Prime Life Limited

Peaker Park Care Village

Inspection report

Trojan Place
Rockingham Road
Market Harborough
Leicestershire
LE16 7FP

Tel: 01858414460
Website: www.prime-life.co.uk

Date of inspection visit:
12 July 2018
13 July 2018

Date of publication:
03 October 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 July 2018, and was unannounced. Peaker Park Care Village is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Peaker Park Care Village is a large residential and nursing home comprising of three separate buildings on one site. These are called Melody, Mulroy and Fiddlers Corner. Melody is the largest building and this is divided into four separate units. The four separate units are called Gumley, Bowden, Albany and Clipston. The home houses a maximum of 137 people, with between 20-30 people living in each unit.

People who live in the Gormley site are more independent. Fiddlers Corner mainly supported people with re-ablement from hospital, although this contract had recently ended. People who lived in the different units in Melody had more physical nursing needs and/or dementia care needs. At the time of our visit, the home had 110 people living there.

The home had a registered manager. 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 home had staffing vacancies which they were actively recruiting to. Sometimes there were not staff available to meet people's needs at the time they wanted them met, especially at night time. Staff deployment meant there were times when people were not safely supported by staff.

People were safeguarded from harm. The registered manager and staff knew, and adhered to safeguarding procedures.

The risks related to people's health and well-being had been identified, and actions to reduce the risks from becoming a reality had been taken by staff. Medicines were managed safely.

People's healthcare needs were met by the nurses on duty; and by access to other healthcare professionals when requested or needed.

Good liaison between different health and social care professionals supported people to receive effective care.

The equipment people used was adequately maintained and clean; and the premises kept in safe and good repair. The home was clean and staff had a good knowledge of infection control measures.

Staff received training from the provider's in-house training department, and this provided them with the skills and knowledge to meet people's needs. They received support from their line managers to help them do their jobs well.

People received a choice of meals and regular fluids to keep them hydrated. There were mixed opinions about the quality of meals and the choice of food. The meal time experience of some people with higher dependency needs was rushed and task focused.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were caring and kind to people. They supported people's dignity and privacy. Staff provided to support to people at the end of their lives.

There was a range of activities available to people, although some people who lived with dementia did not have their interests or needs provided for as well as others. Some people had not been supported to undertake activities they had previously enjoyed.

The registered manager responded to complaints as they arose, but some people were not satisfied that enough changes had been made in response to their concerns.

Visitors were welcomed into the home.

The registered manager was respected by their staff team. They were open to learning from mistakes and passionate about providing good quality care to people who lived at the home.

The provider undertook regular audits of the home to ensure quality and safety. The provider and manager were aware of the improvements required and were addressing them.

This is the first time the home has been rated as 'requires improvement' since it's last rating of 'good'.

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.

The service had staff vacancies which they were trying to recruit to. This meant people did not always experience continuity of care.

The provider's recruitment practice reduced the risks of employing staff unsafe for care work

People were safeguarded from harm.

The risks to people's health and well-being were identified and appropriate actions taken.

Medicines were managed safely.

The premises were safe, and the home and equipment was kept clean

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to support people with their care. They were provided with good support by the management team.

Meals provided people with sufficient nutrition to support their well-being. Drinks were available throughout the day.

People's healthcare needs were well supported, and there was good liaison between staff at the home and different health and social care professionals to help ensure this.

The provider had followed the requirements of the Mental Capacity Act, and Deprivation of Liberty Safeguards to safeguard people.

Is the service caring?

Good

The service was caring.

Staff supported people in a kind and compassionate way. They provided people with support which ensured their dignity and privacy.

People's individual needs were supported, and staff recognised the importance of supporting people's human rights and equality and diversity.

Friends and relatives were welcomed visitors to the home.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

There was a wide range of in-house and external activities available to people, but some of those who lived with dementia had little to engage them.

People's care records provided staff with detailed information about people's physical, emotional, social and spiritual needs.

People were supported with end of life care.

The manager responded to complaints and concerns, however some people felt the responses had not led to the changes they wanted.

Is the service well-led?

Good

The service was well-led.

The provider undertook a range of audits to support the safety and well-being of people in the home.

The registered manager and provider were trying to recruit new staff to the home to fill vacancies. They were aware of areas of improvement required and were working hard to make changes.

The registered manager was well respected by the staff group who found them supportive and open to ideas and concerns.

Peaker Park Care Village

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.

The inspection was prompted in part by a whistle-blower's allegations that staff conduct was not being managed appropriately, and a safeguarding concern.

The inspection took place on 12 and 13 July 2018 and was unannounced. The team consisted of six people. This included four inspectors, an assistant inspector and a specialist nursing advisor, who specialised in end of life care.

Before our inspection visit we reviewed the information we received from other health and social care professionals and members of the public. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the home, what the service does well and improvements they plan to make.

During our visit, we spent time at each of the home's six units. During the time we spent at each unit we observed how people and staff worked and lived with each other. We spoke with a total of 23 care and nursing staff, the catering manager, one of the activity workers, the registered manager and the regional operational director. We spoke with 19 people and seven relatives to ensure we spoke with staff and people who worked and lived in each of the units.

We also observed the care and support provided to people. 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.

On each unit we looked at a selection of records. In total this included 11 care plans and risk assessments, 18 medicine administration records, nine repositioning charts and 11 food and fluid charts, as well as daily records which demonstrated the care and support provided by staff. We also looked at management

records, including three staff recruitment records, quality audits, care team and resident meeting minutes, health and safety records, and records of other professional reports about the service.

Requires Improvement

Is the service safe?

Our findings

All people we spoke with felt safe at Peaker Park, however many told us there were times when they felt there were not enough staff available to provide people's nursing and personal care.

People told us that sometimes the staffing level on their unit reduced from the expected three staff per shift to two. A staff member would have to cover for a staff absence on another unit and this meant staff were not so readily available to meet their needs. Staff told us they thought there was usually enough staff to support people. However, they said when people phoned in sick, they had to 'work short', or a member of staff might be taken away from their unit to support another unit. This led to the remaining staff on the unit not having as much time to support people's health and care needs.

The registered manager informed us the home was experiencing a challenging period in terms of ensuring sufficient staff were available to meet people's needs. At the time of our inspection visit, there were eight night-staff vacancies and two day-staff vacancies; there were also several staff who were absent through sickness. The provider's internal audit confirmed in June 2018 there was a very high turnover of staff at the home which required further investigation.

The registered manager had advertised for the vacant posts but was experiencing difficulties in recruiting to them. In the mean-time they were filling the gaps in the rota by using their own staff to provide additional cover; the provider's bank of additional staff; and from the use of agency staff to support the night time. However, this proved to be a challenge to fill all the gaps in shifts and despite their best efforts there were periods of time when cover could not be found for all the gaps in the rota.

The registered manager told us when this happened the management team (who were not included in the rota) stepped in to help staff; and some ancillary staff who had received training in health and social care would also support care staff.

During our inspection we observed a person on Albany try to leave their chair. Their care plan said they were at risk of falling. There was no staff available to support this person, and we had to go and look for a member of staff to help ensure the person was safe. On each occasion there was not enough staff deployed in the unit to ensure people were safe.

At teatime people from the Albany unit and Clipston unit had their meal together. This was very task focused. We saw one member of staff standing over a person to support them eat a yoghurt as opposed to sitting down with them. No staff appeared to have the time to sit and talk with people; and as soon as people had finished their meals, plates were cleared away and the table immediately re-set ready for the next sitting. This meant there were not enough staff deployed to support people have an enjoyable meal time experience.

Some people told us they often had to wait 20 minutes before their needs were responded to. One person told us they became anxious waiting for the call bell to be answered so they could go to the toilet. They said

they were frightened they would have an 'accident'. They felt it was worse at night time. A couple of people said they were unsure if their call would be responded to because there was no visual mechanism to determine whether the buzzer had worked or not. One person said, they sometimes wondered if the battery had run out because 'no one comes for what seems a long time." Another told us they needed help to go to the toilet. They said, 'this sometimes takes too long and I leak urine." They said they 'hated' this happening. A person who was more independent told us there were enough staff to support their needs but not everyone. They told us staff were 'rushed' at times and were 'too busy', but they did not want to 'make a fuss.'

We discussed this with the registered manager. They undertook monthly audits of the 'wait' time for call bells to be answered. They provided us with audits for call bells during the months of March, April and May. These showed that most of the calls (approx. 85 percent) were responded to within 5 minutes. The May audit showed just under seven percent of calls were responded to within 5-10 minutes; just under seven percent of calls were responded to between 10 and 20 minutes, and 0.1 percent took over 20 minutes to respond to. The audits also demonstrated the registered manager was noting if there had been any changes to the data and was working with staff to improve this. They also had run off individual reports of call bell activity, when relatives had expressed concerns about call bell times for their relation, to identify any issues and respond accordingly.

The registered manager had a good understanding of safeguarding, and had informed the local authority and the CQC of most of the safeguarding concerns raised at the home. Prior to our inspection visit the registered manager had received information from a whistle-blower which raised concerns about people's safety at the home. They had used their professional judgement in line with the Leicestershire and Rutland safeguarding guidance to investigate this without referring the concerns as a safeguarding alert. A thorough investigation had taken place but the registered manager had not notified us at the CQC of the allegations. They told us they thought they did not need to do this because they had not sent an alert to the local authority. They had since notified us of the allegations; and confirmed they would do so in the future.

We also followed up a safeguarding notification sent to the CQC about alleged harm caused by one person to another. We found the registered manager had contacted the appropriate authorities, and had put plans in place to minimise any future risks related to people in the home.

We looked at a recent local authority monitoring report which demonstrated the local authority had been satisfied that other safeguarding concerns had been addressed appropriately.

Staff knew their roles and responsibilities to report any incidents that place people at risk from harm or abuse) to the senior on duty. Staff also knew how to 'whistle blow' if they had concerns that safeguarding was not being investigated as it should. The whistle blowing information was displayed prominently in the manager's office (a whistle-blower is a worker who discloses wrong doing in the organisation, in the public interest).

The provider's recruitment practices reduced the risk of employing staff unsafe to work with people who lived at Peaker Park. The registered manager ensured they had received references from previous employers or people who knew staff well; and criminal record checks from the disclosure and barring service (DBS) before any new staff started their employment at the home.

Each person's care record had up to date assessments about any risks related to their health and care needs. For example, the risk to a person from falling, or of a person not eating well and therefore being at risk of malnutrition. Where a risk had been identified, plans had been put in place to help reduce the risk of

the person's health and welfare being compromised. So, where a person was at risk of falling, the home had introduced more frequent observations; and where a person was at risk of malnutrition, they had been referred to a relevant external health care professional for advice on how best to improve their dietary intake.

The premises were kept in good condition, and checks were made to water, gas, electrical and fire systems when required, to ensure people's environmental safety. We saw one of the pumps used for an air flow mattress had a broken arm and one of the casings on another was cracked, which might have impacted on a person's safety. After our inspection visit the registered manager told us these had been replaced, and they had reminded staff to put all issues into the maintenance book for timely repair.

Some of the bed bumpers were torn, stained and dirty. A team leader told us, "We clean the bed rail covers, but we struggle as they are stained and torn." The registered manager told us they had already noted the beds in the Clipston unit required new bumpers and these had been ordered in June 2018. After our inspection visit they confirmed they had all arrived and were now on the beds. This meant the provider helped to protect people from the risk of an acquired health infection.

It is recommended the provider remind staff to report any issues for repair to prevent unsafe practices.

Care equipment used by people such as hoists and slings were also regularly checked to ensure they were safe to use.

People told us they were happy with the cleanliness of the home. Infection control measures were practiced by staff. This included hand washing, and ensuring they wore fresh pairs of gloves when providing personal care to everyone. A team leader told us of the steps they took to limit the spread of infection when there was a diarrhoea outbreak. They said, "We barrier nursed every resident, we had strict hygiene control and the units were closed to visitors...we encouraged people to drink and worked with the GP to keep people safe."

Medicines were managed safely. Some people who lived with dementia received their medicines in disguise (covertly). This meant people received their medicines without knowing, as these medicines were hidden in food or drink. People had been assessed by the GP for their mental capacity to refuse their medicines, a best interest decision had been made by health professionals and the person's family and the decision to provide medicines covertly after normal routes had been refused, was recorded.

The service had sought pharmacy advice as to which medicines could be crushed, but the advice given by the pharmacy did not include what foods or drinks they could be crushed in. Since our visit, the service contacted the pharmacy to ensure this guidance was also provided. Where people had their medicines crushed, they had since our visit, checked with the pharmacy and the GP to determine whether there had been any adverse impact with the food and drink medicines had been crushed in, and there were no concerns.

People who needed staff to administer medicines for them, told us their medicines were given to them at the time expected and in accordance with the prescription.

Staff had information about the medicines people were prescribed, what they were for and any side effects. Medicines were stored safely and at the right temperature. When medicines were not required they were either destroyed safely or returned to the pharmacy. Medicine administration records accurately recorded the medicines administered to people. All the medicines we checked had been given in line with the GP's prescription. Where medicines had been given on an 'as required' basis, medicine plans had been written to

ensure staff knew why the medicine might be required and what signs and symptoms to look out for which might indicate the person required them.

Where people had been admitted to the home for end of life care, or were nearing the end of their lives, staff had worked with the person's GP to ensure medicines which relieved a person's symptoms were prescribed in advance. This was to ensure they were available when the person needed them. Anticipatory medicines were available at the home, and were regularly checked to ensure their safe use for when needed. This helped to ensure people's comfort and avoid any unnecessary hospital admissions.

Good

Is the service effective?

Our findings

People's care and treatment was delivered in line with evidence based guidance to achieve effective outcomes. For example, staff used assessment tools to ensure effective action was taken to prevent malnutrition, and pressure sores from developing. Staff contacted relevant health care professionals such as tissue viability nurses and speech and language therapists when required, and followed the guidance given by them. People told us staff knew what they were doing and understood their needs.

Staff had received an induction to support them working at Peaker Park Care Village. The induction period included staff getting to know their role and responsibilities and that of the other staff in the home; getting to know the people who lived at the home and any risks related to their wellbeing; and understanding how to safeguard people and treat them with dignity and respect. New staff were given a three-month period to complete the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

All staff attended training considered mandatory by the provider to enable them to effectively provide people's care. The provider had its own training team to support staff's training needs at each home. The training team also supported staff to have more in depth training in areas such as dementia. One member of staff said, "The training is very good here. We had sensory dementia training, some families had the training to help them understand what their relative was experiencing." Another member of staff told us this had been their first care job. They told us they had lots of training and at a good pace; this had left them feeling confident in their role. They told us during the 'moving people' training they practiced putting each other in slings (for hoisting) and this helped them understand how a person might feel when using the hoist.

Nursing staff were supported to have the training in skills that met people's needs, and to ensure they received their revalidation as nurses. This included syringe driver training so that registered nurses could support people with medicines given continuously; such as for effective pain relief and symptom control. We were also told of planned training being delivered by the Leicestershire Training NHS Partnership and Social Care Protocol (HCSP) which will provide nursing staff with competency to deliver training to care staff in oxygen administration, catheter care, and specific dressings. The home had two clinical leads to support nursing staff with their nurse practice.

Staff were supported by their team leaders and managers in their role through formal supervision sessions, and more informal short supervisions which identified any areas of improvement required. Each member of staff also had a yearly appraisal of their work performance. Staff told us if they identified a training need, the provider was usually good at supporting them to fulfil this need.

The home provided sufficient food to meet people's dietary needs. There were also enough drinks provided to people to ensure people remained hydrated, particularly in the hot weather. People at risk of malnutrition were monitored closely to check their weight; and if there was weight loss, the right healthcare professionals were contacted and advice sought. Records showed this advice was acted on.

We saw lunch and dinner being serviced at each of the units in the home. People were seen to be offered choice of meal, and we saw drinks being regularly replenished. One person living with dementia was not being sure whether to have sandwiches with brown or white bread, and so a selection of both was put on their plate which they readily ate.

The registered manager and staff worked well with organisations to deliver effective care, support and treatment. One visiting practice nurse we spoke with, told us the staff were always very helpful when they visited. They told us people always looked well-kept and they did not have any concerns about people's care. A social worker told us they had visited the home on numerous occasions and were satisfied with the care people received. The podiatrist told us the home was 'very on the ball' but commented that sometimes those who were more independent in getting themselves dressed and who did not require staff to provide them as much personal care could 'slip through the net' because their toe-nails could get overly long. The GP attended the home regularly.

People had access to healthcare services when needed. People told us they could see different healthcare professionals when required, and people's records confirmed staff contacted the appropriate healthcare professionals to meet people's needs. One person told us they had a sore eye. They told us the nurse asked the GP to come to the home and have a look at it; and they now have a cream which was helping. During our visit we also saw good liaison with the hospital Intravenous Therapy nurse, a visiting diabetic specialist nurse and the mental health in reach team consultant (who visited weekly).

We also saw staff, being concerned about a person's health, refer the person to their GP and work with the GP to arrange for an ambulance to take the person to hospital. They continued to work with the outreach nurse from the local hospital when the person returned to the home. Staff were vigilant in assessing the person's ongoing health and reporting any changes to the nurse.

The premises had been designed to ensure there was enough space for people and staff to use equipment such as wheelchairs and hoists safely. There were secure gardens to support people who wanted fresh air to go out and enjoy the garden; and one of the dementia care units had been decorated in a way which reflected people's dementia care needs. The registered manager had identified that as some people's needs had changed, they needed to reconfigure some of the units and had recently held a consultation exercise with people and their relatives about people moving rooms. This was to support people with higher dementia care needs live on the ground floor where they had easier access to the garden.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Staff knew people's capacity to make decisions, and care plans explained to staff what they needed to do, to aid communication and support people in making decisions. People we spoke with told us staff always asked their permission before undertaking any care task. During our visit we saw staff check people agreed with any action they planned to take, before it was taken. For example, one person was at risk if they did not use their frame when walking. The staff member noted they were beginning to walk unaided. They wanted to make sure the person was safe so explained why it was important to use the frame and offered to walk with them. On hearing the explanation, the person agreed to accompany the staff member to a place of safety.

During our visit we observed MCA/DoLS training provided to three staff, as well as a person who lived at the home who joined in with the training. The trainer worked through the five key MCA principles, ensuring staff whose English was not their first language, could understand.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
All people who had been assessed under the MCA as not having capacity to make their own decisions, had been referred to the local authority for DoLs to ensure they were deprived of their liberty legally.

Each person's care file had a DNACPR record which informed whether the person wished cardiopulmonary resuscitation (CPR) in the event of their heart stopping. Where people did not have the capacity to make such a decision, this had been made in their best interest by the appropriate professional. This meant the home worked within the principles of the MCA.

Good

Is the service caring?

Our findings

All people we spoke with felt staff treated them with kindness. When we asked people what their views were about the support they received from staff, comments included staff being 'kind', 'helpful', 'magnificent', 'the nicest girls you would want to meet', 'I am really well looked after.' The provider's quality assurance survey showed 100% of respondents thought the staff were outstanding or good in terms of providing a caring and dignified service at the home.

Relatives were positive about the staff support provided to their loved ones. One relative of a person who lived with dementia told us, "The staff have got to know [person's] personality; on a bad day they know to leave him for 10 minutes…all the staff know to talk to [person]. He eats for them, and they are patient." Another relative told us they can often hear from their relations bedroom, laughter, singing and friendly banter between staff and people who lived at the home. They told us staff did not know they were being listened to, and this gave them reassurance that it was not an act.

All staff we spoke with told us they enjoyed their work and supporting people who lived at Peaker Park. One staff member said, At the end of the day we are tired, but we do all love our jobs.'

During both days of our inspection we saw all staff provided support to people in a kindly manner, giving emotional support when necessary. For example, one person was walking and looked tired. A member of staff said to them, "Would you like to lie down, or sit in your chair? The person said they would like to lie down. When staff supported them to go to their bedroom, the person checked it was the right place as they could not remember. The staff member kindly said to the person, "Yes, this is the right place", the person replied, "Good, because I've been to all sorts of places."

We saw a team leader inform staff they were going to a meeting. At that point in time they could see a person was restless and needed some support. Instead of going straight to the meeting, they ensured the person's needs were met. This meant they were late for their meeting, but the person was made the priority.

During our two days we saw people being comfortable in expressing their views to staff and where possible were actively involved in making decisions about their care and life at the home. Many of the people we spoke with had been involved in resident and relatives' meetings, and had met with the team leader or manager to address any issues or concerns they had. A relative told us their loved one had regular meetings with the manager; and they were happy that the person could feel confident to go to the manager about their views.

Throughout our time we saw people's privacy and dignity was respected. For example, staff knocked on people's bedroom doors and waited for permission to enter before they walked in. They also knew not to divulge private information about one person to another. For example, one person asked after another person's health. The staff member would not provide the person with this information because it was confidential. The person asking for the information said, "I respect that."

In one of the units; the office door was left open with no staff in it and confidential information was available for people to access. We spoke with the registered manager about this. She said she would remind team leaders of the importance of securing the office when no one was using it.

Care plans informed staff of what people's routines were during the day and evening. One person said they enjoyed staying up until later, and liked to sit in a communal area of the home until gone 10pm. They went on to say, "I can get up and go to bed when I like, and shower when I like, I never feel pushed." A staff member told us, "We don't get anybody up who is not ready to get up". One lady likes to go to bed at 6.00pm and this is respected."

Whilst nobody who lived at Peaker Park presented as LGBT (lesbian, gay, bi-sexual or transgender), staff were positive about supporting people's individual needs if they came from this community. We found the staff group at the home comprised of some people from the LGBT community who also felt supported by management at the home.

During our visits, we saw visitors to the home were made welcome by staff.

Requires Improvement

Is the service responsive?

Our findings

People knew how to complain and raise concerns but did not feel the provider always acted on these. One person said they had complained about the food and missing clothes items but 'nothing happens'. Another said they too had complained about the food but 'nothing happened.' One said their relative had complained on their behalf about having to wait a long time to go to the toilet, but they felt not much had changed.

Some people told us the home was not responsive in dealing with their concerns about the choices of meals provided. During our visit, some people told us the food was 'very good', where-as others told us of their unhappiness about some of the meals and options provided. For example, one person said, "The food is average," and went on to say, "And that is being generous." Their main concern was whilst there was choice, it was often the same choices at lunch time each day (jacket potato, range of sandwiches, and soup). One person told us the home was, "An expert on crumble," because 'crumble' always seemed to be on offer.

This had been expressed to the management team at a previous 'residents meeting'. We looked at the minutes of the last meeting and these demonstrated that the registered manager and their team had listened to people's concerns and had made changes to accommodate people's views about meals and choices.

Staff told us if they received any concerns from people they would refer these to the team leader for them to address them. We saw the registered manager had kept a log of complaints made and the outcome of the complaint investigation. There had been two complaints registered in 2018, one regarding medication, and one about the length of time it took for call bells to be answered. The complaints log had no information about people's complaints about the food or about missing clothing. It is recommended that all complaints are logged in one place to ensure they can be tracked more effectively to identify trends or ongoing issues.

Staff in the Clipston and Albany units, supported people with dementia. We found contrasting dementia care. Staff on both units were kind and caring towards people, but the Clipston unit was much more responsive to peoples' dementia care needs. The environment was dementia friendly, and staff actively engaged with people's social and emotional needs.

On the Albany unit we found little to engage people. Few people were sat in the communal lounge, and those who were, had very little engagement or stimulation from staff throughout the day and as a result did not have purposeful lives. This was because staff were not available to provide that engagement. During our visit, the team leader showed us some new activities they were going to introduce to people with dementia. After our visit we were informed that because of a higher incidence of falls, some of the boxes with activities in them had been cleared away to make the room clutter free. The registered manager said they were now going to work with the staff to make sure people were safe, but at the same time ensure people had sufficient activities to provide purposeful lives.

There were specific dementia care initiatives in place. For example, the home used 'doll therapy' with some

of the people they supported. This therapy is known to enhance the well-being of some people with dementia and help to reduce any behaviours which may be challenging for others. People see the dolls as living beings they can give care and support to, and this adds to their own emotional well-being.

The registered manager and staff had recognised people living with dementia would be better accommodated on the ground where people had easier access to the enclosed garden. After a period of consultation with relatives and people who lived at the home, plans were in progress to move people in the home to areas which would better reflect their needs. The registered manager informed us this was one of the reasons the Albany unit was not as well designed for dementia care as the Clipston unit, as they were waiting for the move before making the unit more dementia friendly. They recognised it was not currently providing as responsive a service to people with dementia as those on the Clipston unit.

People's care records provided detailed information about them. This included their history; their likes and dislikes, and what their previous or current hobbies or interests were; and what their current support needs were and how staff could help deliver their support. The care records were written as if the person was instructing staff how they liked their care to be provided. For example, one person's care record said, 'Please speak in short clear sentences and allow me time to respond.' We found all people's physical care needs were met well, and staff we spoke with had a good understanding of each person and their life history.

To meet people's social needs, there was an activity programme which included activities within the home environment and trips out in the minibus to various places in the locality. The activities included reminiscence sessions, bingo, cake making, games and puzzles, and outside entertainers. The day after our inspection, the home was holding a fete for people who lived at the home, which was also fundraising to support activities. The activity workers also worked alongside other staff in the home to support those who did not wish to, or could not, join in group activities because of ill-health or choice. This was to provide activities which met people's individual needs. A member of staff told us they had recently returned from supporting a person with their shopping and went to a café with them to have coffee and cake. Another told us they did flower arranging with people last week, and had arranged a 'wimble-lounge' (lounge based tennis) session for people.

People were mostly satisfied with the organised activities but some told us their own interests had not been supported. Two told us they used to like crafts, but this had not been offered. One person told us they liked to 'skype' but they needed staff support and staff were often busy; another told us they liked doing jigsaws but needed to have their jigsaw board set up for this to happen. They felt staff did not have time to do so. However, others told us staff had responded to their individual needs. For example, one said, "The staff know I am a big Leicester football fan, so staff got me wi-fi in my room and I have my own TV'. Another said they liked to travel in to the local town. They said a member of staff had supported them to get good rates from a local taxi firm. A third person had an easel in their room and was helped to be in a position where they could use the easel to paint. Their room was decorated with their art from their earlier years and recent times.

The registered manager and activity workers also recognised the importance to many people who lived in the home, of having young children in their lives, and how this impacted on their health and well-being. We were told every few weeks a local nursery would bring children to meet and play with people who lived in the home; or the mini bus would take people from Peaker Park to their nursery.

Staff understood people's communication needs. Each person's communication needs were assessed as part of the care planning process. Staff were reminded to ensure people who had sight or hearing impairments had their glasses or hearing aids to support them with their vision and hearing. One person at

the home who was visually impaired had recently started using a popular 'digital assistant'. This technology helped them with entertainment and meant they did not have to wait for staff to be available when they wanted to hear music or wanted entertained. Staff reported this had really helped this person's quality of life.

Staff received 'end of life' training during their induction to the home, but this was approximately one hour in duration, providing advice on how to speak with people and their families at the end of people's lives. Staff had experiential learning, but none had accessed specialist end of life training.
It is recommended that staff who support people with End of Life Care receive specialist training to support them in their roles and responsibilities.
People had end of life care plans which were completed with the person and/or the person's representative. This included the person's spiritual needs and symptom management, and the person's wishes if they lost capacity to make decisions in the future.

Staff at the home were supported with the provision of end of life care by a GP from the medical centre. The GP visited people who were moving towards the end of their life, every two weeks, or when called, or provided telephone advice. Staff were also supported by the community Macmillan nurse and the specialist Parkinson's disease nurse. Two hospices, one located in Leicester, and the other in Kettering, provided consultant domiciliary visits and reviewed the 'End of Life' care provided to people at the home. The clinical lead told us staff used these visits as an opportunity to update their knowledge and skills of providing good end of life care.

The nursing staff had received training to provide people's end of life medicines when needed for their comfort, via syringe driver equipment. We saw nursing staff administer this medication to a person receiving end of life care. We saw they were kind and considerate to the person and explained what they were going to do. Staff undertook all procedures considered good practice to ensure the right person got the right medicine at the right time (when they needed it).

Good

Is the service well-led?

Our findings

The provider and registered manager were aware of, and were trying their best to address the staffing issues at the home, and fill staff vacancies. They had rated 'staffing' as 'amber' on their internal rating system (amber meant that there was a risk, but had been identified and worked on). They had also identified that changes needed to be made to support people with dementia care and were in the process of making these changes at the time of our inspection visit. Issues discussed prior to our visit, and highlighted during our visit were quickly acted on and addressed.

The regional manager undertook monthly compliance visits at the home and reported back to the registered manager and Prime Life Ltd the actions required because of their visits. They checked the expected monthly audits were undertaken. This included audits on infection control, safeguarding, falls, incidents and accidents, medication, and weights and nutrition. The compliance visits also included a 'walk around' the home and identified areas which needed improvement.
The registered manager promoted a culture in the home which was open, inclusive, and aimed to achieve good care outcomes for people who lived there. During our two days at the home, all staff we spoke with were extremely positive about the support the registered manager gave them as workers, and of her passion to ensure people who lived at Peaker Park had a good care experience. Typical comments from staff included, "[Registered Manager] is fab. She has an open door. You can talk to her about anything. She is the best manager I've worked for – strict but fair." Another said, "The RM is very approachable. She is there to listen and give me guidance if I need it."

The registered manager was clear with staff about their roles and responsibilities. Where staff had not acted in line with the provider's policies and procedures, the registered manager had undertaken the appropriate disciplinary action for that member of staff. The registered manager was aware that sickness rates in the home were higher than they should be, and was working with staff to reduce this by having 'return to work' interviews with staff when they came back to work.

People we spoke with mostly knew who the registered manager was and some had direct contact with them. Others did not know the manager, but knew who led the team in the unit where they lived and felt able to speak with them about any concerns.

The registered manager was supported by two clinical leads and a group of team leaders (one for each of the six units). They met with this group every day to discuss any immediate issues of concern, and monthly to discuss items in more detail. The registered manager was also supported by a regional manager. After our feedback about the Albany unit, the regional manager undertook a 'sit and see' exercise in the unit. They saw similar issues to us, and as a result they and the registered manager acted to support staff improve the outcomes for people on the unit to improve the safety and well-being of people who lived there.

During our inspection we spoke with people and relatives who informed us they attended 'relative and resident' meetings, and had also met individually with the registered manager when there were issues they wanted to discuss or address.

The registered manager and provider were aware of their responsibilities to notify the CQC of any events relating to people who lived in the home. They had not done so with one notification; however, this was because of a misunderstanding relating to when the CQC should be notified about safeguarding, not because of any wilful intention to not inform us of concerns. They also ensured the most recent rating of the home was published on their website and was available for people in the home to read.