Teme Care Limited

Temecare Limited - Teme Court Residential Care

Inspection report

Old Road
Lower Wick
Worcester
Worcestershire
WR2 4BU

Tel: 01905426991

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31 October 2017

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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**

Summary of findings

Overall summary

Teme Court provides accommodation and personal care for up to 21 people. On the day our inspection commenced there were 20 people living at the home.

We undertook a comprehensive inspection of this service on 24 May 2016. At that inspection the provider was rated good overall.

Following our inspection in May 2016 we received concerns in relation to how people were safely cared for. As a result we undertook an unannounced comprehensive inspection to look into those concerns on 24 and 27 October 2017. The inspection was carried out by two inspectors. On 31 October 2017 one inspector and an inspection manager returned to the home to have further discussions with the registered provider.

There was a manager in post but they had not yet applied to register with the Care Quality Commission. 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 not checked staff's suitability to deliver care and support during the recruitment process. Staff had not received an induction and on-going training to carry out their role effectively. The manager had identified staff required further training to ensure they had the awareness and understanding to support people living at the home

Risks to people's health and safety were not always assessed and planned for. Some risk management plans had not been updated to reflect changes in people's needs to ensure people received consistent support to keep them safe. Improvements were needed in the storage management of medicines.

The provider had not taken actions to ensure people were supported safely and in an environment where they were not placed at risk. There was a culture of complacency where known risks were not reduced or monitored.

People did not consistently receive care that was individualised to their needs. People told us staff were kind and caring, but were so busy doing tasks they had little time to interact with them.

People did not always have interesting things to do on a regular basis. When people living at the home lacked stimulation. There were not dementia specific activities on offer.

The lack of quality auditing in the home had led to many risks to people's safety not being identified and acted upon.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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 longer be in special inadequate for any of the five key questions it will no measures.

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

People were not provided with a safe environment.

People did not consistently have risks identified and assessed, or their identified risks mitigated.

People were not always supported by sufficient staff, deployed effectively to ensure they remained safe.

Medicines were not consistently stored safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People were not consistently supported by staff that had up to date training and the skills to meet their needs. Some staff had not received an induction programme when they started work at the home.

Staff had not received regular supervisions.

People were confident staff had contacted health care professionals when they needed to.

People's consent was sought before care was delivered.

Is the service caring?

Requires Improvement

This service was caring.

People said although staff were kind and caring they were task orientated.

Staff protected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not responsive

People did not consistently have their needs met, and the service was not always responsive to their changing needs and preferences.

People did not always have interesting things to do with their time.

People who lived at the home and relatives knew how to raise concerns.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not always gain people's views on how the service was delivered.

Systems and processes to monitor assess and improve the quality and safety of the care provided to people was not comprehensive or effective.

Audits did not always identify shortfalls and when shortfalls were identified, it was not clear what action, if any, the provider had taken.

People's opinions had not been sought about the service they received from the provider through regular questionnaires and surveys.

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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 checked 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.

The inspection was prompted in part by information of concerns we received regarding the way staff were recruited by the provider. This inspection took place on 24,27,31 October 2017, and was unannounced. The inspection team consisted of two inspectors.

We looked at information we held about the provider and the services at the home. This included notifications which are reportable events which happened at the home which the provider is required to tell us about. We also checked information which had been sent to us by other agencies. We requested information about the home from the local authority and Healthwatch. The local authority has responsibility for funding people who used the service and monitoring of the quality of it's contractual arrangements. Healthwatch is an independent consumer champion, which promotes the views and experiences of people who use health and social care. We used this information to focus our inspection.

We spoke with seven people who lived at the home and two relatives. We spent time with people and saw the care provided. In addition we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with seven people who lived at the home and two relatives. We spoke with three care assistants, one senior care assistant, deputy manager, the manager and the provider. We looked at two people's support plans, quality assurance documentation, and eight staff recruitment files, minutes for meetings and the complaints records.

Inadequate

Is the service safe?

Our findings

At this inspection we found that people living at the home were at risk of harm. This was because risks had not been identified and appropriate actions had not been put in place to reduce these risks and to protect people.

There were risks to people's safety due to shortfalls in preventing the spread of fire and keeping people safe in the event of an emergency. We saw some fire doors did not close properly into the frame. These doors were designed to hold back a fire and provide time for people to escape. We saw linen was stored in cupboards without fire door protection and were left open. Precautions to help stop a fire spreading had been ignored. We found an emergency light and lights in the upstairs hallway did not work so in the event of fire the exit would not have been illuminated to ease evacuation from the building. We saw a fire exit from the laundry room was cluttered with garden matter and debris, making it difficult for people to escape from the building in an emergency. Following our concerns we shared this information with Hereford and Worcestershire Fire and Rescue Service, who joined the inspectors at the home on 27 October 2017 to assess the immediate risk to people's safety. They told the provider what immediate action they must take to protect people's safety.

At the time of our inspection two waking care staff covered the night shift. However when we spoke with staff it was not clear who had responsibility for the shift and who was in charge. Contingency plans were unclear ,such as the action to be taken in the event of a fire and where people could be moved to in the event of a fire especially at night had not been finalised.

Although risk assessments identified people as being at high risk of falls, the provider had not taken action to mitigate the risks and keep people safe. We found the carpets around the home environment were often frayed and lifting so had become a trip hazard. The manager told us staff did not always identify risks for people they cared for. For example the manager had removed perching stools (equipment for people to sit on when performing activities, not intended for showering) from the bathrooms. This was because staff had been using the perching stools to assist people when showering. The manager told us they had put in an urgent request to the provider to purchase designated shower chairs, so people could shower safely.

When we looked at the maintenance of the lifting equipment used in the home. We found the hoist service was overdue as it should have been serviced in May 2017. The service and assessment of equipment such hoist are to ensure they are safe to use. The servicing of equipment was therefore four months out of date. As a result the provider could not be assured the equipment was safe.

We found the home environment could potentially put people at risk. The provider had extended the property including some new bedrooms. Despite these rooms not having the required signing off under building regulations and were not registered with Care Quality Commission one person was living in this area. On day three of our inspection the provider told us and we saw the person had moved to another area within the home.

In the conservatory area of the home we saw one wall had a recess which was covered in mould. The provider told us this was due to a leak from the flat roof a few weeks ago. On day three of our inspection we saw work had been started to repair the wall.

We observed the medicine round at lunchtime, we saw the senior care assistant, had left the medicine trolley with one of the doors open and with keys in the lock. Medicines were left on top of the trolley whilst they obtained a glass of water for one person. The contents of the medicine trolley were clearly visible and could have been accessed by unauthorised persons including people living at the home. When the medicine round was finished the medicine trolley was placed in the office but was not secured to the wall in line with the provider's medicine procedures..

We saw some people's medicine records did not have a photograph of the person to identify whom the records were for. A staff member told us they had requested the provider purchased a camera some time ago but their request had not yet been fulfilled.

We found people's PRN [medicines to be administered as necessary] medicine protocols had not been reviewed since 2015. Therefore the provider could not be sure this was the most up-to date direction for staff to follow.

All of the above constitutes a Breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Safe care and treatment.

We looked at the provider's recruitment procedures. We found that not all staff working at the home had a personnel file despite being employed at the home for a period of eighteen months. We saw some staff did not have references or proof of right to work documentation. In addition, we found some staff did not have a had not had a Disclosure and Barring Service Check (DBS) prior or after they had been employed at the service for several months. A DBS check is performed to ensure potential staff members were of good character and suitable to work with people who lived at the home. The provider had failed to do this, so could not be sure staff were suitable to work at the home and keep people safe. The provider told us recruitment procedures had not been followed since the absence of management within the home. Following the inspection the provider suspended staff without a DBS working on shift and told us they had applied for a DBS for all staff working at the home, to ensure staff were of safe to work there.

This constitutes a Breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Fit and Proper Persons Employed.

People we spoke with felt there were sufficient staff available during the day to meet their needs. Although one staff member felt more staff should be available to organise activities for people. The number of staff seen on duty matched the number we were told would usually be working by the manager and staff we spoke with. The provider told us the staffing levels were determined on people's assessed needs. The manager told us they were trying to recruit more staff but in the interim was using agency staff to ensure people's care needs were met.

People we spoke with told us they felt safe living at the home and told us they received their medicines as prescribed. We spoke with staff about how they made sure the people they provided support for were safe. They were able to tell us how they would respond to and report allegations or incidents of abuse. Staff could describe the different types of abuse people were at risk of and were able to explain the different agencies they could report concerns to in line with the provider's policies and procedures. One staff member we spoke with told us "I feel sure the manager [manager's name] would report any incidents to safeguarding,

CQC [Care Quality Commission] or the police if I raised concerns." Another staff member described what action they would take if they thought a person was being harmed by a staff member. They said " I would ask the staff member to remove themselves from the room and if necessary I's ask them to leave the premises. then report the incident immediately to the manager."

Requires Improvement

Is the service effective?

Our findings

We spoke with staff about the training they received from the provider. A new staff member told us they had completed an induction period but when we checked with the manager we were told it had only consisted of one shadow shift. The manager told us they felt this was insufficient and felt the induction should be over a two week period. When we checked the staff files records for confirmation of an induction programme having taken place these were not signed off by the employee or the manager. We could not find any evidence of staff having completed the Care Certificate. The Care Certificate is a set of standards that should be covered as part of induction training of new care workers. Staff told us they had training in the form of e-learning packages, which they felt were informative. We checked with an agency staff whether they had received an induction when they started working shifts at the home. They told us " I worked a night shift shadowing an experienced member of staff and read people's care files so I knew what to do."

However when the fire officer arrived on site they asked three staff members to demonstrate how they would assist people evacuate the building in the event of a fire. All three staff were unable to find the keys to open the fire doors. As a result of this, we asked the provider to ensure all staff were instructed again on the fire evacuation procedures to ensure people were kept safe.

We looked at the staff training records and staff told us they did not receive regular training. We saw in the records many staff had not received training in moving and handling since 2015. One person had a supervision record showing they needed to complete this training while other supervision records highlighted other training staff needed to complete. Other shortfalls were seen in the training records. For example ten staff members had not received any infection control training. We were not provided with an indication on how the provider had planned to make sure all staff had the training they required to effectively meet the needs of people they cared for.

The provider did not ensure sufficient numbers of suitably qualified, competent, skilled staff were deployed. This was a breach of Regulation 18(1) HSCA 2008 (Regulated Activities) Regulations 2014

Staff told us they did not receive regular support and supervision, so were not given the opportunity to reflect on their practice and discuss their training needs. A staff member told us they had only started to receive supervisions since the new manager had come in to post. We saw staff meetings had taken place to introduce the new manager.

This was a breach of Regulation 18(2a) HSCA 2008 (Regulated Activities) Regulations 2014

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.

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 in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. For example some people required one to one supervision with staff to prevent them hurting themselves.We reviewed how the manager had ensured people's freedom was not restricted. We found applications had been made to the local authority as needed. The manager was aware of the applications which had been granted by the local authority. They told us they were due to undertake further training with the deputy manager regarding mental capacity. Throughout the inspection we saw staff asked people for their consent before performing any tasks.

One person told us, "The food is very good." We saw people were offered choices to meet their preferences at mealtimes and were not rushed. Where people needed support from staff in order to eat safely or to choose from a range of food and drink options this was provided. We saw people had access to jugs of juice left around the home for easy access.

People told us they had access to health professionals when required to help them remain well. One person confirmed this, "If I am not well the doctor will come." We could see from people's care records they had accessed health professionals such as chiropodists, opticians and district nurses when required. The manager told us the local medical practice had arranged weekly visits to the home to help ensure people stayed healthy.

Requires Improvement

Is the service caring?

Our findings

We asked people if they felt the staff were caring, we received the following comments, "The staff are very kind and considerate." Another person described the staff as, "They look after you well." A further person told us they were spoilt living at the home. Additionally people also told us they liked living at the home.

We spent time in the communal areas to see how people were cared for. We saw staff approached people in a respectful, patient and friendly manner. Staff were seen assisting people with their meals and with a drink. They were however extremely busy and task orientated so did not always have the opportunity to stop and chat to people. One person told us " Staff don't always listen, it's not their fault they don't have time." One staff member told us "I do the best I can. I would hope people are content."

There were a number of rooms, in addition to people's individual rooms, where people could meet with friends and relatives in private if they wished. People told us they could have relatives and or friends visit whenever they liked. A relative told us they were, "Always welcomed when they visited the home and offered refreshments."

People were given choices and involved in decisions about their care. One person said, "I get up when I like and go to bed when I like." Another person said, "We have good banter with the staff." During our inspection we saw examples of good banter between people who lived at the home and staff.

We saw staff used people's preferred names and people were relaxed in the company of staff. Some people and their families had shared information about their life history with staff to help staff get to know them.

We saw people had been supported to maintain their appearance because we saw staff had assisted people to choose their clothing. We saw some people chose to wear particular favourite items of jewellery.

People were encouraged to be as independent as they could be. We saw staff assisted people with mobility difficulties move into the dining room. They walked by the side of people and gently encouraged them whilst they used their walking aids to give reassurance.

People's diverse needs were recognised. Staff told us representatives from people's chosen religion visited the home to assist people to follow their individual faiths. One person told us "We have communion once a month, but it's your choice if you attend."

Staff knocked on people's doors before they entered when they checked whether people needed anything. We saw people were treated with dignity and staff had a good understanding of what dignity meant for people. One person told us, "They always make sure my bedroom door is closed before they help me get dressed." A staff member told us, "I always treat people like I would like to be treated."

People's care plans and associated risk assessments were stored securely and locked away. This made sure that information was kept confidential.

We saw people's end of life wishes had been considered and recorded in their care plans.

Requires Improvement

Is the service responsive?

Our findings

During our inspection one person told us they had nothing to do during the day. Other people told us they could read a book to keep them occupied. We looked at what activities were available for people to keep them occupied. We found there was little activity specifically designed for people who lived with dementia to engage in. We saw the television was on in one of the lounges although this had the sound turned down. We didn't see or hear staff consult with people to see if they would like to hear the sound on the television.

Some jigsaws were available on tables in front of people in another of the lounge areas. We did not see any staff members assist people or encourage people in the completion of these jigsaws and saw people sleeping with these in front of them. Staff were seen to be focused on completing care tasks and had limited time to sit and be with people to chat. As a result they had little time to sit and engage with people. We heard a relative say, "They have music but nothing ever happens." We could not see any evidence of planned activities to choose from.

When we spoke with some staff, they could not tell us about people because they were agency staff and unfamiliar with people's needs. For example, we saw staff being unsure of people's names, what sort of meal they required and how people liked to be cared for. The staff member had not attended a hand over meeting at the start of their shift, so was not up-to date with people's needs.

When we looked at people's care plans we could not evidence that people had been consulted about their contents. In one of the care plans we reviewed there was no personal history and life history completed. The activities people 'liked to do' section were not filled in. So there was no guidance for staff to follow and ideas of how to stimulate each person so people sat around bored.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Person Centred Care.

Care plans were reviewed by senior staff to provide other staff members with guidance on how to meet people's needs. We saw in one care plan instructions on how to keep the individual staff. During our inspection we saw how staff discreetly check on the whereabouts of the person. We saw people's end of life wishes had been discussed with people and were recorded within the care plans.

We saw staff respond to people when their needs changed, for example at lunchtime we saw a person become unwell, so staff sat next to the person reassuring them until they recovered.

People told us they knew how to complain. People we spoke with told us they had not raised a complaint about the service in the past. One person said, "I would tell the manager, the one in charge of the place if unhappy". The same person added they, "Haven't had to" make a complaint as they were happy with the care provided. Another person told us, "I would tell them [manager] if I was unhappy but I've not needed to do this." We reviewed the provider's complaints records and saw there were no complaints recorded since the last inspection.

Inadequate

Is the service well-led?

Our findings

We carried out this inspection as a result of concerns raised by a social care professional and a member of the public.

At the time of our inspection, the service had a manager in place for six weeks, but had not yet registered with the Care Quality Commission. A registered manager is a person who has registered with CQC to manage the service. The manager was on duty during our inspection. Following our visit, the provider advised us that the manager had resigned from the organisation.

Systems and processes to monitor assess and improve the quality and safety of the care provided to people was not comprehensive or effective. Audits did not always identify shortfalls and when shortfalls were identified, it was not clear what action, if any, the provider had taken. For example we saw the maintenance records where staff had entered faults such as lighting not working, but there was no record when the action had been taken to remedy the situation.

When we looked at the accident and incident file, we found although accidents were reported there was no follow up information of what action had been taken so lessons could be learned and risks reduced.

We could not find any record of the provider audits. Although the provider told us they regularly visited the home, they had failed to identify shortfalls in the environment. For example we identified several of the fire doors were not shutting properly. We found many of the carpets were lifting and fraying and presenting as a trip hazard for people. Lighting including some emergency lights were not working on the upstairs landing. We highlighted a radiator cover coming away from the wall. The manager told us nobody had told her about the radiator. These shortfalls and faults could be potential risks to people and the provider should have had systems in place to identify these and the action they had taken to rectify them.

The provider had failed to notice the unsafe recruitment process of staff being employed without a Disclosure and Barring Service Check (DBS) check so putting people at potential risk of having unsuitable staff caring for them. When we spoke to the provider they told us, "They had taken their eye off the ball" and assured us they would want to work with authorities to put things right."

We found the provider did not have enough permanent staff and was reliant on agency staff to cover the staff rota. However, they had not put measures in place to ensure agency staff were appropriately checked and inducted to the service. It was unclear which agency they were employed by.

The provider had not taken actions to ensure people were supported safely and in an environment where they were not placed at risk. There was a culture of complacency where known risks were not reduced or monitored. When we spoke with the provider they told us " I have taken my eye off the ball, since [registered manger's name] has is sadly no longer here things have not been as good as they should have been. I didn't check."

Failure to appropriately monitor the quality and effectiveness of the service this a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance.

Following our inspection, the provider sent us action plans detailing how they would address these concerns and gave assurances that they would be compliant with this regulation.

When we spoke with staff they were not always clear of the line of responsibility. For example we were told two care staff were on duty at night, but no one had overall responsibility of the shift. One staff member told us thought it's was the staff member who has worked here the longest who was in charge. We discussed this with the provider who told us they would address the situation as a matter of urgency.

The new manager told us they did not know when the last relatives/ people using the service questionnaires were sent out to gain people's views on the service they received. We could not be assured that people's voices were being listened to in the running of their home.

Since coming into post the new manager had started to complete staff supervisions and address some of the staffing issues identified. Staff told us they thought the new manager was good at her job and was approachable. Staff told us they felt supported by the new manager and they had identified a number of concerns around the home regarding the environment and were addressing these with the provider.

The provider had displayed the rating of their last inspection within the hallway of the home for people and visitors to see.