Prime Life Limited

Rutland Care Village

Inspection report

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Date of inspection visit: 20 May 2015
Date of publication: 16/07/2015

Ratings

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

Overall summary

We carried out an unannounced inspection of the service on 20 May 2015.

Rutland Care Village provides nursing and personal care for up to 84 people. At the time of our inspection 76 people were using the service. Rutland Care Village is a purpose built home split into four units. The village includes a day care facility.

A registered manager left the service in January 2015 when an interim manager took over the management of the service. At the time of our inspection the interim manager had applied to be the 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.

Summary of findings

People were safe because staff knew how to recognise and report signs of abuse. People were supported to be as independent as possible. Enough suitably skilled and experienced staff were available to meet people's needs.

Staff used equipment safely when they transferred people or assisted them with their mobility.

The provider had robust recruitment procedures.

People received their medicines on time.

People using the service told us they felt staff were knowledgeable about their needs Staff received relevant training and support to be able to meet the needs of people using the service.

The manager, deputy manager and senior staff had a good working knowledge of the relevance of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Other staff had an awareness of the legislation.

People's nutritional needs were met. People had a choice of foods and drinks and spoke in complimentary terms about the meals that were provided. Staff were attentive to people's health needs and supported people to access health services when they needed them.

Staff were caring. We saw examples of staff showing kindness and compassion. People using the service and their relatives had opportunities to be involved in decisions about their care and support. People were treated with dignity and staff respected people's privacy.

People received care and support that was centred on their needs. However, we saw that recent changes to a person's care plan had not been implemented and they may have been at risk had we not brought the matter to the provider's attention. People had access to social activities and staff supported people to follow their interests and hobbies. The provider had begun to pilot a new programme to support people living with dementia by providing individually tailored activities for them.

People had opportunities to make suggestions and raise concerns. They told us they were confident about raising concerns and that they would be listened to. The provider had acted upon people's comments and feedback, for example in relation to social activities.

The management team were clearly visible and available to people using the service. The management team had clearly defined aims and objectives about what they wanted to achieve for the service. Staff felt well led. The provider had effective procedures for monitoring and assessing the service.

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.

Staff supported people to understand how they could stay safe. The provider deployed enough staff to ensure that people's needs were met. People received their medicines at the right times.

Good

Is the service effective?
The service was effective.

Staff had received relevant training and development to be able to meet the needs of people using the service. People were supported with their nutritional needs and had access to health services when they needed them. Staff understood and put into practice the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Good

Is the service caring?
The service was caring.

Staff understood people's needs and developed caring and supportive relationships with people. They supported people to be as independent as possible. People were encouraged to express their views and be involved in the planning and delivery of their care.

Good

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

People received care and support that met their individual needs, but changes to a person's care plan were not acted upon until we brought the matter to the manager's attention. Staff supported people to lead active lives based around their hobbies and interests. The provider sought people's views and acted upon their views.

Requires improvement

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

People's views and experience were used to improve the service and staff were involved in developing the service. The provider had effective procedures for monitoring and assessing the quality of the service.

Good

Rutland 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We carried out an unannounced inspection on 20 May 2015. The inspection team was made up of two inspectors, a nurse specialist advisor and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had expertise in caring for elderly people.

Before our inspection we gathered and reviewed all of the information we held about the service since our last inspection in January 2014. This included the notifications we had received from the service concerning deaths, serious injuries and incidents involving people using the service.

We used the Short Observational Framework for Inspection (SOFI) in one of the units used by people living with dementia. SOFI is a way of observing care to help us understand the experience of people who could not talk to us.

We spoke with 11 people who used the service and relatives of three other people. We spoke with the regional manager, manager and deputy manager, four team leaders, two nurses and two care workers. We also spoke with a doctor who made a professional visit to the service on the day of our inspection. We looked at six care plans and associated records. In addition we looked at a staff recruitment file and records of the provider's monitoring of the service.

We contacted the local authority that funded some of the people at Rutland Care Village.

We requested additional information from the provider in relation to the results of the most recent survey of people using the service and improvement plans the service had implemented. We received the information promptly and used it as part of our inspection.

Good

Is the service safe?

Our findings

All of the people we spoke with told us they felt safe. One person told us they felt safe because since moving to Rutland Care Village they had had no falls in contrast to having had several falls when living in their own home. Relatives of people using the service told us they had no concerns about the safety of their family members.

People told us that if they had any concerns about their safety they would talk to staff. A person told us, "I can talk to the carers and the team leader [if I had any concerns]." The manager and deputy manager operated a `manager's surgery' for relatives so they could raise any concerns in person. Two relatives we spoke with told us they felt confident about raising concerns if they felt they needed to. Another relative said, "Staff always find time to listen."

The provider had policies and procedures for keeping people safe. These included safeguarding and whistle blowing policies. We saw `whistle blowing' information posters on display in every unit. Staff we spoke with were aware of the policies. They understood their responsibilities for identifying and reporting signs of abuse. Staff knew they could raise safeguarding concerns externally with the local authority safeguarding team and us if they felt their concerns had not been taken seriously. People using the service could be assured that staff knew how to keep them safe.

Most staff had attended safeguarding training. The provider had arranged refresher safeguarding training for staff in June 2015 to maintain staff awareness of safeguarding procedures and responsibilities.

Staff followed the provider's procedures for reporting accidents or injuries experienced by people using the service, for example as a result of falls. These were investigated by the manager and deputy manager. Staff supported people to walk safely by helping them understand how to avoid falls. The service provided people with lower beds and fall mats to protect them from serious injury and requests had been made to people's GP to consider referrals to a NHS falls clinic.

People were supported to be safe without undue restrictions on their freedom and choices about how they spent their time. Adjustments were made so that people could safely participate in activities such as gardening.

People's care plans included risk assessments associated with people's personal care routines. Care plans and risk assessments provided care staff with information about how to support people safely with those routines.

People's views about staffing levels were influenced by how long it took staff to respond to calls for assistance or complete personal care routines. People's views about this were mixed. One person told us that staff usually took 15 to 20 minutes to respond to his call bell. Another said, "I'd like a bit more attention but they don't have the time". Another person told us that staff were in rush that morning adding "they didn't clean my teeth today – they said they'd do it later but I knew they'd forget". A relative told us that a week before our inspection their family member had used the call bell but no staff responded. However, another person using the service told us, "You only have to press this bell and they come to you". Two other relatives we spoke with felt enough staff were on duty because they were confident that their family member's care routines were always fully carried out. Staff we spoke with felt enough staff were on duty most of the time. Our own observations were that staff responded promptly when people called for assistance. Staff were busy but we saw staff spending time having conversations with people.

Staffing levels were assessed by the manager and deputy manager. Staffing levels were based on the assessed and changing needs of people using the service. The manager could request additional staffing resources by submitting requests to the provider's human resources department if they had reason to believe more staff were required. When staff rotas were planned, the manager or deputy manager ensured that the staff rostered had sufficient skills, knowledge and experience. We saw that to be the case after we looked at rotas for the four weeks before our inspection and a summary of training staff had received.

People using the service told us they had their medicines at the right times. A person told us, "I have tablets in the morning; they watch to make sure I've taken them". However, we found that three people were given their medicines at times that were different to those on the prescription. When we checked this we found that that the actual dispensing times were in accordance with people's medical needs and the administration records were amended appropriately.

Four people using the service received their medicines without knowing because it was in their best interests this

Good

Is the service safe?

should happen. Each had a `covert medicines plan'. However, the plans were not dated and none contained instructions on how the medicines were to be given. This was important as the administration method could have affected the medicines' potency and effect. This was brought to the attention of the provider and instructions were put in place before the end of the inspection. There was a risk that had we not brought the matter to the provider's attention, action would not have been taken until a thorough review of care plans had taken place.

Medicines were safely stored and the provider had effective arrangements for the disposal of unused medicines.

Good

Is the service effective?

Our findings

People using the service did not express their views about the quality of staff, but relatives did. A relative told us they felt staff had the necessary skills and knowledge to support the person using the service. They told us, "We are more than happy. We are confident [person using service] gets the care they need. Relatives had left complimentary feedback about staff and the service in a comments book. Feedback left in the month before our inspection praised the quality of staff and care. One comment expressed that a person had experienced a `remarkable' transformation [for the better] since moving to Rutland Care Village. Other comments described the service as `wonderful' and `excellent.' The results of the provider's most recent survey of people using the service and relatives showed that they were satisfied with the care provided.

The service had a training and development plan for staff that was monitored monthly by the manager and verified by a regional director. This was aimed at supporting staff to increase their skills and knowledge. Staff received training in subjects such as moving and handling, dementia and understanding and managing behaviour that challenged. Monitoring of the training plan had ensured that the majority of staff had either completed training and others were booked to attend training.

Training was reinforced through supervision, observation and assessment of staff competencies. There were plans to ensure that all staff had a minimum of six supervision / appraisal meetings with their line manger each year. Supervision meetings were scheduled to December 2015. There had been some slippage in the frequency of supervision / appraisal meetings in the first three months of 2015 because of changes in the management team, but those meetings had begun to take place as scheduled. Staff told us they felt well supported through training and supervision. They felt they had opportunities to develop their careers. Most of the team leaders had begun their careers as care workers at Rutland Care Village or other locations run by the provider.

Staff we spoke with understood the requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Managers and senior staff, for example team leaders and nurses, had a good working knowledge of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. These safeguards are there to make sure that people in care services are looked after in a way that does not inappropriately restrict their freedom. A person should only be deprived of their liberty when it is in their best interests and there is no other way to look after them, and it should be done in a safe and correct way. Senior staff understood and implemented their responsibilities under MCA and DoLS. At the time of our inspection there were people using the service who were under a DoLS authorisation. Care workers we spoke with understood why those people were under the authorisation and they supported people in line with it.

One unit at Rutland Care Village supported people with the highest level of dependencies. Some of the people displayed behaviour that challenged others. Staff had training in how to support people at those times. They did so through non-physical intervention techniques. We saw staff manage difficult situations by taking with people, offering reassurance by explaining how they could help people and diverting a person's attention to other things.

All staff we saw communicated with the residents effectively and used different ways of enhancing that communication by touch, ensuring they were at eye level with those residents who were seated, and altering the tone of their voice appropriately. We heard and observed staff seek people's consent before they provided support and personal care.

People were complimentary about the food they had. A person using the service said of the food, "It's very good home cooking." People told us staff respected their food choices and preferences and when they ate their meals. A person told us, "The kitchen staff prepare me boiled vegetables or stir fries – they are really helpful". They added that staff provided her with soya milk which she prefers. The same person told us, "I like to eat at funny times and normally eat in the dining room on my own – I'm very happy with that". Other people told us they were offered choices of sandwiches during the day.

We observed a lunchtime meal. People had a choice of contrasting main meals. We saw people having steak and kidney pie with mashed potato, broccoli and sweet corn whilst others had chicken stroganoff with rice and the same

Good

Is the service effective?

vegetables. They all appeared to be enjoying their meals. People that required help with their meals were supported by staff who made an effort to engage with people whilst they ate.

Drinks of people's choice were served throughout the day and people were supported or prompted to drink appropriately. There were jugs of fruit juice and water in each of the lounges.

Staff monitored people's health and well-being and supported them to access health services when needed. People told us that health professionals such as opticians, chiropodists and their GP visited them. A relative told us, "[Person using service] is probably healthier now than she has been in the last two years". Other relatives had left written feedback in a comments book to the effect that their relative's well-being had improved since they came to Rutland Care Village. One described the improvement they'd seen as `remarkable'. A doctor who was visiting the service told us, "We [the medical practice] have an excellent relationship with Rutland Care Village." They told us they visited the service every week and had no concerns about the quality of care provided by staff.

The provider had implemented an action plan to improve the environment of the unit where people with dementia were supported. This involved working with a charity specialising in dementia care. Improvements included introducing dementia friendly décor, signage and sensory equipment.

Good

Is the service caring?

Our findings

People using the service told us that staff were kind. One person told us, "I like the staff, they're really kind." Another said, "The people (staff) are very nice and do anything for you" and another said "They're (staff) so kind, nothing is too much trouble". A relative we spoke with told us, "The manager is great; he's very approachable and supportive." We saw comments that relatives had made in a comments book shortly before our inspection. These included, `The carers are patient and kind. I'm impressed by their sympathy and understanding' and `the staff are kind, caring and thoughtful.'

Staff we spoke with told us they grew to understand people's needs by talking with them, observing them and reading people's care plans. We saw staff in one of the units taking time to engage in conversation with people. Non care staff also talked with people. We heard domestic staff engaging in conversation with people they clearly enjoyed. Staff showed concern for people. We saw that care staff had reported concerns about people's health and well-being to team leaders and nurses so that they could take the appropriate action which included reviewing care plans or arranging a visit from a health professional. This showed that staff cared and this contributed to people feeling that they mattered to staff.

We observed that the way staff supported and interacted with people was in a caring and respectful manner. Staff explained to people how they were going to support them to make them comfortable or provide personal care. They told people about the times of meals. They were welcoming towards visitors to the home and we saw they had a positive rapport with them.

People who were able to be involved in decisions about their care and support. They told staff what their likes and dislikes were and how they preferred to be supported. The information they gave was added to care plans and used by staff. Relatives were involved on behalf of people who were less able to be involved. People were involved in more general aspects of their care and support through residents / relatives meetings where they expressed ideas and suggestions about things like activities, outings and food.

People were provided with information about the service in information packs. This included information about independent advocacy services people or their relatives could access.

Information about people, for example care plans and records of their care and support were kept securely in team leader's offices. People using the service and their relatives could be assured that information about them was accessible only to authorised people.

People were able to spend time as they wanted. We saw people in communal areas but also spending time in their rooms reading or watching television or listening to radio. A person told us "I like to keep to myself". We saw that staff respected people's privacy. They knocked on people's doors and waited to be invited in before entering people's rooms. When staff supported people with personal care they showed they were mindful of people's privacy.

The provider promoted dignity in care. Each of the four units had a `dignity champion' who had received additional dignity in care training which they used to support other staff to understand good practice, for example referring to people by their preferred name and respecting people's choices. We saw staff offer people choices of activity and they supported a person who changed their mind about what they wanted to do.

Relatives were able to visit without undue restriction. The visitor's book showed that relatives visited throughout the day and early evening. Relatives were able to visit at night if they wanted. We saw that staff showed kindness and compassion to visitors who were concerned about their relatives.

Requires improvement

Is the service responsive?

Our findings

A relative told us they were very pleased with the care and support their parent received. They said, "I'm over the moon about the improvement in [person using the service] since they came here." A few days before our inspection a relative contacted us to say, "I am extremely happy with the level of help and support [person using service] receives".

We saw from information included in people's care plans that they were involved in the assessments of their needs. Where people were not able to be involved their relatives were. Two relatives told us they had been involved. The manager and deputy manager made it easier for relatives to be involved in discussions about their family members care by arranging meetings outside relative's working hours, for example during early evenings if they wanted.

People's care plans were based on people's needs and preferences. Care plans included people's life history, information about their interests, what was important to them and how they wanted to be cared for and supported.

People's care plans were regularly reviewed, usually each month, by team leaders and nurses. Those reviews were carried out to monitor people's health and well-being. In depth reviews took place annually and involved health professionals, social workers, the person using the service if they wanted to be involved and their relatives or representatives. A relative told us they had been involved in the review of a care plan.

People told us they were able to give their views about their care to the staff. A person told us, "I can talk to the carers and the team leader." Another person told us they knew they could speak with the manager. A relative told us, "We're often asked for our [family] views. They [staff] are very open to discussion. Our suggestions have been acted upon, staff helped [person using the service] to watch her favourite television programmes."

Care plans we looked at included information about how people needed to be supported with their nutrition. For example, some people needed help when eating and other's weight had to be monitored. We found an instance where staff had not followed a person's care plan.
The person's care plan made clear that the person needed to be upright when eating and assisted and encouraged by staff to eat. However, we saw that over a period of an hour and a half the person's lunch was on a tray above their bed. The person held a piece of food in their hand and close to their mouth. They were not upright and no staff were present. This presented a remote risk that the person could choke if they placed the food in their mouth. We discussed this with the manager and action was taken to review the care plan and bring it to the attention of staff. However, the person had been at risk of harm before our intervention.

On the day of our inspection we saw that people attended an on-site activities centre where they participated in activities. These included games and quizzes that supported people to interact with each other. People also participated in those kinds of activities in other communal areas. Other people spent time in their rooms doing what they wanted to do. We didn't see staff supporting people with their interests and hobbies, but we saw from records this was something that happened regularly. For example, people who enjoyed painting or gardening were supported to enjoy their interests. The service has a weekly activities programme providing a range of activities for people using the service available for residents at the home. The activities were a mix of social and recreational events promoting integration and psychological wellbeing. On the morning of the inspection there was a hairdressing session which a number of residents attended.

People living with dementia were supported with dementia friendly activities, for example `memory' sessions where staff talked with them about their past, for example about their lives and the jobs they had. The provider had begun working with a national charity to pilot a new programme to support people living with dementia by providing individually tailored activities for them. This work was in its early stages. During our inspection we noted that there was very little stimulation for people in the dementia unit. The décor of the unit was bland with little by way of sensory stimulation. The provider had an action plan to address this which was about to be implemented which meant that at the time of our inspection there were improvements that were planned but not yet evident.

The provider had a complaints procedure that was geared towards identifying areas that could be improved. People using the service and relatives had access to the complaints procedure. People we spoke with knew about the complaints procedure but they told us they preferred to raise any concerns by speaking with staff of the manager. They told us they were confident any concerns they raised

Requires improvement

Is the service responsive?

would be dealt with. The provider investigated complaints, apologised to complainants for any shortcomings and took appropriate action, for example to recompense people where personal belongings had been lost.

Good

Is the service well-led?

Our findings

People using the service, relatives and health professionals we spoke with were complimentary about the management of the service. They knew the names of team leaders and the manager and deputy manager. A relative told us, "The manager is great. He is very approachable and supportive. Another told us "[The manager] sorts things out."

People who wanted to be were able to be involved in discussions about the development of the service. This was through an annual survey, residents / relatives meetings and speaking with the manager. People contributed ideas and suggestions about activities and menus and these had been acted upon.

Staff were involved in developing the service through regular meetings, though meetings were mainly used to discuss the care and support of people using the service. Team leaders and nurses told us that they had meetings every day and that they had on occasion made suggestions about how care and support was delivered. We observed one of those meetings. People present told us they found the meetings useful and that any decisions made at the meetings were put into action by the manager, for example contact with health professionals to the service or reviews or care plans.

Staff were supported to question practice if they felt people's safety or the quality of care was not what it should be. The provider had a whistle blowing procedure for staff to use which allowed them to contact senior managers to discuss concerns, anonymously if they wished. The manager and deputy manager promoted dignity in care and encouraged staff through meetings and supervision to raise any concerns they had. A care worker told us, "The manager of the home is very approachable and accessible as is the deputy."

Leadership operated at other levels. For example team leaders supported care workers to settle into routines. We saw care staff going about their work in a way that demonstrated they knew what was expected of them. We saw team leaders respond to care staff who came to them for advice about how to support a person using the service. A team leader told us, "I have trust in the team and I am confident they would alert me to any concerns."

The provider's procedures for monitoring and assessing the quality of the service operated at two levels. These procedures were based on 11 `key indicators of performance'. The registered director carried out a range of scheduled checks and monitoring activity to provide assurance that people received the care and support they needed. They reported their findings to a regional manager who carried out their own checks to verify the registered manager's findings. The reports to the regional director were detailed and clearly set out what the manager was trying to achieve for the people using the service. The regional manager's reports were reviewed by the provider's operational board. This meant the most senior managers in the provider organisation knew how the service was performing.

The provider's quality assurance processes took account of the Care Quality Commission's current guidance about the new regulations that came into force in April 2015. The provider had detailed action plans for the service for achieving internal key indicators of performance that were being implemented and monitored.