B & M Investments Limited

Templemore

Inspection report

121 Harlestone Road
Northampton
Northamptonshire
NN5 6AA
Tel: 01604 751863
Website: www.bmcare.co.uk

Date of inspection visit: 14 and 31 October 2014
Date of publication: 21/01/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

This unannounced inspection took place over two days the 14 and 31 October 2014.

Templemore Care Home provides accommodation for people requiring personal care. The service can accommodate up to 72 people. At the time of our inspection there were 62 people using the service. The home is divided into three areas and people live in the area that is best suited to their needs. The residential unit provides care for older people and both of the Cedar units provide care for people living with dementia.

There was a registered manager in post at the time of 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.

The provider had systems in place to safeguard people from the risk of abuse.

Summary of findings

Staff recruitment procedures were in place to ensure staff were of good character and there were enough staff on duty to support people with their care.

Medicines were administered in a safe way and there were systems in place to prevent people receiving unsafe care.

Staff received training and development and were suitably supported by their manager to do their jobs.

The registered manager and staff were aware of their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). There were procedures in place to assess people's ability to make decisions about their care. Staff understood how to make best interest decisions when people were unable to make decisions about their care.

There was a choice of nutritious food and drinks on offer; however people had not always received support and encouragement to eat their meals.

People received support to maintain their health and wellbeing and staff worked well with health professionals to ensure people received the treatment and care they needed.

People received support to undertake a range of social interests and hobbies.

The provider had a system in place to manage people's complaints. However, complaints were not always recorded appropriately. This made it difficult to evidence how people's complaints were fully investigated and resolved.

There were systems in place to assess and monitor the quality of service provided and people and their relatives gave their feedback on the quality of service received.

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?
The service was safe.

Safeguarding incidents were reported to the local safeguarding authority and other agencies involved in the safeguarding of adults.

There was a recruitment system in place to ensure staff were of good character before they worked at the home. There were sufficient numbers of staff working to provide people with appropriate support and care.

There were systems in place to manage risks to people's care.

People received their medicines when they needed them and in a safe way.

Good

Is the service effective?
The service was not always effective.

There was a system of training and development in place and staff received support to undertake their roles. However, dementia training was not always put into practice to meet people's needs.

There were systems in place to assess people's decision making abilities and staff made decisions in people's best interests when they were unable to make decisions about their care.

People had enough to eat and drink. However, people had not always received the support and encouragement needed to eat their meals.

Requires Improvement

Is the service caring?
The service was not always caring.

Staff had an inconsistent approach to communicating with people with dementia.

People did not always receive care that preserved their dignity.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People received support to maintain their health and wellbeing and staff worked well with health professionals involved in people's care. People received support to undertake a range of social activities, hobbies and interests.

People's complaints were appropriately dealt with and were resolved to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?
The service was well-led.

Good

Summary of findings

There was an open culture in the service and staff were able to raise any concerns with their manager.

The provider quality assurance system in place to regularly check and monitor the quality of service received.

Templemore

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 unannounced inspection took place over two days, the 14 and 31 of October 2014. The inspection team consisted of a lead inspector and a second inspector. The inspection team was supported by an Expert-by-Experience (Ex-by-Ex) and a specialist advisor. An Ex-by-Ex is a person who has personal experience of using or caring for someone who uses this type of care service. The specialist advisor was a registered nurse with experience of providing dementia care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the provider. We also spoke to health and social care professionals and service commissioners. They provided us with information about recent monitoring visits to the service including the outcomes of safeguarding investigations.

During this inspection we spoke to the provider, the registered manager, the deputy manager and ten care workers. We spoke with nine people who were using the service and seven relatives.

We undertook general observations in communal areas and during mealtimes. 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 reviewed the care records of 13 people who used the service and five staff recruitment files. We also reviewed records relating to the management and quality assurance of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home and there were systems in place to safeguard people from the risk of abuse. The staff had a good understanding of the different types of abuse and signs to look out for. There were clear lines of reporting safeguarding concerns and appropriate referrals and notifications were made to agencies such as the Local Authority and the Care Quality Commission (CQC). We saw that safeguarding investigations were taken seriously by staff and the registered manager had worked with officers from the Local Authority and the police to resolve safeguarding concerns.

The provider had systems in place to protect people from the risk of unsafe care. For example, we saw that people were assessed for a range of risks that included the risks of developing pressure ulceration, of falling and of not eating and drinking enough. We saw that there were systems in place to record and monitor any accidents and incidents in the home and this information was used when assessing people's risks. The staff had a good knowledge of risks relating to people's care and knew how to minimise this by taking preventative action. We saw risk assessments that were sufficiently detailed and provided staff with the information and guidance they needed to help keep people safe. However, a risk assessment for a person who self-harmed had no information about the likely triggers for this behaviour. We would have expected to see this information included in a documented risk assessment and used to guide staff on strategies to use to support the person so that the risk was minimised.

Staffing levels had been set based upon people's need for care and people and their relatives told us there were enough staff. The home is divided into three areas and people live in the area that is best suited to their needs. We observed that staffing levels varied between each area of the home and reflected their need for care. For example a higher number of staff were deployed to the "Cedar two" area of the home as people had a higher need for care. Staff told us there were enough staff to meet people's needs and we saw staff had time to interact with people and support them with their social activities. There were procedures in place to cover shortfalls in staffing such as sickness or annual leave and care was delivered by a consistent and permanent team of staff.

There were recruitment processes in place to ensure staff were of good character and able to work with people. This included obtaining references from previous employers and ensuring staff had a Disclosure and Barring Service check (DBS). This check helps employers make safe recruitment decisions and ensures that people who are of good character are employed to work with people.

People received their medicines safely when they needed them. For example we observed the staff administering medication were solely engaged in that task and were free from any expectation to undertake other tasks. We saw that staff wore a red waistcoat which said "Do not disturb undertaking medication round" and staff told us they would not be disturbed while assisting people with their medicines. We observed that staff safely administered people's medicines by checking that they administered the correct medicine, to the right person at the right time. We also saw that staff observed people taking their medicine and maintained accurate medication administration records (MAR). There was a system of medication audits and checks in place to identify any medication errors and these were reported to the registered manager who took any necessary action. We saw that medicines were stored safely and securely and systems were in place for managing controlled drugs.

Requires Improvement

Is the service effective?

Our findings

Staff received a programme of training and development; however we observed this did not always provide them with the skills to do their jobs. For example, whilst staff told us they received dementia training and knew how to put this training into practice, we observed that some staff had poor practice. Staff interacted well with people with dementia that could speak. By contrast, however, staff were not so good at interacting positively with people who were unable to respond verbally. The registered manager told us that while all staff had received basic dementia training, there were plans to provide advanced dementia training for all staff.

Staff training records showed that there was a programme of training and development in place which included induction training for new staff and regular training updates for all staff. This included training in subjects such as manual handling, infection prevention and control, the safeguarding of vulnerable adults and the management of medicines. Staff were provided with additional opportunities to study for vocational qualifications in care to enhance their knowledge of providing care to people. Staff told us they were well supported to do their jobs and received regular supervision of their work performance to ensure standards of care were maintained.

People who were unable to make informed decisions about their care were appropriately supported by staff. The registered manager was aware of their responsibilities under the Mental Capacity Act 2005 and in relation to Deprivation of Liberty Safeguards (DoLS). People who were unable to provide their consent for their care had received an assessment by the Local Authority and appropriate safeguards were in place.

Staff were aware of how they needed to involve people's families and health professionals in the making of best interest decisions. Relatives also confirmed that they were involved in making decisions about their relatives care. However, we saw that people's records did not always include information about how a best interest decision had been made. We raised this with the provider and they implemented a new system of paper work to prompt staff to record how best interest decisions had been made.

People received a choice of nutritious food and drinks. We observed that a hot meal was served at lunch time and this looked appetising. One person told us they really enjoyed the meal served and said "It's very nice, I couldn't get better at the Ritz". We observed that staff adapted the consistency of people's meals based upon their dietary needs. For example, people with swallowing difficulties received a soft or blended diet. The staff told us that people were given regular choices of meals and snacks throughout the day and alternative meals were available on request. A relative told us that they had seen the food being served and this looked to be of a good standard and had seen staff cater for people's individual tastes and preferences.

We saw that people who needed physical assistance to eat their meals received the help they needed; however people who lacked motivation to eat their meal without staff encouragement had not always received this care. This resulted in four people not eating all their lunch. We saw that the staff cleared the people's plates away and did not acknowledge that they had not fully eaten their meals. Staff told us that they monitored these people's food intake as they were at risk of losing weight, We observed that whilst, records were in place to monitor the food and drinks they had received, staff did not reflect that they had eaten poorly. We saw that staff had recorded that they had eaten their meal which made it difficult to monitor their nutritional status.

There were systems in place to monitor and respond to people's health and wellbeing needs. For example, the staff showed us how they monitored people at risk of developing pressure ulceration by checking their skin each day. We saw the district nurse was contacted promptly when there were signs that a pressure ulcer might be developing. Any advice, such as assisting the person to move their position was put into practice straight away in order of meeting the person's changing needs. Relatives also told us that in their experience staff responded quickly to people's changing needs and their family member received access to a range of health and medical professionals. People's care records confirmed that staff responded to signs of ill health and took appropriate action such as contacting people's G.P's to ensure effective care.

Requires Improvement

Is the service caring?

Our findings

There was an inconsistent approach to communicating with people with dementia. We observed that some staff communicated well with people with dementia; however there were several instances where staff practice needed to be improved. For example, one member of staff was observed trying to get a person to move out of their chair. We saw they used techniques such as dancing in front of the person to get a response from them. We also observed that the staff's body language conveyed their frustration with this situation and they leant over the person in an attempt to coax them out of the chair. This resulted in the person using behaviours that challenged the staff and the member of staff had to leave the person seated in the chair. We also observed that some staff appeared to lose their patience with people. For example, we observed a person made a request to staff several times. Whilst, care staff had responded to the person's request we observed that their tone of voice expressed frustration with the request being repeated throughout the day. Towards the end of the day, another staff was observed responding to people with a sharp tone in their voice and we observed that they were losing patience with people using the service.

We also observed some good examples of staff communication with people. For example We observed that staff adopted a calm and patient approach when supporting people to move around the building and we saw that they spoke to people in a pleasant and reassuring way, People and their relatives told us that in their experience the staff were of a kind and caring nature. One relative said "The atmosphere here is lovely really and the staff are always nice, kind and friendly". Another relative told us "the staff appear caring and I think this is a good home".

The arrangements to support people to express their views and preferences needed improvement. For example, while people were given choices about the activities and pastimes they wanted to undertake there was little evidence of how people made other choices about their care. The staff worked from a daily list of people to shower and bath and there was a lack of evidence which demonstrated how people were involved in making these choices. Whilst, staff told us that people were consulted about their meal preferences, we observed that at lunch time meals were served from a trolley with food being put onto plates then handed out to people. There was no explanation of what was being served or choices available such as different vegetable or alternative options. This approach did not support people living with dementia who may not remember the meal option that they have chosen earlier in the day.

Staff did not always provide care that respected people's dignity. For example, we observed that on occasions, some staff referred to people using terms such as "good girl" and "good man" rather than addressing people by their preferred name. This approach to delivering care may result in people not feeling valued or respected. During lunch time we also observed some staff adopted a more task orientated approach to care which might result in people feeling de-valued. We observed some staff stood up while they assisted people to eat their meal. They appeared to be hurried in their approach and lacked time to interact with people while assisting them to eat.

Another person who required assistance to eat had their meal time continually interrupted as staff kept leaving them to attend to other duties. After, the inspection the registered manager informed us they had a meeting with staff to discuss the importance of interacting with people in a positive way and assisting people with sensitivity and dignity.

We saw that people had access to their own bedrooms and bathrooms and staff sensitively supported people with their personal care needs. People's relatives told us that their family members were supported in a respectful way and they were satisfied with the arrangements to protect people's privacy and dignity.

Requires Improvement

Is the service responsive?

Our findings

The complaints system in place could be strengthened to ensure that all complaints were looked into and action taken to improve practice where needed. For example, although we found that most people's complaints had been resolved informally by staff, one complaint had not been responded to appropriately. We saw that a relative had made a serious complaint about their family member's care. This had been dealt with by senior staff and had not been reported to the registered manager. This resulted in the complaint not being fully investigated and there was no evidence that a satisfactory response had been given to the complainant. The registered manager told us they would look into this complaint and make sure staff were aware of their responsibilities in reporting people's complaints to them so they could be dealt with in line with the provider's policy and procedures.

People and their relatives were regularly involved in the planning and review of their care and systems were in place to make sure the care provided met people's needs. Relatives also told us that they were invited to attend care planning meetings to review their family member's progress and to ensure care met their individual needs. We saw that people had an individual plan of care containing information about their health and social care needs. The staff reviewed this information each month or when people's needs changed to ensure care met people's requirements. We saw that some care plans reflected people's preferences, likes and dislikes for care, however, other care plans focused on the tasks that staff needed to complete.

We saw that people received referrals to healthcare professionals when required. For example one person had a series of falls and staff had referred them to a falls prevention service. We also saw that when people's health care needs changed or they were unwell staff responded promptly by contacting the person's G.P or district nurse.

People were supported to undertake a range of social activities, hobbies and pastimes. For example, we observed people enjoyed activities such as singing songs and playing floor skittles. There were a range of activities taking place such as visits from musicians and singers and one to one support for people to enable them to undertake their chosen activities and pastimes. People and their families had been invited to participate in a range of events such as a summer barbeque, a fireworks night and Christmas celebrations. One relative told us "The barbeque was a fantastic event, there were lots of activities going on and families were welcomed".

Good

Is the service well-led?

Our findings

Staff and relatives told us there was an open culture at the home and any concerns were reported to the registered manager who dealt with them appropriately. Staff told us they were familiar with the whistle-blowing policy and procedure and knew how to contact external agencies such as the Care Quality Commission (CQC) and the local safeguarding authority. Whistle-blowing is when a member of staff suspects wrongdoing at work and makes a disclosure in the public interest.

We saw that the provider had made significant quality improvements to the service. For example, they had refurbished people's bedrooms, bathrooms, living areas and had built a new conservatory and garden area. The registered manager told us that people had been involved in making decisions such as how their bedrooms had been re-decorated. People and their relatives told us that they were happy with the improvements made to the home.

Staff regularly held meetings for people and their relatives and we saw that discussions were recorded about activities or entertainment that people wanted at the home. We saw that the registered manager regularly invited people from the local community into the home, for example local school children came to sing to people at Christmas time. The registered manager had completed a range of surveys and this showed that people, their relative's and staff were largely satisfied with the service provided. The registered manager had implemented a "comments box" in the reception area of the home to encourage relatives to feedback about the service.

There were clear lines of accountability in place and staff understood their duties and responsibilities well. For example, staff were responsible for daily audits that checked that people had received safe care. Accidents and incidents were reported and any concerns about people's health or safety were escalated to the registered manager. We saw, therefore, the registered manager had an overview of concerns that had arisen at the home and took appropriate actions to ensure people's safety. For example, they were aware of their duties in reporting safeguarding incidents to the Local Authority and CQC. We saw that the registered manager fully investigated safeguarding concerns and responded to the local authority promptly. We also saw that the registered manager had improved their quality assurance systems in response to a safeguarding investigation and had implemented a series of spot checks to ensure people received good care at night time.

There were systems in place for managing risks and making improvements, however these had not always identified risks to people's health and safety. For example people's newly refurbished bedrooms did not contain hand washing products for staff to wash their hands following personal care. Whilst the provider took immediate action to put this in place this had not been identified through the system of risk management. However, we saw that there were other systems in place to assess risks to people and monitor their care. This included a regular system of medication and falls audits and checks of the safety of premises, equipment and of the fire detection systems.