Temple Mead Care Ltd

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 13 January 2016 and was unannounced.

We last inspected this service on 1 and 17 September 2015 when this service was rated as providing an inadequate service in response to the questions is the service safe and well. As a result of our findings at that inspection we issued warning notices to the registered manager and provider in respect of not ensuring that checks were carried out on staff that had been employed and the poor governance of the service. The service was also put into special measures so that we could continue to closely monitor the service.

At this inspection we saw that sufficient improvements had been made so that the special measures were no longer in place. However we saw that further improvements were needed to ensure that the provider had good governance processes so that that the quality of the service improved.

Temple Mead Care Limited provides personal care to people in their own homes. At the time of our inspection there were 62 people who were receiving a service. Most people were elderly, had complex health needs or a physical disability.

There was a registered manager in post. 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.

The provider had some systems in place that enabled them to assess and monitor the quality of the service provided. These systems were not used effectively to ensure that people received a consistently good quality service and further improvements in the quality of the service were needed. We identified that this was a breach of regulation. You can see the actions we have asked the provider to make at the end of this report.

People told us that they felt safe with the staff that supported them because staff knew how to protect people from harm. Where concerns had been raised the registered manager liaised appropriately with the local authority to ensure people's safety.

There was a system in place to ensure that checks were undertaken when staff were first employed by the provider. These included police checks and checks with previous employers.

There were sufficient members of staff employed to meet people's needs but systems in place did not ensure that people always received support at the times agreed.

Risks associated with people's care needs were identified and plans put in place to ensure people were protected from unnecessary risk.

People were supported to take their medicines and received their meals as required except when calls were late.

People were supported by staff that had received training to equip them with the skills and knowledge to support people safely.

People were supported to make decisions about the care they received and there were no restrictions on their liberty.

People received care and support from staff they had got to know and built up a relationship with them. Staff were caring towards people and ensured that they maintained people's privacy and dignity. People were supported to remain independent.

There were systems in place to gather the views of people but issues were not always followed up promptly.

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.

People were protected from abuse because staff had sufficient knowledge to identify abuse and systems were in place to protect people from harm and injury.

People were protected from the risks associated with the care provided because staff knew how to keep people safe.

There were sufficient staff to meet people's needs but systems in place did not ensure that people always received support when they wanted or needed it.

Systems were in place to ensure that recruitment processes ensured that people were safe. However, not all the required checks were undertaken to ensure only people eligible to be employed were employed.

People were reminded to take their medicines as prescribed by their GP.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were supported by trained staff that had the skills and knowledge to meet their care needs.

People were supported to make decisions about their care where possible. People's human rights and rights to liberty were maintained.

People did not always receive care and supported as planned because systems in place were not effective in identifying addressing calls that were not attended as required.

People were supported receive food, drink and medical attention to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People had developed positive relationships with staff that were caring and
considerate. However, Systems in place did not always ensure that people were kept informed about delays in their service.

People were able to make decisions about the care they received.

Privacy, dignity and independence were promoted.

Is the service responsive?

Good

The service was responsive.

People felt listened to and involved in their day to day care and people's changing needs were met.

There were systems in place to gather people's views and people felt listened to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People were happy with the service but felt it could be improved during the weekends.

The leadership had not ensured that all the required improvements had been achieved. Improvements had been made to the systems to monitor the quality of the service but they were not sufficient to ensure that people received a consistently good quality service and that actions were taken in a timely manner.

Some staff felt valued but others did not.

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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 13 January 2016 and was unannounced. The inspection was carried out by two inspectors.

This inspection was carried out to check on whether the warning notices issued following our last inspection in September 2015 and to consider if the service had made sufficient improvements to be removed from special measures.

We looked at the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. Notifications are required from the provider about their service in relation to accidents/incidents and safeguarding alerts which they are required to send us by law. We contacted the local authority that purchases the care on behalf of people to see what information they held about the service.

We spoke with 11 people who used the service, three people's representatives and six care staff. During the office visit we were supported by a care manger, two care coordinators and the registered manager. We looked at the recruitment and training records of four care staff. We looked at four people's care records, computer records and daily logs to check the care provided to people and records associated with monitoring the quality of the service. We reviewed all the information we hold about the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection during September 2015 we found that people were not being kept safe because the required recruitment checks were not always carried out before staff started their employment. At this inspection we saw that improvements had been so that the appropriate checks had been undertaken before staff were able to start their employment.

Staff spoken with told us that their employment checks had been carried out before they commenced their employment. We looked at four staff files to check that this was the case. We saw that for the three people who were supporting people in their own homes the Disclosure and Barring Service check (DBS) and previous employment checks had been completed appropriately. The DBS check is carried out to ensure that people that were barred from working in this type of employment were not able to access employment in the care sector. However, we saw that for one these three people there was no evidence available on the file that they were entitled to work the hours stated. For the fourth person the previous employment checks had not been completed, however, this person had not been out to visit people in their homes at the time of our inspection. This person did however, have access to personal information about people. This showed that although improvements had been made to the recruitment process it was not robust.

At our last inspection we found that there were not sufficient staff available to ensure that people always received the service they required. At this inspection we saw that although there were fewer missed or late calls there continued to be some because there were not always staff available to cover sickness and holidays. People told us that the problems of late or missed calls arose mostly during holidays and weekends. Staff told us that sometimes this was because there were not sufficient staff to cover staff sickness or holidays. Some staff told us that they felt pressurised to cover calls even when they felt ill because otherwise calls would be missed. Some people confirmed that there were late, missed calls and only one carer arrived to carry out a two carer call occasionally but that things had improved. We saw that some missed calls had occurred because calls had not been allocated or staff said they had said they were unable to attend the calls. The registered manager told us that they were in the process of recruiting more staff. This showed that some people were not receiving the service they required sometimes which put them at a potential risk of not receiving support, medicines or food and drink at the time they required.

People told us that they felt safe with the staff that supported them. Staff told us that they had received training in how to keep people safe from harm and staff were able to tell us about the actions they would take if they had any concerns. Information we held showed that where needed the registered manager reported concerns to the local authority and us so that the issues could be followed up to ensure people's safety.

People were supported to take their medicines as prescribed. Most people spoken with were able to take their own medicines or had relatives to support them. Staff told us that they prompted people to take their medicines. Prompted means that staff reminded people to take their medicines. Staff told us and records showed that they had received training in supporting people with their medicines. Care files showed that the medicines people were taking were recorded and risk assessments were carried out to ensure that systems

were in place for the safe storage and re-ordering of medicines so that they were available when needed.

Requires Improvement

Is the service effective?

Our findings

People were supported to receive a service that met their needs. People told us that they had been involved in planning the service they received. One person told us, "The care plan was done with me. They [staff] asked what help I wanted." Another person told us, "They [staff] asked what help I wanted and we discussed the risks." People also told us that they were asked what help they wanted each time staff attended the call. Everyone we spoke with told us that there was a care plan available in their home. Staff told us that they had regular calls to attend and had got to know people's routines but always asked people what help they wanted. One member of staff told us that when they took on a new call they were given basic information about people's needs and then read the care plans or asked people what help they wanted.

Staff were supported to carry out their roles through training, supervision and spot checks. Supervision and spot checks were carried out by senior staff to ensure that staff attended their calls and carried out the tasks required in the way agreed with people. Most people spoken with were happy with the care provided by the staff. One person told us, "I have no complaints about the girls." Another person told us, "Girls are very good. They [the service] send the same two girls as often as possible." Another person told us, They [staff] are very knowledgeable and helpful." However, one person told us that some of the staff did not understand what they needed to do and had raised this with the staff in the office. Staff spoken with told us that they had received induction training and had shadowed experienced staff so that they knew how to carry out their roles. Staff told us that the registered manager provided induction training included moving and handling training and protecting people from harm. We looked at the training records and saw that along with watching DVDs staff answered some questions on those topics to show their understanding. We discussed with the registered manager that there was a lot of training to be covered in two days and that some of the answers were brief and did not show full understanding. The registered manager told us that she had discussed the answers with people but these discussions had not been recorded to show that any shortfalls in understanding had been addressed.

Most people told us that they were happy with the care provided but some people told us that there had been missed and late calls and were not happy about this. One person told us, "They [staff] are regular." This person also said that the staff could be up to 30 minutes late but they didn't mind that. Another person told us, "Most times they [staff] are punctual." However, some people were not happy with the times of their calls. One person told us, "There have been times when they are late. If it's more than 15 to 20 minutes late I tell them [office staff]. I'm not having it. Last week there was [staff] sickness and the carer was over an hour and half late. They [office staff] have apologised." Another person told us that the timings at the weekends were not very good and calls that should have been at 9am were sometimes carried out at 11am. They told us, "I would ring them about 10am. I have rung and then I have cancelled the call." Whilst we were talking with one of the people that received a service we were told that the member of staff was late and they had not been informed that they were running late. The staff should have been there at 5pm and arrived at 6.15pm whilst we were speaking with the person. When we checked with the registered manager during our office visit why the staff had been late the registered manager told us that they were unaware that the call had been attended late. One person's representative told us that they were not always confident that the calls had taken place because there was no record of care provided in the daily records book. They had

raised this concern recently but had not had a response at the time of our inspection.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff spoken with told us that they always involved people or their relatives in making decisions about their care. This showed that staff were working in line with the requirements of the MCA.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this for people in their own homes are called the Deprivation of Liberty Safeguards (DoLS) and applied for through the Court of Protection. We were told by the registered manager that there no DoLS in place for the people they supported and no one was subjected to any restrictions on their liberty.

People were supported to receive food and drink at the times required. One person told us, "They get me my breakfast, at lunch I put the meal in the oven so that staff can get it out for me when they come." Another person said, "They [staff] get me my breakfast, they ask me what I want." Staff told us that they always asked people what they wanted to and drink. They said they offered people choices form the food that was available in their home. One member of staff told us, "I always ensure a drink is left so that (person being supported) has a drink assessable." One person told us, "I was short of milk and bread and the carer went and got it for me even though it wasn't part of her role."

People were generally supported by families to attend appointments but staff told us that if they felt people were not well they informed the office staff or relatives or called for emergency services. One person told us, "They call the doctor if needed." Another person told us, "I'm sure they would change the time of the call if I had an appointment." Care records looked at showed that health care professionals involved in people's care were recorded in the care plans so that they could be contacted if there were any changes in people's needs or people needed additional support.

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, "[Name of staff] is very kind". Another person said, "They [staff] make me tea, help me dress and help me with my shoes. They are a bit of company." A third person said "The girls are marvellous. They do a brilliant job."

People told us that they were able to express their views and make decisions and choices about the care they received. One person told us, "They [care staff] always listen to me they're lovely girls." Care records looked at confirmed people's involvement in planning their care and the way they wanted to be supported. People told us that they were offered choices in the food they ate and the clothes they wore. A member of staff told us, "We always communicate with people. We always give choices of food. Although we know what they like they may want something different."

People told us that the staff treated them with respect and their privacy and dignity was maintained. One person told us, "You have no dignity left when you have to have someone help you with personal things but the girls are always good with me. We have a bit of a laugh." Another person said "They [staff] are always nice to me, they are lovely." Another person said, "They [staff] always knock the door before coming in." Another person told us, "They [staff] always listen to what I want." 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 did this. A member of staff told us, "I always ensure that personal care is carried out away from other people in the house, unless they want them involved. I always check that people are comfortable with the help we are giving."

Some people told us that they were informed if a carer was going to be late but some people told us that they were not kept informed if staff were going to be late. We were told by staff in the office that a member of staff had made arrangements to attend a call later than planned so that they could attend a personal appointment. The office staff had not been informed of this beforehand so that alternative arrangements could be made to cover the call. This showed that changes to call times were not always made for the benefit of the person being supported. This along with the fact that other people told us that they had received late or missed calls did not show that the service was always caring.

People were supported to remain as independent as possible. One person told us that staff supported them to "scrub their back" but otherwise they were able to bathe themselves. Another person told us that they were able to choose their meal and put it in the oven ready for staff to take it out for them as they were unable to pick it up with both hands and walk. Several people told us that they were not supported to take their medicines as they were able to manage these themselves. Staff spoken with told us that they would support people to do things for themselves wherever possible but assist them if they were not able to do something because they understood the importance of people maintaining their independence and doing things for themselves.

Good

Is the service responsive?

Our findings

People told us that they had been involved in the planning of their care and received a service that met their individual needs. Most people told us that their needs were being met because they had regular carers and mostly staff came at the times agreed. All the staff spoken with were knowledgeable about people's needs. Staff told us that they provided care according to the care plans so that people received the care they needed and wanted. One member of staff told us it was important for one person to be called by a name that was not her real name as that was what they preferred.

We saw that where people's needs had increased the appropriate actions had been taken to meet those needs. Staff told us that they would inform the office staff if there was a change in people's needs. We saw that when the needs of one person had been identified as having increased the registered manager had liaised with the local authority for the care package to be increased. The registered manager told us that they had provided two staff to provide care to a person that had been identified as only needing one carer until an agreement had been arrived at with the local authority.

We saw that there were systems in place for gathering the views of people. People were contacted by telephone to check if they were happy with the service received. People told us that they had been contacted by telephone and asked if they were happy with the service they received.

People told us that they knew how to raise any concerns they had and felt listened to. One person told us, "Staff now seems to know what we want but before the girl used to leave the kitchen in a state. We told the office we didn't want her and she doesn't come anymore." People told us that there was an out of hour's phone number they used to contact the on call person if their concerns arose out of office hours. People told us they were always able to get a response on the telephone.

Requires Improvement

Is the service well-led?

Our findings

Most of the people spoken with were happy with the service they received although some people identified that there had been some missed and late calls, particularly at weekends. Most people commented that the service had improved recently. One relative told us that they had specifically asked for Temple Mead to provide a service when their family member returned from a stay in hospital and that they were "extremely happy" with the service.

At the time of our last inspection we found that the service was not being managed in a way that ensured people received a good quality service that met their needs. As a result we issued a warning notice to the provider and registered manager to ensure that improvements were made.

Following our last inspection we received an action plan showing the actions that were to be taken. The action included actions such as improving the recruitment process, training for staff to repeated annually, call monitoring system to be put in place, checks to be carried out on staff and a quality management programme and quality manager to be put in place.

At this inspection we saw that some improvements had been made to the systems in place to monitor the quality of the service but they did not ensure that actions were taken in a timely manner to improve the service for people. Systems were not being used to identify developing themes and trends. Not all the actions identified in the action plan had been completed. As a result we identified there was still a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An electronic call monitoring system had been put in place since our last inspection so that issues such as late or missed were picked up and addressed quickly. However, we saw that staff were struggling to use the system and many call times were not being correctly inputted onto the system. As a result a large number of calls were being identified as being late or not attended even if they had been attended. On some occasions the required time of the call had been put on the system incorrectly. This presented the risk that actual missed calls would not be identified and followed up quickly because the system was not accurately showing which calls had not been attended at the required time. For example, we saw that the day before our inspection the system had raised an alert that an individual had not had received their evening or tuck in call. The registered manager told us that they had tried to contact the member of staff but been able to make contact. We were told that no follow up had been made with the service user to check if they had received a call.

We saw that identified shortfalls in the service were not followed up and addressed quickly. We were told by the registered manager that a report of missed calls could be obtained from the computer. We looked at the lists for November and December but there was no record of how these had been followed up and addressed or any analysis of any trends or actions taken to prevent reoccurrences. For example, where staff had not attended a call because they did not know the call was on their rota or no staff had been allocated to a call there was no plan of how this was to prevented from re occurring.
We saw that during October and November 2015 spot checks had been carried out on staff. Spot checks are

unannounced checks on staff to ensure that they attend calls at the agreed times and carry out tasks as identified in people's care plans and checking with people if they were happy with the staff. However, we saw that at the time of our inspection no analysis had been carried out to see if there were any patterns that needed to be addressed.

We saw that the records made by staff of the support provided to people were being audited but the auditing process had not identified gaps in recordings indicating potential missed calls and consequently there was no follow up to determine the reason for the gap in recordings.

We saw that there were some systems in place to get the views of people who received a service. People told us that they had been asked by telephone if they were happy with the service. We saw records of the telephone calls to people to ask their views about the service provided. We saw that there was no overall analysis of these calls to determine what issues were being raised by people. We saw that 20 out of 44 people spoken with had raised an issue that needed to be attended. We saw that the process of making appointments to discuss the issues raised had begun. This showed that issues were not being dealt with in a timely manner. The registered manager told us that any immediate actions were undertaken but there was no evidence of the actions taken

People told us that they were able to ring the office or use the out of hours phone to raise any concerns they had. We saw that concerns raised were addressed on an individual basis but there was no system for bringing complaints together so that analysis of developing themes and trends could be carried out and actions could be taken to prevent or minimise reoccurrence of the same complaints.

The registered manager told us that the structure of the office staff was being developed so that in addition to the registered manager there was a care manager, three care co-ordinators and team leaders to assist in the monitoring of the service and management of staff. We saw that a care manager and care co-ordinator had been employed. Team leaders were yet to be employed. Office staff spoken with told us that the priority for the service was to deliver good quality care to people. They said that this would be achieved through speaking with people face to face to hear their views and follow up any complaints. Staff would be more closely monitored with more spot checks. We saw that although some of these checks had been undertaken there was a lack of analysis of the findings and follow up actions where issues had been identified. The registered manager told us that the senior staff team would be undertaking training organised by the local authority in respect of meeting quality standards and risk assessments so that they would be better able to meet quality standards and ensure a good service. Most staff spoken with told us that they felt able to speak to the registered manager and that they would be listened to however some staff did not feel valued. Some staff felt that there were many consequences for them but little praise for the job they did. Some staff felt that they were pressurised to continue to carry out their calls when they felt ill. This showed that staff did not always feel listened to and supported.

Following our previous inspection the local authority contract had been suspended so that the service was unable to bid for new contracts. The registered manager told they had agreed an improvement plan with the local authority to improve the service. The registered manager told us that no new packages of care had been taken on by the service since November and some packages of care had been handed back to the local authority as they were not able to meet people's needs.

There was a registered manager in post. Our records showed that we had been notified about occurrences that we were required to be notified about such as allegations of abuse. This showed that the registered manager was fulfilling their legal responsibility to inform us about the required occurrences.

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 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) and (e)