RUTLAND CARE VILLAGE IMPROVEMENTS REQUIRED

Overall summary of this service

Rutland Care Village provides nursing care, personal care and support for up to 82 people. It is made up of a purpose built home split into four units, one of which is a specialist dementia care unit. The village also includes a day care facility known as 'Brambles' and residential bungalows. These were not included in our inspection.

We found the provider had appropriate systems in place to help ensure that people were protected from the risk of abuse and avoidable harm. When appropriate, people's capacity to make decisions had been considered and the provider had acted in their best interests. People were cared for in an environment that was safe and appropriate for their needs. People and their relatives felt their care and support needs were being met and nobody we spoke with raised any concerns about their care or treatment.

People received care and support that met their needs and promoted many aspects of their well-being. Care plans provided guidance for staff about how people's needs should be met and these had been regularly reviewed and updated. We found that people's health had been monitored and guidance from health professionals had been sought when appropriate. People had been protected from the risk of malnutrition and dehydration and people's special diets or food preferences had been catered for. However, care plans did not always record people's involvement in the planning and delivery of their care.

Staff had a good understanding of the needs of people who used the service and had many had completed an induction programme. However, the staff team had not always been supported to deliver appropriate and effective care as many had not received training in important areas such as infection control, Mental Capacity Act and Dementia Awareness. This meant there had been a breach of the relevant legal regulation and the action we have asked the provider to take can be found at the back of this report.

We observed that the staff team were mostly friendly and professional in their interactions with people and staff were able to give examples of how they protected people's privacy and promoted their dignity. We used our SOFI (Short Observational Framework for Inspection) tool to see what the experiences of people living in the specialist dementia unit were. We found that staff did not always have the skills required to support people with dementia. Staff interactions were focused on tasks such as giving people drinks and taking them to the toilet rather than positive communication. Many staff had not shown consideration for people's emotional well-being when supporting them during our period of observations. We saw limited attempts to interact with people or provide activities in any meaningful way. However, when staff did take the time to engage with people we found they did respond positively. We have asked the provider to make improvements in this area.

There were sufficient numbers of staff to ensure the safe and effective delivery of care and our observations showed that staff responded promptly to people when they required support. Most of the staff we spoke with felt staffing numbers were

adequate and people we spoke with told us they had the care and support they required at the time it was needed.

People and their relatives had been involved in the running of the service and had been asked for their views in regular meetings and an annual questionnaire. However there was no action plan to record the improvements highlighted by the meetings or survey or to assure that they would be made. People's complaints and concerns were recorded and responded to promptly.

However, people's involvement in the planning and delivery of their care was not always consistent. The majority of care plans and records we looked at contained insufficient information about people's choices, wishes and preferences so they could not be assured that they would be met. The provider had a day centre which had a programme of activities. However, many people had not been encouraged to access this service and during our inspection people who did not visit the day centre were not encouraged to engage in alternative activities that were relevant to them. Some people told us they would have liked more opportunities to go into the community or attend activities and others told us they had been lonely at times. This meant there had been a breach of the relevant legal regulation and the action we have asked the provider to take can be found at the back of this report.

People we spoke with and their relatives considered that the service was well managed and many of them told us about the improvements the registered manager had made since they had been in post. Staff were also positive about the management of the service and were clear about their roles and responsibilities.

There was a management system in place which monitored and assessed the quality of service provided. This included audits and reviews of care plans and records, checks of the environment and other audits such as call bell audits and falls audits. These had been carried out regularly and were well documented. However this could be improved by ensuring that action taken as result of these checks had been recorded.

Safe No action required

Summary

We found that people were protected from the risk of abuse because the provider had effective systems in place to help ensure that allegations of abuse were reported and responded to. Staff we spoke with had received training about the safeguarding of vulnerable adults and were clear about their responsibilities. People who used the service may benefit from being provided with more information about adult protection in an accessible format.

The manager of the service had a good understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). This meant that they could respond appropriately to follow relevant legislation in the appropriate circumstances. We found that mental capacity assessments had been carried out and, when appropriate, the decision that had been taken was in people's best interests. However, staff had a limited understanding of the MCA and DoLS and

many had not received any training in this area. This meant that there was a risk that the provider may not identify the need to apply the legislation.

The provider had carried out a number of risk assessments in relation to people's health, safety and the environment and actions were in place to minimise risks that had been identified. These assessments had been incorporated into people's care plans. This meant that the delivery of care had been planned in a way that was intended to ensure people's safety and well-being.

People were cared for in a safe, clean and hygienic environment and there were appropriate systems in place to prevent the risk of cross contamination.

Effective Improvements required

Summary

We spoke with people who used the service and their relatives and they told us they were receiving appropriate care and that their needs were met. People were complimentary about the staff team and described them as friendly and hardworking.

People's basic needs had been assessed and care plans detailed how people's needs should be met. These took into account any risks that were associated with the delivery of care. We observed that people's care had been delivered in accordance with their care plan. Our specialist nursing advisor found that nursing care was appropriate and effective. However, we found that the majority of people's plans of their care gave limited detail about their choices and preferences and did not record whether people had been consulted with about how they would like their care to be delivered.

The provider had good systems in place to protect people from the risks of malnutrition of dehydration. There was a choice of meals available at all times and kitchen staff were aware of people's dietary needs and preferences.

People were supported to maintain good health by on-going monitoring and referral to appropriate health professionals when necessary and we found service had developed good relationships with health professionals in the local community.

Staff demonstrated a good understanding of the needs of people who used the service and were positive about their role and the service. Although most staff had completed an induction programme they had not always received relevant and appropriate training and support to ensure they delivered effective and person centred care. This amounted to a breach of Regulation 23 of the Health and Social Care Act 2008.

Caring No action required

Summary

People we spoke with told us that staff were helpful, friendly and courteous and our general observations showed that staff responded to people promptly and in a

professional manner. There were policies and procedures in place to ensure people's privacy, dignity and human rights were respected However although many staff had completed an induction programme, many lacked sufficient training in these areas.

In addition, to our general observations we used our SOFI (Short Observational Framework for Inspection) tool to help us see what some people's experiences of the service were like. We found that staff did not always have the skills required to support people with dementia. Staff interactions were focused on tasks such as giving people drinks and taking them to the toilet rather than positive communication. Many staff had not shown consideration for people's emotional well-being when supporting them during our period of formal observation. We saw limited attempts to interact with people or provide activities in any meaningful way. However, when staff did take the time to engage with people we found they have responded positively. We have asked the provider to make improvements in this area.

Responsive Improvements required

Summary

People's relatives that we spoke with felt they had been involved in the care and support delivered to their family member and were happy with the communication they received. We found that 'residents and relatives' meetings had taken place and people had the opportunity to contribute to the development of the service. The service had also carried out an annual questionnaire which asked for people's views. There was an appropriate complaints policy and the manager responded to concerns and complaints effectively. However there was a lack of organisational learning associated with complaints to ensure that best practice was achieved and maintained.

However, we found a lack of proper consideration had been given to supporting all people who used the service to engage in activities that were relevant to them. Activities were mostly limited to 'Brambles' the provider's day centre which the majority of people did not use. We saw no attempt to engage people who had not gone to the day centre in meaningful activities during our inspection. Some people we spoke with said they would have liked the opportunity to participate in more activities or go into the local community whereas others told us they had experienced loneliness whilst living at the home.

Care plans and records contained limited information about people's involvement in the delivery of their care and there was no evidence that people's choices, preferences and wishes had been sought and considered in most of the care plans we looked at. This included consideration of people's religious needs. This amounted to a breach of Regulation 17 of the Health and Social Care Act 2008.

Well-led No action required

Summary

People who used the service and their relatives were satisfied with the management of the service and told us about the improvements the registered manager had made. One person said, “Things are much better now”. People felt able to raise their concerns or complaints with the manager of the service and were confident they would be considered and addressed.

Staff felt supported by managers and other senior staff at the home and were clear about their roles and responsibilities. Staff told us the service was well-managed and had confidence in the registered manager. They were aware of the provider’s whistleblowing policy and told us they would be comfortable in raising any concerns they had. The provider had ensured there were enough staff on duty at all times to provide effective and appropriate care to people. This was determined by carrying out an assessment which then informed the rotas that were in place. Our observations showed that when people required assistance staff were available to help them promptly.

There was a robust quality assurance system in place that monitored the risks to people and others and ensured the service was learning and continually improving. However, this could be improved by ensuring that audits and checks documented any action or learning that had taken place as a result.