one whose liberty they felt was being restricted. This showed that people were supported in line with the requirements of the mental capacity act and deprivation of liberty safeguards.

People told us that they had built up good relationships with their regular care staff but they did not always have regular staff to assist them. Some people were not happy that there were a lot of staff changes and some missed calls which meant that the service was not always effectively providing the service required. One person told us, "It's not the same carers everyday but it's alright that they send different ones. It would be nice if they sent the same ones." Another person said, "There are different carers but all are very good." One relative told us, "[Person's name] asked the staff to change the bed and they did. They [staff] have a good sense of what [person's name] needs."

People were supported to eat and drink where needed. People told us that drinks and meals were prepared for them. One person told us, "I get my own breakfast but they make a sandwich and tea in the evening and one at night. They make sure I have some food and drink handy. They will ask me what I want."

People told us that staff would assist them to receive medical care if needed. One relative told us that the carer had called the ambulance and had been marvellous when their family member had fallen. Staff told us that they would call the ambulance if needed and would inform the office staff if they felt that someone was unwell so that the relatives could be informed. We saw that care records included where other professionals such as district nurses were also providing support to people.

Requires improvement

Is the service caring?

Our findings

People told us that they were happy with the staff that supported them and people had built up good relationships with the staff. One person told us, "Staff are nice." Another person said, "[I} Get on well with the carers. No qualms about the carers." Another person told us, "Carers are pleasant."

People told us that they were able to express their views and make decisions about the care they received. People felt that they were listened to by the care staff and staff were able to tell us about the things people were able to do themselves. Care records looked at confirmed people's involvement in planning their care and the way they wanted to be supported. However, people did not always receive their calls, or not at the times they wanted which showed that staff did not always take care that people's needs were met how they wanted. For example, one person told us their six o'clock evening call was sometimes carried out at 4 o'clock. A relative told us, "A carer had to come back later as they had come to put [family member] to bed over an hour earlier than required."

People were happy that their privacy and dignity was being maintained. One person told us, "Staff do respect my privacy. They use a towel to cover me when they help with washing." All the staff spoken with had a good understanding about how to promote privacy and dignity and were able to give good examples of how they maintained people's privacy and dignity. This included ensuring doors and windows were closed and people were kept covered whenever possible when personal care was provided.

Staff told us that people's care records provided enough detail about how a person's care should be provided and included detail about how to care for the person in a way that promoted the person's dignity and independence. One relative told us, "[Person's name] tries to be independent. They [staff] check his cleanliness, supporting rather than doing it for [person]. They don't try and take over."

Requires improvement

Is the service responsive?

Our findings

People that we spoke with told us that they had been involved in the planning of their care and some people told us they had had a review of their care. One person told us, “Staff know what to do or ask what I want.” Staff told us that they asked people about what help they wanted. Staff told us and records showed that needs were assessed and care was planned so that care was provided based on the individual needs of people. Staff were knowledgeable about people’s needs. They were able to describe to us how they met people’s care needs in a personalised way and how they supported people to express their choices and maintained their independence by encouraging them to do as much as they could for themselves with staff support.

People told us that they knew how to raise any concerns they had. Some people were happy that their issues had been resolved but three of the nine people spoken with told us they were not always happy with the responses they received. One person said that when they phoned the office, “No one answers the phone. This is frustrating.” Another person said that when they phoned the office about staff being late they were told they, [office staff], didn’t have the answers and couldn’t do anything about it. We saw that there was a complaints log however, not all the concerns we were aware of in respect of missed calls were not recorded. We saw that no analysis of the complaints received had been completed so the service would not be able to minimise reoccurrences. People told us they had never had any visits from the office to check if they were happy with the service however; some people told us that they had recently received a telephone call to check if they were happy. Systems for monitoring the service provided to people were not sufficient to ensure people were listened to so action could be taken to improve people’s experiences.

Inadequate

Is the service well-led?

Our findings

Most people spoken with were happy with the care provided by the staff and felt supported to live in their own homes. However, some people felt the service could be improved because there was a lack of continuity of staff and the responses from the office staff were not very understanding and helpful. We saw that there were limited opportunities for staff and people to express their views about the service. We had received whistle blowing information of concern regarding financial sanctions placed on staff for not attending meetings and not responding to emails. Although staff were aware of their responsibilities in raising any concerns about abuse to the care co-ordinators, care co-ordinators were not aware of their duty to report any suspicions of abuse to the local authority who are the lead in safeguarding matters. This could mean that not all suspicions of abuse were logged so that the local authority could monitor the safely of people. This indicated that there was not an inclusive culture in the service.

There was a registered manager in post but they had not been available during our inspection. We saw that we were not always notified of all the occurrences that we were required to be notified about such as allegations of abuse. This meant that the registered manager was not fulfilling their legal responsibilities.

During our inspection we saw that management systems in place were not sufficient to ensure that the service was safe and the quality of the service monitored so that there were continual improvements in the service. We saw that the employer's liability insurance had expired and this was renewed when we identified it. We saw that the manager's first aid certificate had expired and moving and handling training was provided by a person who was not trained to do so. The registered manager was not aware of this. We saw that one of the duties of the on-call person was to cover any calls where no carer could be identified to cover a call. However, it had not been assured that the on call person was able to meet the requirements of the service and able to provide appropriate cover. We saw that there were no systems in place to ensure that all staff received regular supervision and that spot checks were carried out to ensure that they were providing care as required. People spoken with told us they had never had anyone come to their home to ensure the care staff were providing good care. We saw that where it had been identified that a member of staff needed closer monitoring this was not put in place.

We saw that there were some systems in place to get the views of people who received a service and staff that provided support. We saw that most of the questionnaires completed by people that received a service were positive. One person we spoke with told us that although they had received a questionnaire they hadn't completed it because they were not happy with the service and they [staff] knew they were not happy. One person had commented, "First class service. Very helpful." However, where people had raised issues such as things going missing from their home or needing additional support there was no evidence that the issue had been followed up and what actions had been taken as a result. We were told by some people that recently there had been some phone calls to ask if they were happy with the service but the majority of people told us there had been no contact with them. People told us that there had not been any reviews carried out with them where they had been asked if they were happy with the service other than at the 28 day review following the start of their service. This was confirmed in the care records we looked at.

Some people said they felt the responsibility was put on them to inform the office if calls were not attended. This was confirmed by one of the care co-ordinators as there were no systems to identify missed and late calls. This could leave people who were unable to inform the office staff at risk of not receiving a service. There were no systems in place to ensure that missed calls were identified and audited to ensure that themes and trends were identified. There was no auditing of the complaints received to ensure that all concerns received were logged so that any trends could be identified and actions taken to prevent reoccurrences. We saw that there was insufficient auditing of the recruitment processes. This was 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: People who use services did not always receive the support that met their preferences and needs. Regulation 9 (1) (b) and (3) (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems in place did not ensure that the registered person was able to assess, monitor and improve the quality and safety of the services provided including the quality of the experience of people that received a service. Regulation 17 (1) and (2) (a)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The registered person had not ensured that persons employed to carry out the regulated activity were fit and proper persons with the competence, skills and experience to provide care. Regulation 19 (1) (a) (b) and (3) (a).

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
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems in place did not ensure that the registered person was able to assess, monitor and improve the quality and safety of the services provided including the quality of the experience of people that received a service. Regulation 17 (1) (2) (a) (b) (d)(i)(ii)(e) and (f)

The enforcement action we took:
Warning Notice

Regulated activity	Regulation
Personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: The registered person had not ensured that persons employed to carry out the regulated activity were fit and proper persons with the competence, skills and experience to provide care. Regulation 19 (1) (a); 19 (2) (a) and 19(3) (a)

The enforcement action we took:
Warning Notice