Prime Life Limited

The Old Rectory

Inspection report

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Ratings

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

Overall summary

We inspected The Old Rectory on 29 October 2015. This was an unannounced inspection. The service provides care and support for up to 44 people. When we undertook our inspection there were 42 people living at the home.

People living at the home were older people. Some people required more assistance either because of physical illnesses or because they were experiencing memory loss. The home also provided end of life care.

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.

CQC is required by law to monitor the operation of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) and to report on what we find. DoLS are in place to protect people where they do not have capacity to make decisions and where it is considered necessary to deprive their freedom in some way, usually to protect them. At the time of our inspection there was one subject to such an authorisation.

Summary of findings

We found that there were sufficient staff to meet the needs of people using the home. The provider had taken into consideration the complex needs of each person to ensure their needs could be met through a 24 hour period.

We found that people's health care needs were assessed, and care planned and delivered in a consistent way through the use of a care plan. People were involved in the planning of their care and had agreed to the care provided. The information and guidance provided to staff in the care plans was clear. Risks associated with people's care needs were assessed and plans put in place to minimise risk in order to keep people safe. Medicines were stored and administered safely.

People were treated with kindness, compassion and respect. The staff in the home took time to speak with the people they were supporting. We saw many positive interactions and people enjoyed talking to the staff in the home. The staff on duty knew the people they were supporting and the choices they had made about their care and their lives. People were supported to maintain their independence and control over their lives.

People had a choice of meals, snacks and drinks. The meals could be taken in a dining room, sitting rooms or people's own bedrooms. Staff encouraged people to eat their meals and gave assistance to those who required it.

The provider used safe systems when new staff were recruited. All new staff completed training before working in the home. The staff were aware of their responsibilities to protect people from harm or abuse. They knew the action to take if they were concerned about the welfare of an individual.

The provider was addressing issues of staffing in the domestic department to ensure the home was clean and safe to live in.

People had been consulted about the development of the home and quality checks had been completed to ensure services met people's requirements.

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?

Requires improvement

The service was not consistently safe.

Sufficient staff were on duty to meet people's needs.

Staff in the home knew how to recognise and report abuse.

Medicines were stored safely and were in a clean environment. However, care was required when administering medicines to ensure people received their prescribed medicines.

Cleaning schedules were not always adhered to due to shortages of staff. However, the provider was addressing issues by recruiting more staff and employing an external cleaning company.

Is the service effective?

Good

The service was effective.

People told us they were happy with the meals provided. However, staff did not always record when people, who required assistance to maintain an adequate diet had eaten a balanced meal.

Staff received suitable training and support to enable them to do their job.

Deprivation of Liberty Safeguards and the key requirements of the Mental Capacity Act 2005 were understood by staff and people's legal rights protected.

Staff were able to identify people's needs and recorded the effectiveness of any treatment and care given.

Is the service caring?

Good

The service was caring.

People's needs and wishes were respected by staff.

Staff ensured people's dignity was maintained at all times.

Staff respected people's needs to maintain as much independence as possible.

Is the service responsive?

Good

The service was responsive.

People's care was planned and reviewed on a regular basis with them.

Activities were organised for people to take part in and a plan was displayed.

People knew how to make concerns known and felt assured anything raised would be investigated in a confidential manner.

Summary of findings

Is the service well-led?

Good

The service was well-led.

People were relaxed in the company of staff and told us staff were approachable.

Audits were completed to review and measure the delivery of care, treatment and support against current guidance.

People's opinions were sought on the services provided and they felt those opinions were valued when asked.

The Old Rectory

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 29 October 2015 and was unannounced.

The inspection team consisted of two inspectors.

Before the inspection we reviewed other information that we held about the service such as notifications, which are events which happened in the service that the provider is required to tell us about, and information that had been sent to us by other agencies.

Before the inspection, the provider completed 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 also spoke with the local authority who commissioned services from the provider in order to obtain their view on the quality of care provided by the service. We also spoke with other health care professionals during and after our visit.

During our inspection, we spoke with five people who lived at the service, two relatives, a visitor, and three members of the care staff, a cook, two housekeeping staff and the registered manager. We also observed how care and support was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at eight people's care plan records and other records related to the running of and the quality of the service. Records included maintenance records, staff files, audit reports and minutes of meetings which had been held with people who used the service.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe living at the home and did not have any concerns about the staff caring for them. They told us their needs were being met. A relative told us how their family member was protected because they had a tendency to walk around unaided and due to their memory loss would not be able to find their way back to the home. The relative was happy that the home had put measures in place to ensure they were as safe as possible. A visitor told us they had observed staff dealing with people with memory loss who had become quite anxious. They said staff had behaved very professionally and talked to them to calm the person.

Staff were aware of the signs of abuse and the action they should take if they identified a concern. One member of staff told us they would escalate to the local authority safeguarding team if necessary. Notices were on display in staff areas informing staff how to make a safeguarding referral. Staff said they had received training in how to maintain the safety of people who spent time in the service. The training records confirmed that all staff had received safeguarding training in 2014 and 2015. This ensured staff knew how to protect people from abusive situations.

Accidents and incidents were recorded in the care plans. The immediate action staff had taken was clearly written and any advice sought from health care professionals was recorded. There was a process in place for reviewing accidents, incidents and safeguarding concerns. This ensured any changes to practice by staff or changes which had to be made to people's care plans was passed on to staff. Staff told us they were informed through meetings and notices when actions needed to be revised.

Individual risk assessments had been completed for people to assess their risk of developing pressure ulcers, falls and nutritional risk. These had been reviewed approximately three monthly. However, we found one person had bed rails in place, but we could not find any evidence of a bed rails risk assessment having been completed. The registered manager told us they would rectify that immediately.

Care records we reviewed contained a Personal Emergency Evacuation Plan (PEEP) to identify the person's support needs and possible reactions if an emergency evacuation of the building was required. This ensured people would be moved safely.

The home had two hoists in use on the day of the inspection. There were separate slings for each person to ensure there was a reduced risk of cross infection. Pressure relieving mattresses and cushions were in place for people at high risk of developing pressure ulcers. Staff told us there was adequate equipment to meet people's needs. They did not have any issues with sufficient stocks of supplies.

We checked the staff rosters and saw the number of care staff on duty was in line with the planned rosters on all but one day over the last month. Staff told us that in the case of staff sickness or other absence efforts were made to find staff to cover the shift. They said this was sometimes difficult as their bank staff had other work, but we saw shifts had been covered. This ensured there was sufficient staff available to meet people's needs.

We checked two recruitment files of staff. Checks had been made prior to the commencement of the staff employment to ensure they were safe to work at the home. One member of staff told us they were aware checks had been made with the Disclosure and Barring Service (DBS) and references had been received prior to their commencement of employment. They had completed an application form and an interview before starting employment. There were some staff vacancies in the housekeeping and kitchen departments and the registered manager told us they were in the process of recruiting.

Medicines were stored securely and the temperature of the room had been checked daily to ensure medicines were stored correctly and safe to use. We talked with staff about the process for the supply of medicines for people at the home and were told medicines arrived in a timely manner. We checked the medicines administration record sheets (MARS) for 15 people and did not see any evidence of medicines being missed due to lack of availability. MARS contained a photograph of each person so staff unfamiliar with people could recognise them.

We observed medicines being administered and saw most people were provided with their medicines and staff stayed with them until they had taken them. We saw people who required the dose of their medicine to be monitored and

Requires improvement

Is the service safe?

adjusted according to blood results, had regular blood tests and the dosage adjusted in line with the instructions. However, we asked the registered manager to look into the records of two people who were receiving a certain medicine as they records were not clear whether they had received the correct dosages. This information was given to us after the inspection and no harm had come to the two people.

We saw independent medicine audits had been carried out by the local pharmacy a few days before our inspection and the manager had also carried out medicines audits. Any actions were passed onto staff to complete. Staff told us they received training from the external pharmacist and had their competency checked prior to administering medicines independently. We saw records to confirm this.

People told us staff kept their rooms clean for them and changed their bed linen regularly. One person said, "They clean my room every week while I am out of my room for lunch."

Staff told us they were short of staff in the housekeeping department, but other departments had helped them. They said they tried to get through all the tasks on their cleaning schedules, but this was sometimes difficult. Some staff told us of their frustrations when other staff did not follow correct procedures for keeping areas clean and ensuring infection control policies were adhered to. For example, some staff did not know how to use the correct laundry sacks for the disposal of soiled linen. The registered manager had ensured staff were up to date with their training in infection control and had displayed notices reminding staff of certain procedures; such as the use of the correct laundry sacks. However, some staff were still using the incorrect laundry sacks.

We saw that some areas of the home were not clean. For example, we noted the floor in the communal area was in need of vacuuming during the inspection and it was more littered than would be expected if cleaning was occurring as regularly as would be expected. We saw various pieces of equipment which were in need of a through clean. These included a turning aid which was heavily soiled on the base, a comb by a hand basin in a person's room was very soiled and various pieces of equipment in bathroom areas were soiled. We saw people sitting in wheelchairs which had not been cleaned. This meant that people were not living in a particularly clean environment.

We saw the cleaning schedules staff completed each day. This included daily tasks and room deep cleaning schedules. Staff had recorded when tasks had been completed. An infection control audit had been completed in August 2015 by the provider which showed the home had scored 93% compliance.

We brought the areas of concern about cleanliness in some areas of the home to the registered manager's attention. We were informed the following day that an external firm had been instructed to commence a deep clean the following week. This was confirmed by the provider and another health professional visiting the following week, who passed this information to us.

Good

Is the service effective?

Our findings

People we talked with said they had confidence in the knowledge and skills of staff. One person told us staff were knowledge about their particular condition and what they had to do if an emergency arose. We observed a shift handover and found key information relating to the past 24 hours was passed to a senior carer coming on shift. This ensured people's immediate needs were being passed on quickly.

Staff told us they had an induction when they came to the home which involved shadowing more experienced staff and completing induction training. They told us this should be completed within three months. However, we saw three people had started over four months ago who had not completed their training. The registered manager confirmed that due to the numbers of new starters across several locations with the company the training had not been as quick as normal, but new starters had 13 weeks to conclude their induction training. This was confirmed in the provider's training policy. Most staff had completed their mandatory training within the previous year and there was evidence of attendance at a range of additional training relevant to people's needs who used the service. The registered manager had a flexible approach to staff training and extended time scales when required to ensure they felt adequately trained and supported.

Staff told us they had supervision approximately every two months and they had previously had their yearly appraisals. We saw the supervision planner for 2015. This gave the dates of when supervision sessions had taken place. Staff confirmed these had occurred. Staff told us they could express their views during supervision and felt their opinions were valued.

The Mental Capacity Act 2005 (MCA) legislation provides a legal framework for acting and enabling adults who lack the capacity to make decisions themselves. Deprivation of Liberty Safeguards (DoLS) is a framework to approve the deprivation of liberty for a person when they lack the capacity to consent to treatment or care. The MCA 2005 code of practice ensures the human rights of people who may lack mental capacity to take particular decisions are protected.

Staff were knowledgeable about how to ensure that the rights of people who were not able to make or to communicate their own decisions were protected. Staff had undertaken training in the Mental Capacity Act 2005 in 2014 and 2015. This ensured they were aware of how to monitor people's capacity and how to record decisions made. Staff told us the course had made them more aware and it had been useful.

Staff told us that where appropriate capacity assessments had been completed with people to test whether they could make decisions for themselves. We saw these in the care plans. They showed the steps which had been taken to make sure people who knew the person and their circumstances had been consulted. We saw in the care plans that consents to care and treatment had been signed by the person themselves or a family member acting on their behalf.

We had mixed views given to us about the provision of meals. One person said, "The food is good". Other people told us they did not have a choice. One person said, "The food is alright." However, others told us the reverse. We saw there was a menu with two main meal choices at lunchtimes on display in a staff area. A relative told us their family member had lost weight and the staff had tried everything they could to tempt their relative to eat, outside of the menu choices.

We observed the lunchtime meal. We did not see any menus on display in the dining room which would have been a reminder to people about the choices they had made. People were brought drinks individually according to their prefences prior to the meal being served. People were served their meals from a list. This meant that some people on the same table were waiting a longer time than others for their meal. However, staff were observed walking around the tables encouraging people to eat. Some people were given assistance, but staff were not aware of other people who could have benefited from some assistance. We had to bring to the staff's attention that everyone in the dining room had their meals served except one person. Staff rectified this immediately.

We saw meals being taken to people in their bedrooms. Staff generally ensured that people had everything they required to eat their meal. However, we brought to the registered manager's attention that one person asked us for assistance, which was readily given. We also told the manager that two people were observed being assisted with their meal but were not given much time to eat it. There was a lot of wastage on both plates. The registered

Good

Is the service effective?

manager approached the staff member and people concerned to see if they required a different meal. We saw in the records of both people that a plan was in place to try and encourage them to eat a balanced diet. We noticed that people who were in their rooms all day had been provided with a jug of juice to enable them to access drinks.

The care plans gave details of how people's dietary needs had been assessed. Monitoring sheets were in place for some people whose weight had fallen below a certain level and who had difficulty maintaining a balanced diet. The food and fluid charts were generally well completed. However, we saw one person's chart which showed they had had less than 500mls in 24 hours for four days. The registered manager felt this was a recording issue rather than the person having not been provided with additional drinks and would investigate with their staff.

Each person had an accident and emergency grab sheet in their notes to provide key information about the person in the case of them requiring admission to hospital. There was evidence of people's access to other professionals such as the community mental health team, a family doctor, an optician and chiropodist. One person said, "They get the doctor out when I need them."

The home had set up a system with the local GP surgery of nurses and GPs' visiting regularly. Staff told us this ensured the GPs' and district nurses could plan the visits and follow up quickly on new treatments. A health professionals' visit was taking place during our visit. Staff had all the information available to ensure the sessions could run smoothly. Health professionals told us staff were good at ensuring changes in people's needs were passed on quickly.

Good

Is the service caring?

Our findings

People we talked with told us staff were caring. One person said, “Did not have any problems”, when referring to staff caring for them. Another person said, “Overall, I think I could be a lot worse off.”

People we talked with told us staff knocked on their door before entering into their bedroom and closed the curtains when providing personal care. We observed this as we walked around the building.

We observed that staff visited all the communal areas throughout the day. They talked kindly to people and were interested in what people wanted to talk about. Staff approached people in a kindly and non-patronising manner. However, we did see in one sitting room that people, who were in wheelchairs which they could not push themselves, had not been placed in the room very well. Two people had to move to ensure they could still watch the television and one wheelchair was placed in front of another so one person could not see the television or other people in the room. They tried to turn in the chair to speak to others, but this was difficult for them. When we brought this to the staff’s notice they rectified this immediately to ensure everyone was in a place they could converse with others if they wanted to and could look out of the window or watch the television.

The relatives felt involved and fully informed about the care of their family members. They said the staff were kind, courteous and treated the people with respect. A relative told us, “They are all very caring and they are very good with [named person]. That is the best thing about the home. They always have time for [named person].”

We observed staff ensuring people understood what care and treatment was going to be delivered before commencing a task, such as helping with a bath, ensuring people knew when meals time were about to commence and informing them a health care professional was about to visit them. Staff assumed people had the ability to make their own decisions about their daily lives and gave people choices in a way they understood. They also gave people the time to express their wishes and respected the decisions they made.

Staff knew the people they were caring for and supporting. They told us about people’s likes and dislikes. For example, when they liked to get up in the morning and if they preferred to smoke in the smoking room or go outside. This was confirmed in the care plans. Practical action was taken when people were distressed. We observed not just care staff, but housekeeping staff responding to people who were worried and anxious. If they could not answer a person’s query the registered manager was called to assess each situation. One person was distressed about other people approaching them who lived at the home, but they were reassured by staff and the registered manager. Another person was distressed because they had taken up residence with a friend, who because there was no bedroom available was not on the same floor. Staff and the registered manager reassured them they would rectify this as soon as a bedroom became available. They ensured the two friends met during the day.

Staff responded when people said they had physical pain or discomfort. When someone said they felt unwell, staff gently asked questions and the person was taken to one side. When the emergency call bell was sounded we saw staff respond to the person’s need. As soon as possible the minimum amount of staff stayed with the person, not to frighten and worry them.

Some people who could not easily express their wishes or did not have family and friends to support them to make decisions about their care were supported by staff and the local advocacy service. Advocates are people who are independent of the service and who support people to make and communicate their wishes. We saw details of the local advocacy service on display.

Good

Is the service responsive?

Our findings

People told us they could make choices as to when they got up and went to bed and the clothes they wore. People told us staff cared for them well and understood their needs. One person said, "You can't say anything wrong against them."

People told us that staff attended to their needs as quickly as they could. One person said, "Sometimes you have to wait a while but they are never long." They said if they rang their call bell staff would respond promptly, but would sometimes explain if they were busy with someone else and would come as quickly as they could. They said if their need was urgent, staff would deal with it without delay.

Pre-admission assessments had been completed for people to assess their care and support needs. Each care plan had a personal profile to provide key information about them. Each person had a range of care plans providing information on their care and support needs. These were generally informative but we noted one person who had swollen legs and required their cellulitis to be monitored had no information of how this should happen. So staff were not aware whether the person's was responding to treatment. We found an under inflated pressure relieving mattress on a bed so the person was not receiving the benefit of it. We brought these two concerns to the registered manager's attention and she instructed staff to rectify these concerns immediately.

People told us staff obtained the advice of other health and social care professionals when required. In the care plans we looked at staff had recorded when they had responded to people's needs and the response. For example, when people had leg wounds after a fall or a person's condition required regular blood tests to be taken. Staff had detailed when they had obtained advice from district nurses,GP's and other health care professionals.

People told us there was an opportunity to join in group events but these were very few. We had mixed comments from people about the range of activities on offer. One person said, "I get bored and so I walk out for a while." Another person told us, "I don't get bored. There is always someone around. They don't get a lot of time but they will have a chat." One person told us about the two outings they had participated in and enjoyed.

People in their rooms all day were watching the television; some had visitors for part of the day and some were reading books and magazines. One person had their daily newspaper delivered. Staff interacted with people in their bedrooms and were observed sitting, holding hands and talking to people. One person told us that it was their preference not to mix in communal areas, but staff came to see them frequently and they were content with their radio and books.

There were pictures on display of events which had taken place; such as craft workshops, parties and entertainers who had visited. A weekly activities plan was displayed covering a range of activities. These were for group events. There was information in the care plans about people's own hobbies and interests. This ensured staff were aware what people liked and how they could help them to participate in events. People told us they would like to go out more but realised this was limited in a rural community. Staff told us they often visited a local garden centre and shopping centre. This was recorded in people's care notes.

People told us they were happy to make a complaint if necessary and felt their views would be respected. They told us what they would do if they had any concerns, which followed the provider's policy. No-one we spoke with had made a formal complaint since their admission. People told us they felt any complaint would be thoroughly investigated and the records confirmed this. We saw the complaints procedure on display. Details were on display of a service which could translate to other languages or other types of communication methods such as braille.

The complaints log detailed three formal complaints the manager had dealt with since our last visit. It recorded the details of the investigation and the outcomes for the complainant. One was still under investigation by the provider's human resources department, so there was no outcome. Lessons learnt from the completed cases had been passed to staff at their meetings. Staff confirmed these messages had been passed on. We saw this in the minutes of staff meetings for April 2015 and May 2015. They included topics such as meals and record keeping.

Good

Is the service well-led?

Our findings

People told us they saw the registered manager regularly. One person said, "The manager is very good." They told us they participated in meetings and information was passed to them by staff about the running of the home. They said they could voice their opinions and their opinions were valued by all staff.

People who lived at the home and relatives completed questionnaires about the quality of service being received. Some people told us they had completed questionnaires in the past. We saw the results of the questionnaires for January 2015 and February 2015. The results were positive. The analysis showed how some processes had been changed after their submission. For example changes to menus. The results also covered questionnaires returned from health care professionals, relatives and other visitors. The results were on display in the main entrance hall. This ensured people visiting and those living in the home were aware of the results. Staff told us people were also informed through the residents meetings. We saw the one for June 2015 which covered a number of topics such as meals and activities.

Staff told us the provider values and aims were displayed in the home. One staff member said, "I think this is a good home. It is the way people are treated. Everyone is kind and caring." Staff told us they worked well together as a team and there was good team work.

Staff told us there was a whistleblowing policy in place and they would use it if they had concerns and were not being listened to. However, they said the registered manager would act on any concerns reported to them. Staff told us the manager was readily available and easy to talk to. They said she would often check on them, ask how they were doing and if they needed help.

Staff told us staff meetings were approximately every month and they could voice their opinion, which was valued. We saw meetings of staff meetings in April 2015 and May 2015 where staff had been given the opportunity to give their opinion of topics raised. These covered areas such as accident recording and the use of pressure relieving equipment.

There was sufficient evidence to show the registered manager had completed audits to test the quality of the service. These were split into different categories. Covering areas such as care issues with audits on diabetes care and pressure ulcer care. Also an analysis of accidents and incidents. The registered manager told us results were available for staff to see, which we saw in a staff area. Staff confirmed results were available, they knew where the folders were and information was passed on through staff handover periods, memos and meetings. Staff told us any changes to people's care needs were dealt with immediately, which we saw in people's care records.

Other members of the provider's regional team visited the home regularly. People told us they came to speak with them and ask their opinions. Staff told us regional team members spoke with them on visits to gain their views about the service. We saw the visit reports a member of the regional team had completed for August 2015 and September 2015. These included a number of topics the manager had been asked to complete and comment upon; such as delivery of care, staffing structure and audit reports. Any actions were listed and if not completed referred to on the next report with a new completion date. This ensured the provider had an overall view of how care and treatment was being delivered and how the home was running.

People's care records and staff personal records were stored securely which meant people could be assured that their personal information remained confidential. The manager understood their responsibilities and knew of other resources they could use for advice, such as the internet.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. The manager of the home had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.