Drumconner Limited

Drumconner Lancing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

he inspection took place on 27 March 2017 and was unannounced.

Drumconner Lancing provides nursing support for up to 57 older people, some of whom have physical disabilities or are living with other conditions such as diabetes and dementia and who may need support with their personal care needs. On the day of our inspection there were 46 people living at the home. The home is a large property, with attractive gardens, situated in Worthing, West Sussex, on the south coast of England.

The provider of Drumconner Lancing, also owns another home in the south west of England. The home had a registered manager, however we were informed at the inspection that the registered manager had left employment. A registered manager is a '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 home is run. The management team consisted of a clinical lead, who was the registered manager of the provider's other home and a manager. Subsequent to the inspection we were informed that both the clinical lead and the manager had left employment.

We carried out an unannounced comprehensive inspection on 18 November 2015. Areas in need of improvement were found, these included a lack of meaningful, person-centred activities and stimulation for people and a lack of access to staff training in relation to peoples' specific needs. Breaches of legal requirements were found in relation to a lack of notifications submitted to CQC with regard to events that had occurred within the home and a lack of detail within peoples' records to confirm the support that had been provided. Following the inspection the provider wrote to us to say what they would do in relation to the concerns found. At the inspection on 27 March 2017 we found that significant improvements had been made in relation to these areas. However, despite this we found areas of practice that were in need of further improvement.

People told us that they felt safe. One person told us, "Oh yes, I've felt safe. The accent is on safety here". Risk assessments related to some peoples' needs were in place to ensure that people were provided with safe care. However, not all risks, specific to peoples' needs had been considered.

Medicine records raised concerns as not all people had access to medicines when they required them. There were concerns with regard to the administration and storage of some medicines. For example, some people who self-administered their own medicines did not have a secure way of storing their medicines and this posed a potential risk to their own and others safety as people, for whom the medicine was not prescribed, may have come into contact with it. One person, who had been assessed as having swallowing difficulties, had been prescribed a thickening agent to be added to their drinks. There were concerns with regard to the person's safety as observations showed them to have access to un-thickened drinks as well as the thickener itself and the person was at risk of choking and asphyxiation. The administration and access to medicines as well as the management of risk to peoples' safety were areas of concern.

People were asked their consent before being supported. However, when people lacked capacity to make specific decisions relevant people had not been consulted when decisions were made on their behalf. Necessary applications, for some people who were being deprived of their liberty, had not always been undertaken.

People had access to a range of activities and were complimentary about the activities on offer. One person told us, "There is plenty going on and we have choice to join in or not. We enjoy the quizzes and we like the entertainers who come in. We always have a cake on our Birthdays". However, there was a lack of engagement and stimulation for people who were less able to take part in activities and there was a risk that some people were socially isolated.

There was mixed feedback with regard to the staffing levels. Observations and records demonstrated that there were sufficient staff to meet peoples' needs, however, some people told us that there was not always enough staff. One person told us, "No, there are not enough staff, they are over-stretched". People's comments were fed back to the management team to enable them to reassess staffing levels. People were protected from harm and abuse. Staff were skilled and experienced and had undertaken the necessary training to enable them to recognise concerns and respond appropriately.

People had access to external healthcare professionals when they were unwell and advice and guidance provided by the professionals had been implemented in practice. One person told us, "Without question, they would call the doctor if needed. I have had a pressure sore and it's on the mend". People told us that they were happy with the food and drink provided and observations showed that people had a positive dining experience with a varied range of food and drink that they could choose from. One person told us, "Someone comes round to ask us what we want for lunch and supper the next day. We have our meals here or in the dining room. We have the choice".

Care plans documented peoples' needs and wishes in relation to their social, emotional and health needs and these were reviewed and updated regularly to ensure that they were current. People were complementary about the care they received. They told us that the staff were kind and caring and our observations confirmed this. Comments from people included, "The staff are marvellous, they're very friendly towards me" and "I find the staff very helpful and long suffering. They are all very polite and efficient". People told us that staff were respectful of their privacy and dignity and our observations confirmed that people were treated in a sensitive and respectful manner. People, if this wished, could plan for care at the end of their life and were able to stay at the home until this time.

The manager welcomed and encouraged feedback and used this to drive improvement and change. There were quality assurance processes in place to enable the manager and clinical lead to have oversight of the home and to ensure that people were receiving the quality of service they had a right to expect. People, relatives and staff were complimentary about the leadership and management of the home.

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 home was not consistently safe.

People did not always have access to medicines when they required them. There were concerns regarding the assessment of risk and the administration and management of medicines.

Peoples' freedom was not unnecessarily restricted. There were risk assessments in place to ensure peoples' safety and people were able to take risks and maintain their independence.

There were sufficient numbers of staff working to ensure that people were safe, staff were aware of how to recognise signs of abuse and knew the procedures to follow if there were concerns regarding a person's safety.

Is the service effective?

Requires Improvement

The home was not consistently effective.

People were asked their consent before being supported. However, when people lacked capacity to make specific decisions relevant people had not been consulted when decisions were made on their behalf.

People were happy with the food provided and were able to choose what they had to eat and drink. People had a positive dining experience.

People were cared for by staff that had received training and had the skills to meet their needs. People had access to health care services to maintain their health and well-being.

Is the service caring?

Good

The home was caring.

People were supported by staff who were kind and caring and who knew their preferences and needs well.

Positive relationships had developed and there was a friendly and warm atmosphere.

People were treated with dignity and respect. They were able to make their feelings and needs known and able to make decisions about their care and treatment. This included people at the end of their lives and people were able to plan for good end of life care.

Is the service responsive?

Requires Improvement

The home was not consistently responsive.

People had access to a range of activities, however there was a lack of engagement and stimulation for people who were less able to take part in activities and who were at risk of social isolation.

Care was personalised and tailored to peoples' individual needs and preferences.

People and their relatives were made aware of their right to complain. The manager encouraged people to make comments and provide feedback to improve the service provided.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

People and staff were positive about the management and culture of the home. However, subsequent to the inspection the management team left employment and there were concerns with regard to the on-going management of the home.

Quality assurance processes monitored practice to ensure the delivery of high quality care and to drive improvement.

People were treated as individuals and their opinions and wishes were taken into consideration in relation to the running of the home.

Drumconner Lancing

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 home, and to provide a rating for the home under the Care Act 2014.

The inspection took place on 27 March 2017 and was unannounced. The inspection team consisted of two inspectors 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. The home was last inspected in November 2015, where we found the provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we identified concerns in respect of the lack of meaningful, person-centred activities and stimulation for people, a lack of clear documentation to confirm the care and treatment people had received, a lack of notifications to CQC to inform us of events that had occurred within the home and a lack of training in relation to peoples' individual conditions. The home received an overall rating of 'Requires Improvement', after our inspection on 18 November 2015, the provider wrote to us to say what they would do to meet the legal requirements in relation to these breaches.

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Prior to this inspection the provider had completed a Provider Information Return (PIR), this is a form that asks the provider to give some key information about the home, what the home does well and any improvements they plan to make. Other information that we looked at prior to this inspection included previous inspection reports and notifications that had been submitted. A notification is information about important events which the provider is required to tell us about by law. We used this information to decide which areas to focus on during our inspection.

During our inspection we spoke with ten people, four relatives, seven members of staff, the manager and the clinical lead. Some people had limited or no verbal communication and were unable to speak to us. Therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records about peoples' care and how the service was managed. These included the individual care records for ten people, medicine administration records (MAR), four staff records, quality assurance audits, incident reports and records relating to the management of the home. We observed care and support in the communal

lounges and in peoples' own bedrooms. We also spent time observing the lunchtime experience people had and the administration of medicines.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that the home was a safe place to live. Comments from people included, "Oh yes, I've felt safe. The accent is on safety here" and "Oh yes, we feel safe. There is always someone around to get help". However, observations of practice and of records, raised concerns over peoples' safety and we found areas of practice that required improvement.

People were assisted to take their medicines by registered nurses, who had their competency regularly assessed. Peoples' consent was gained and they were supported to take their medicine in their preferred way. People, who were able, told us that they received their medicines safely and on time. One person told us, "I get my medication on time and they give me painkillers when I need them". Most medicines were stored correctly and there were safe systems in place for receiving and disposing of medicines. Some people were supported to have their medication given covertly. People who may not be able to make decisions about their care and treatment may need to be given their medicines without them knowing, for example, hidden in their food or drink. Records for one person showed that the manager had assessed the person's capacity to make a decision with regard to their medication and had ensured that a best interests decision had taken place. A letter from the person's GP had been received which advised staff that it was appropriate to give some of the person's medicines covertly. However, records were not sufficient to inform staff of what medicines were to be given covertly and how they should be administered so as to avoid altering the structure of the medicines. Staff told us that they had not had to provide medicines covertly as the person was continually refusing food and drink and therefore they were unable to administer the person's medicines in this way. However, observations showed the person eating and drinking and it was not evident that staff had attempted to administer the person's medicines covertly or otherwise. Records of healthcare professionals visits showed that a GP had advised, three months previously, that some of the medicines the person was prescribed were stopped, however, had advised that some essential medicines continued. In light of the person not receiving their essential, prescribed medicines, we asked staff what action was being taken to ensure the person's safety. Staff told us that they had been advised to persist. Records showed that none of the person's medicines had been given on any occasion for at least three weeks and records had been marked as refused and destroyed. There were concerns that the provider had not taken sufficient measures to ensure that the person received medicines that were essential for their health and well-being.

Whilst people had been assessed to ensure they were safely able to manage their medicines, we observed, in two cases, that medicines were not stored in lockable cabinets in peoples' rooms. This was inconsistent with the provider's self-medication policy and not all risks were recognised or managed appropriately to ensure the safety and well-being of the person or others who may come into contact with the medicines. People had been prescribed medicines that they could take 'as and when required'. The National Institute for Health and Care Excellence (NICE) quality standards 'Managing Medicines in Care Homes' recommends that care homes should ensure that a process for administering 'when required' medicines is included in the care homes medicines policy. It states that policies should include clear reasons for giving 'when required' medicine, minimum time between doses if the first dose has not worked, what the medicine is expected to do, how much to give if a variable dose is prescribed, offering the medicines when needed and not just during 'medication rounds' and recording 'when required' medicines in peoples' care plans. Although the

provider had a medicines policy, it did not include guidance on 'as and when required' medicines. Not all people had guidelines that informed staff of when to administer 'as and when required' medicines. This was raised with the manager and clinical lead who acknowledged that this was an area in need of improvement. Observations of medicines that were given on an 'as and when required' basis were not managed in a safe and effective way. Records showed that one person had 'as and when required' guidelines which informed staff of how and when to administer this type of medicine. There were no other 'as and when required' guidelines and therefore staff were not provided with sufficient guidance to inform them of when to offer the medicines and how many. For example, one person was prescribed medicines, one or two of which could be given at the nurses' discretion. There was no guidance about the medicine and why its use should be limited; in addition, staff had not recorded how many tablets the person had been given on each occasion and therefore it was unclear how much medicine the person had. Records for another person showed that they had been prescribed a sedative type medicine. Guidance from the pharmacy had advised that staff should show restraint in its use. Staff had placed an X on the person's medicine administration record (MAR), various nights in advance to ensure that the person did not have too much medicine. By placing an X on the MAR in advance staff had not consulted with the person to determine if they needed or wanted their medicines on certain nights and therefore there was a risk that the person did not receive their medicines when they needed them.

Some people, due to difficulties in swallowing, had been assessed by a speech and language therapist (SALT), who had recommended that some peoples' drinks were thickened to enable them to swallow fluids safely and minimise the risk of them choking. Observations of one person, who had been assessed as needing to have their fluids thickened, showed that an un-thickened jug of water and a glass of juice had been left within their reach. This posed a risk to the person's safety. Further observations, of the same person, a short time later showed that their drink had been thickened; however the container of thickener had been left uncovered, alongside the drink and within the person's reach. Thickeners must be stored securely when not in use due to the risk of asphyxiation should the thickening powder be consumed accidentally. NHS England issued a patient safety alert which advised, 'A patient safety alert has been issued by NHS England to raise awareness of the need for proper storage and management of thickening powder used as part of the treatment of people with dysphagia (swallowing problems). The thickening powder is added to foods and liquids to bring them to the right consistency/texture so they can be safely swallowed to provide required nutrition and hydration. The National Reporting and Learning System (NRLS) database has identified patient safety incidents where harm has been caused by the accidental swallowing of the powder, when it had not been properly stored out of reach'.

The provider had not done all that was reasonably practicable to mitigate risks and ensure peoples' safety. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider used a dependency tool to assess the required staffing levels to meet peoples' needs. Peoples' individual care and support needs were regularly assessed and this was used to inform the staffing levels, which could be adapted if their needs changed. There was mixed feedback with regard to the sufficiency of staff. Some people told us that there were enough staff to meet their needs, one person told us, "There is always someone around to get help". Another person told us, "There are enough staff about to look after me". However, other comments included, "There are not always enough staff" and "No, there are not enough staff, they are over-stretched". Records showed that there were sufficient numbers of staff, the provider had taken additional measures to ensure people received support during peak periods. They had employed a 'hostess' which was a member of staff employed to support people in the main communal lounges once staff had supported people to get up in the morning. The hostess spent time with people and assisted them to access food and drink. However, due to peoples' comments relating to the support that

they received from care staff their comments were fed back to the manager and clinical lead to enable them to look into care staffing levels during peak periods.
People had access to call bells within their rooms, however, some people told us that staff did not always respond in a timely way when they summoned assistance. Comments included, "The response time to a call for help varies", "The response times are slow" and "They don't always come quickly, but they do their best". When this was raised with the manager and clinical lead they told us that action had been taken to support staff to respond to call bells more swiftly. The provider had recognised that the home was a large building and there had only been one call bell screen that showed which person was using their call bell to summon for assistance. Staff sometimes had to walk from one side of the home to another to identify who was calling for assistance before they were able to respond, this had impacted on the amount of time it had taken to respond to call bells. The provider had installed a further two screens in different areas of the home, to enable the staff to respond more promptly.

People were cared for by staff that the provider had deemed safe to work with them. Prior to their employment commencing identity and security checks had been completed, and their employment history gained. In addition to this their suitability to work in the health and social care sector was checked with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with vulnerable groups of people. Documentation confirmed that nurses all had current registrations with the Nursing and Midwifery Council (NMC).

Staff had a good understanding of safeguarding adults, they had undertaken relevant training and could identify different types of abuse and knew what to do if they witnessed any incidents. There were whistleblowing and safeguarding adults at risk policies and procedures. These were accessible to people and staff and they were aware of how to raise concerns regarding peoples' safety and well-being. A whistleblowing policy provides staff with guidance as to how to report issues of concern that are occurring within their workplace. One member of staff told us, "I would let my manager know if I suspected abuse. If I had to, I'd go outside, to the CQC". Another member of staff told us, "I would report someone if I thought they were up to no good".

Peoples' freedom was not unlawfully restricted and they were able to take risks. Observations showed some people independently walking around the home. Peoples' needs had been assessed and risk assessments were devised and implemented to ensure their safety. A member of staff told us, "We need to keep people safe but if someone can do something for themselves, we let them, provided it's not harming them". Accidents and incidents that had occurred were recorded and analysed to identify the cause of the accident and determine if any further action was needed to minimise the risk of it occurring again. Risks associated with the safety of the environment and equipment were identified and managed appropriately. Maintenance plans were in place and had been implemented to ensure that the building and equipment were maintained to a good standard. Regular checks in relation to fire safety had been undertaken and peoples' ability to evacuate the building in the event of a fire had been considered, as each person had an individual personal emergency evacuation plan. A business continuity plan informed staff of what action needed to be taken in the event of an emergency.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 18 November 2015, some areas in need of improvement were identified in relation to staffs' access to training for peoples' specific conditions. At this inspection it was clear that improvements had been made. One member of staff told us, "The manager is very keen on training. It's not a problem". Another member of staff told us, "It's much better than it used to be. I think that's improved a lot over the past few months".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager and clinical lead had an understanding of MCA and had completed the relevant assessments. One person told us, "They seem to have our best interests at heart". However, when people were assessed as not having capacity, although best interests decisions had been made on peoples' behalves, records showed that these were made solely by the clinical lead with no apparent involvement from peoples' relatives or other healthcare professionals. Some people had a lasting power of attorney (LPA) so that when the person lacked capacity to make certain decisions the LPA could make these on the person's behalf. However, neither the manager or clinical lead had seen nor held a copy of the lasting power of attorney and therefore was unable to confirm that people involved in decisions affecting peoples' care had a legal right to make decisions on their behalf.

We checked whether people, who had been assessed as lacking capacity to make certain decisions, were being lawfully deprived of their liberty. Appropriate applications to the local authority to deprive people of their liberty had been made, however, not all people, who required a DoLS had one in place. When this was raised with the manager and clinical lead they told us that they would seek further advice and guidance from the local authority.

The provider had not ensured that care and treatment of people was provided with the consent of the relevant person. This was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us that they felt that staff had appropriate and relevant skills to meet peoples' needs. One person told us, "Most staff know what we need in the way of care". Another person told us, "I feel very confident with the senior nurses". The manager had a commitment to learning and development and although staff had undertaken an induction at the start of their employment the manager had recognised that this needed to improve. Staff that were new to the home were supported to undertake an induction

which consisted of familiarising themselves with the provider's policies and procedures, orientation of the home, as well as an awareness of the expectations of their role and the completion of the care certificate. The care certificate is a set of standards that social care and health workers can work in accordance with. It is the minimum standards that can be covered as part of the induction training of new care workers.

Staff had completed training which the manager and clinical lead considered essential, they had arranged for the registered nurses to undertaken courses to maintain their skills, such as venepuncture (obtaining blood samples) and wound management, as well as introducing written short courses for care staff to develop their skills with regard to conditions that were specific to the people that they were supporting, such as understanding dementia. Staff told us that they received sufficient training to enable them to provide care to people in a competent and consistent way. One member of staff told us, "It's very good. There is a lot of training about". There were links with external organisations to provide additional learning and development for staff, such as local colleges and the local hospice.

People were cared for by staff that had access to appropriate support and guidance within their roles. Regular supervision meetings and annual appraisals took place to enable staff to discuss their needs and any concerns they had. They provided an opportunity for staff to be given feedback on their practice and to identify any learning and development needs. Staff told us that they found supervisions and appraisals helpful and supportive, however, explained that they could also approach the manager at any time if they had any questions or concerns. When informing us of the support that staff were provided with, one member of staff told us, "It's so much better now. I feel as if my opinion matters".

Peoples' communication needs were assessed and met. Observations of staffs' interactions with people showed them adapting their communication style to meet peoples' needs and assisting people to use technology to aid communication. For example, when supporting a person who had a hearing impairment staff used the technology appropriately so that the person could hear them correctly. Effective communication between staff was also effective. Regular team meetings, as well as detailed care plans, ensured that staff were provided with up-to-date information to enable them to carry out their roles.

Peoples' health needs were assessed and met. People received support from healthcare professionals when required, these included GPs, opticians, speech and language therapists (SALT) and tissue viability nurses (TVN). Staff told us that they knew people well and were able to recognise any changes in peoples' behaviour or condition if they were unwell to ensure they received appropriate support and people confirmed this. One person told us, "Without question, they would call the doctor if needed". Another person told us, "A doctor has been when I had a chest infection and I've had visits from the optician and dentist".

Peoples' skin integrity and their risk of developing pressure wounds was assessed using a Waterlow Scoring Tool, this took into consideration the person's build, their weight, skin type, age, continence and mobility. These assessments were used to identify which people were at risk of developing pressure wounds. For people who had pressure wounds, wound assessment charts had been completed providing details of the wound and the treatment plan recommended, photographs of wounds had been taken to monitor their improvement or deterioration. There were mechanisms in place to ensure that people at risk of developing pressure wounds had appropriate equipment to relieve pressure to their skin, these included specialist cushions and air mattresses, which were regularly checked to ensure they were at the correct setting. One person told us, "I have had a pressure sore and it's on the mend".

People's risk of malnutrition was assessed upon admission, a Malnutrition Universal Screening Tool (MUST) was used to identify people who were at a significant risk, and these people were weighed regularly, to ensure that they were not losing any more weight. Records showed that referrals to health professionals had

been made for people who were at risk of malnutrition, these included referrals to the GP and SALT. Advice and guidance provided by the GP and SALT had been followed.

People had a positive dining experience and told us that they enjoyed the food and had a choice of menu each day. People ate their meals in the dining room, or in their own rooms, dependent on their preferences and care needs. The dining room and linked bistro area created a pleasant environment for people, tables were laid with tablecloths, placemats and condiments and people could choose what they had to eat and drink. People told us that they enjoyed the food. One person told us, "The meals are very nice. You can ask for a salad or anything else if you don't like the menu". Another person told us, "The food's great, just look at me".

Good

Is the service caring?

Our findings

There was a friendly, homely and relaxed atmosphere and people were cared for by staff that were kind and caring. People and relatives praised the caring approach of staff and told us that people were well cared for. Comments from people included, "The staff are marvellous, they're very friendly towards me", "The staff are very pleasant" and "The best thing is living here and we feel pretty well cared for. We do like it here". A relative told us, "They are very good to my relative, nothing is too much for all the staff". Comments from staff equally demonstrated their caring nature, these included, "I do think we provide a very caring place for people to live. I wouldn't stay here if we didn't", "We have the time, most of the time, to give people the things they want, like a chat or a cup of tea" and "It's very caring here. Everybody gets on really well and that helps make the place feel like home. That's what it should be like".

Observations of staffs' interactions showed them to be kind and caring, they took time to explain their actions, offer reassurance and ensure people were comfortable and content. People were treated with respect and were able to independently choose how they spent their time. Peoples' independence was promoted and encouraged. One person told us, "Staff do encourage me to be as independent as I can be". People were cared for by staff that knew them and their needs well. People were encouraged to maintain relationships with their family and friends and received visits throughout the day. People appeared to enjoy interacting with staff and it was apparent that caring relationships had been developed.

Peoples' privacy was respected. Information held about people was kept confidential as records were stored in locked cabinets to ensure confidentiality was maintained. Staff showed a good understanding of the importance of privacy and dignity and people confirmed that these were promoted and maintained. One person told us, "Staff are always polite. They knock before coming in and they make sure the door is shut and the blinds down when dealing with us". A relative told us, "They keep their door shut and always knock before coming in. Their privacy is protected". Observations further confirmed that peoples' privacy was respected, when discussing information of a personal nature, staff spoke quietly and sensitively with people, asking if they needed assistance in a sensitive and tactful way. Peoples' differences were respected and staff adapted their approach to meet peoples' needs and preferences. People were able to maintain their identity, they wore clothes of their choice and their rooms were decorated as they wished, with personal belongings and items that were important to them.

People and relatives told us that people were involved in decisions that affected their care and our observations confirmed this. Records showed that people and their relatives had been asked peoples' preferences and wishes when they first moved into the home and that care plans had been reviewed in response to peoples' feedback or changes in their needs. People and relatives confirmed that they felt fully involved in the delivery of care and could approach staff if they had any questions or queries relating to it. One relative told us, "Yes, we are involved with their care and treatment". Observations showed relatives talking with staff about the care their relative had received. Residents' and relatives' meetings provided people with an opportunity to be kept informed and to raise any concerns or suggestions that they had. The provider had recognised that people might need additional support to be involved in their care, they had involved peoples' relatives, when appropriate and if required people could have access to an advocate. An

advocate is someone who can offer support to enable a person to express their views and concerns, access information and advice, explore choices and options and defend and promote their rights.

People received good end of life care. Some registered nurses had received end of life care training from a local hospice who then shared their knowledge with other members of staff. People were able to remain at the home and were supported until the end of their lives. Records showed that peoples' end of life care had been discussed and advance care plans devised. These contained details of peoples' preferences with regard to their spirituality, preferred place of care and who they wanted with them at the end of their lives. Anticipatory medicines had been prescribed and were stored at the home should people require them. Anticipatory medicines are medicines that have been prescribed prior to a person requiring their use. They are sometimes stored by care homes, for people, so that there are appropriate medicines available for the person to have should they require them at the end of their life.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection on 18 November 2015, we found an area in need of improvement that related to peoples' involvement in decisions that affected their care, particularly relating to involvement in peoples' care plans. At this inspection it was clear that improvements had been made. People and relatives told us that they were fully involved in the planning, delivery and review of peoples' care. At the previous inspection another area in need of improvement related to the lack of activities, stimulation and opportunities for social engagement for people. At this inspection it was clear that improvements had been made in relation to the provision of activities, however, these needed further improvement and embedding in practice, this related to one-to-one stimulation for people and some people being at risk of social isolation. This is an area of practice that requires improvement.

The provider employed two activities coordinators as well as a hostess who worked three days per week, this meant that a range of activities, both in groups and one-to-one, could be offered. The provider had their own transport and organised trips both locally and further afield in the spring and summer months. Staff told us that people were approached individually and their opinions and preferences gathered in the form of an activity profile. This helped the provider shape the future provision of activities. External entertainers and therapists visited regularly to offer services which included exercise classes and aromatherapy sessions. Staff told us that special interest lectures had taken place, such as those provided by train enthusiasts to interested parties. Special occasions, such as Easter, Christmas and peoples' Birthdays were also marked and celebrated. People were complimentary about the activities that were provided, comments included, "There is plenty going on and we have choice to join in or not. We enjoy the quizzes and we like the entertainers who come in. We always have a cake on our Birthdays" and "There is enough to do, I'm never bored. I like to walk out and go on the beach".

However, despite the varied range of activities provided there were continued concerns with regard to people who were less able to be involved in activities and who required more one-to-one stimulation and engagement. This was echoed within a comment made by one person when talking about one to one activities, who told us, "They could look at being more person-cantered". The Alzheimer's Society state that spending time in meaningful activities can continue to be enjoyable and stimulating for people and taking part in activities based on the interests and abilities of the person can significantly increase their well-being and quality of life. Care records for one person who was living with dementia, stated, 'X is at risk of social isolation. Carers should encourage X to socialise with others, to come down to the dining room for activities so X can see other residents'. However, despite the person being assessed as being at risk of social isolation, observations showed them spending their time alone, in their wheelchair at the dining room table with no apparent interaction or stimulation from people. The person was not supported to watch organised activities that were taking place, in other areas of the home and instead spent their time from breakfast until lunchtime at the dining room table with nothing to occupy their time. Not all of the people received care and treatment to meet their assessed needs or reflect their preferences or wishes. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Peoples' social, physical, emotional, and health needs were assessed when they first moved into the home

and care plans had been devised. These were person-centred, comprehensive and clearly documented the person's preferences, needs and abilities. When possible life histories had been completed detailing information about where people had lived, their families and hobbies, providing an insight into the person's life before they moved into the home. People and relatives told us that they had been involved in the development and review of the care plans. One person told us, "They are setting up a review of my care plan". A relative told us, "Yes, we are involved with their care and treatment".

Staff demonstrated a good understanding of what person-centred care meant. One member of staff told us, "It's care that's just for the person we are looking after". Another member of staff told us, "I suppose it means that we give the care that the person wants. It can change every day but we fit round them". People were supported to make choices in their everyday life. Observations showed staff respecting peoples' wishes with regard to what time they wanted to get up, what clothes they wanted to wear, what they had to eat and drink and what they needed support with. People told us they were happy with their rooms and were able to furnish them according to their tastes and display their own ornaments and photographs.

There was a complaints policy in place, this was provided to people within the residents' handbook as well as on notice boards for people to see. Concerns and complaints had been dealt with appropriately and in accordance with the provider's policy. The manager encouraged feedback. Regular residents' meetings were held to enable people and relatives to make suggestions and voice their concerns. People and relatives told us that they did not feel the need to complain but would be happy to discuss anything with the manager, who was always approachable and listened to their concerns or suggestions.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection on 18 November 2015 the provider was in breach of Regulation 18 of the Care Quality Commission (Registrations) Regulations 2009 as they had not informed us of DoLS authorisations that were in place for some people. At this inspection it was clear that improvements had been made, the manager and clinical lead had submitted notifications to CQC to inform us of certain events and incidents that had occurred to enable us to have oversight of them to ensure that people were safe. Therefore the provider was no longer in breach of this Regulation.

At the previous inspection the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all records, documenting the care that people had received, had been completed. At the previous inspection, care plans for people who were living with diabetes did not identify the risk that their condition posed or treatment plans to ensure their well-being. At this inspection it was clear that improvements had been made. People who were living with diabetes had dedicated care plans in place to enable both them and staff to manage their condition to ensure their well-being. At the previous inspection people who required regular repositioning due to their increased risk of pressure damage did not always have turn charts in place. Turn charts that were in place were not always completed in their entirety or with sufficient information to inform staff of each other's actions, as a result people were at risk of increased pressure damage. At this inspection improvements had been made, turn charts were completed that documented the frequency of repositioning as well as the position that people had been repositioned to. At the previous inspection food and fluid charts had not always been completed sufficiently for people who were at risk of malnutrition and for those whose weight required monitoring. At this inspection improvements had been made. Food and fluid charts had been completed to enable staff to have an oversight of what people were eating and drinking on a daily basis. Therefore the provider was no longer in breach of this Regulation.

The home is owned by a provider who also owns another care home with nursing in the south west of England. At the previous inspection there was a registered manager, operational manager and deputy manager who were responsible for the management of the home. At this inspection we were informed that the registered manager had just left employment and the operational manager and deputy manager had also left some months previous. At this inspection there was a clinical lead, who was the registered manager of the provider's other home, who was overseeing the home and offering clinical support to the registered nurses. There was also a manager, who had been in post several months and who was going to apply to become the registered manager. Following the inspection we were informed that both the clinical lead and the manager had left employment. Therefore there were concerns with regard to the on-going management of the home.

The provider had aims and objectives that stated, 'Drumconner care home aims to provide its residents with a secure, relaxed and homely environment in which their care, well-being and comfort is of prime importance'. It was apparent that this was embedded in practice.

People, relatives and staff were complimentary about the leadership and management of the home. They

told us that they were encouraged to make their feelings known, that the management team was friendly, approachable and listened to and acted upon their comments and suggestions. One person told us, "We see the management occasionally and the senior staff seem to listen and you can talk to them. They do try to respond to questions or problems". Another person told us, "The management do listen when you ask for something. Yes, I'm quite happy here. I like everything". A third person told us, "I know the owner, who is approachable. I think on the whole it's quite well run. Overall, it's a lovely place".

There were good systems and processes in place to ensure that the home was able to operate effectively and to make sure that the practices of staff were meeting peoples' needs. There were mechanisms in place to obtain feedback from people and relatives to enable the management team to have an oversight of the service people were receiving. This ensured that people were receiving the quality of service they had a right to expect. There were links with external organisations to ensure that the staff were providing the most effective and appropriate care for people and that staff were able to learn from other sources of expertise. These included links with the local authority, local colleges, local hospices and other healthcare professionals. The manager attended manager forums to ensure that peoples' needs were met and that the staff team were following best practice guidance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person-centred care. The registered person had not ensured that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 (1) (2) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent. The care and treatment of service users was not provided with the consent of the relevant person. Where the service user was 16 or over and unable to give consent, because they lacked capacity, the registered provider did not act in accordance with the 2005 Act.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The registered person had not assessed the

risks to the health and safety of service users receiving care or treatment. Neither had they done all that was reasonably practicable to mitigate any such risks.