Darbyshire Care Limited

Drake Nursing Home

Inspection report

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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?	Good
Is the service well-led?	Good

Overall summary

The inspection took place on 23 April 2015 and was unannounced.

Drake Nursing Home provides care and accommodation for up to 32 people. On the day of the inspection 32 people were using the service. Drake Nursing Home provides short term and long term care for older people living with dementia, mental illness and physical disability.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and staff were relaxed throughout our inspection. There was a busy but pleasant and relaxed atmosphere. People were seen laughing, dancing and we saw very kind, patient interactions between people and staff. People, relatives and health professionals told us the care was excellent at the home and people enjoyed living in the home.

Summary of findings

People's risks were anticipated, managed well and monitored. People were promoted to live full and active lives where possible and were supported to be as independent as they could be. Activities were meaningful, individualised and reflected people's interests, the seasons and their hobbies.

People had their medicines managed safely. People received their medicines as prescribed, on time and understood what they were for. People were supported to maintain good health through regular access to health and social care professionals, such as GPs, social workers, physiotherapists and district nurses.

People received safe, compassionate care. People and their relatives told us they felt safe. Comments from family included "Whatever roles staff are in they take a real interest in the residents and their well-being." People's safety and liberty was promoted. All staff had undertaken training on safeguarding vulnerable adults from abuse. Staff displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm. Staff confirmed they felt confident any incidents or allegations would be fully investigated. Staff told us "We undertake training in safeguarding, we monitor resident's well-being and make sure they are not distressed, we look for bruising and other signs too."

People were protected by the service's safe recruitment practices. Relatives had been involved in considering interview questions for new staff. Staff underwent the necessary checks which determined they were suitable to work with vulnerable adults, before they started their employment.

Staff received a comprehensive induction programme which included shadowing more experienced staff. There were sufficient staff to meet people's needs. Staff were well trained and had the correct skills to carry out their roles effectively. Staff were encouraged to embed best practice through on-going learning and research. We observed staff used the correct techniques to transfer people and staff demonstrated excellent communication skills and good knowledge of the people they cared for.

People and those who mattered to them knew how to raise concerns and make complaints. People told us they had no concerns. The registered manager informed us any complaints made would be thoroughly investigated and recorded in line with the complaints policy.

Staff, relatives and external professionals described the management as supportive and approachable. Staff talked positively about their jobs and the new owners. Comments included, "Whenever I visit I am greeted in a courteous, professional and friendly manner."

There were effective quality assurance systems in place. The service had an open and transparent culture. The owners and the registered manager had set values that were respected and adhered to by staff to ensure the quality of care remained high. Staff felt listened to and able to contribute ideas to the development of the service to drive improvement.

Incidents were appropriately recorded and analysed. Learning from incidents and concerns raised was used to help drive improvements and ensure positive progress was made in the delivery of care and support provided by the staff. For example, an incident with a wheelchair had resulted in additional training for staff. Staff meetings were used to reflect on the incident and learning from what had occurred and resulted in new wheelchairs being purchased. Information from compliments received from healthcare professionals and family were shared with the staff team and success celebrated.

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?

Good

The service was safe. Safe recruitment practices were followed and there were sufficient numbers of skilled and experienced staff to meet people's needs.

Staff had a good understanding of how to recognise and report any signs of abuse, and the service acted appropriately to protect people.

Staff managed medicines consistently and safely. Medicine was stored and disposed of correctly and accurate records were kept.

The environment was clean.

Is the service effective?

Good

The service was effective. People received excellent care and support that met their needs and reflected their individual choices and preferences.

People experienced positive outcomes regarding their health. The service engaged proactively with health and social care professionals, and took preventative action at the right time to keep people in the best of health.

People's human rights and legal rights were respected. Staff had received appropriate training in the Mental Capacity Act and the associated Deprivation of Liberty Safeguards. Staff displayed a good understanding of the requirements of the act, which had been followed in practice.

People were supported to maintain a healthy balanced diet.

Is the service caring?

Good

The service was caring and compassionate. People were supported by staff that promoted independence, respected their dignity and maintained their privacy.

Positive caring relationships had been formed between people and staff.

People were informed and actively involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive and listened to people's views and concerns.

Care records were personalised and so met people's individual needs. Staff knew how people wanted to be supported.

Care planning was focused on a person's whole life. Activities were meaningful and were planned in line with people's interests.

People were encouraged to maintain hobbies and interests. Staff understood the importance of companionship and social contact.

Is the service well-led?

Good

The service was well-led. There was an open, transparent culture. The management team were approachable, visible and defined by a clear structure.

Summary of findings

Staff were highly motivated and inspired to develop and provide quality care.

Quality assurance systems drove improvements and raised standards of care.

Communication was encouraged. People and staff were able to make suggestions about what mattered to them.

Drake Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The unannounced inspection took place on 23 April 2015 and was undertaken by two inspectors for adult social care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with two people who used the service, two relatives, the registered provider / owner, the registered manager and seven members of staff. We observed the weekly clinical team meeting which discussed the care of people living at Drake Nursing Home. We also contacted the local authority quality team, the GP surgery who supported people within the home and the Care Coordination team who referred people to the home.

We carried out a Short Observational Framework Inspection (SOFI). SOFI is a tool to help us assess the care of people who are unable to tell us verbally about the care they received. We also observed people during the afternoon music activity session and during afternoon tea.

We toured the premises and observed how staff interacted with people throughout the day. We looked at five records related to people's individual care needs and people's records related to the administration of their medicines. We viewed six staff recruitment files, training records for all staff and records associated with the management of the service including quality audits, policies, maintenance checks, and questionnaires completed by people, family and professionals who visited the service.

Good

Is the service safe?

Our findings

People were protected by staff who had an excellent awareness and understanding of signs of possible abuse. Staff felt reported signs of suspected abuse would be taken seriously and investigated thoroughly. Staff were up to date with their safeguarding training and knew who to contact externally should they feel that their concerns had not been dealt with appropriately. Incidents of safeguarding were investigated and discussed with the relevant authorities openly and honestly. People's safety was paramount and discussions were held which related to incidents or situations that may put people at risk. For example, one person could at times behave inappropriately towards females. Staff were mindful to ensure they monitored this and the person sat next to men. This reduced the likelihood of an incident. Staff told us "We undertake training in safeguarding, we monitor resident's well-being and make sure they are not distressed, we look for bruising and other signs too."

People were supported by suitable, skilled and diligent staff. Safe recruitment practices were in place and records showed appropriate checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

People and their relatives felt there were always enough competent staff on duty to meet their needs and keep them safe. Staff told us they felt there were sufficient numbers of staff on duty to support people. The registered manager confirmed the service was fully staffed, and that they reviewed staffing numbers regularly based on people's needs. Additional staff were now on duty in the morning and evening to support people when their needs were greatest. These changes had been beneficial to people, reduced falls and supported those people who were more disorientated in the early evening. Additional staff were used to provide one to one care when needed to keep people safe, this had frequently improved people's quality of life and those of others they lived with. The use of agency staff was minimal so that people received care from staff they knew well. When agency staff were used they had an experience of dementia care, completed an induction and following their shift they were requested to leave feedback on their experience and induction.

Staff were not rushed during our inspection and acted quickly to support people when requests were made. For example, one person stood up in the lounge to move. The person was unsteady on their feet, staff instantly acted to reassure them and guide them to their destination. Staff had time to create positive, meaningful relationships with people. They were upbeat and happy. During the afternoon music and dancing staff engaged people in singing, clapping and moving and helped them to enjoy a dance safely.

People were supported by staff who understood and managed risk effectively. People moved freely around the home and were enabled to take everyday risks. The service had a positive risk taking culture. People were promoted to be as independent as possible whilst ensuring they were as safe as possible. Staff were alert to those who might try to leave the home and were vigilant. The home had key pad locks where they had the legal authority to restrict people's liberty to reduce the likelihood of this occurring.

Technology such as cameras supported staff observation and monitored the hallway area to monitor those arriving and leaving the property. A range of environmental risk assessments were in place, for example some people picked and ate fresh flowers. Those known to be poisonous were removed for people's safety. The home subscribed to the NHS patient safety alert information so they remained abreast of potential risks to areas such as medicines and equipment quickly.

People made their own choices about how and where they spent their time. We saw some people preferred the lounge or dining area whilst other enjoyed the privacy of their rooms. Staff commented how some people had behaviours which could impact on others such as shouting out. Staff were mindful of the impact this behaviour might have on others and how this could place the person at risk. Behaviour charts were used to identify the antecedents and triggers of people's behaviour to reduce risk and keep people safe. For example these had helped identify arguments between two individuals that were occurring over blankets and cushions. Staff ensured there were always ample of these in the area to reduce the likelihood of a disagreement. Staff monitored these people incidents and their GP was involved in reviewing their care where required, for example altering people's medicine times to

Good

Is the service safe?

improve their quality of life. Staff said "We assist people in the right way to prevent an injury, we observe interactions which might lead to confrontation between people and we report incidents and accidents."

Risk assessments were in place to identify health concerns such as those at risk of falls, skin damage or malnutrition. People's risks were discussed and plans and ideas shared amongst staff to help enable risk reduction. For example, we saw one person was at risk of falls, their risk assessment gave staff clear guidance to ensure floors were clutter free to reduce the likelihood of a fall. Another person was at risk of skin damage and had a skin wound, their risk assessment detailed the need to use pressure relieving equipment and keep their legs elevated to improve their circulation. Equipment such as pressure mats were used to alert staff quickly when a person at risk was moving. These helped staff protect people and reduced falls and injury.

Medicines were managed, stored, given to people as prescribed and disposed of safely. Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. Staff were knowledgeable with regards to people's individual needs related to medicines. Policies were in place and staff had access to best practice guidance (Managing medicines in care homes, NICE 2014). For example, staff discussed one person who sucked their tablets and therefore potentially did not receive the maximum benefit. Staff had noticed this and ordered the person liquid medicine. During the medicine rounds, we observed staff knelt down at people's eye level, explained what their medicine was, gave people a drink and ensured they had taken their medicine. Some people needed more time, explanation and encouragement to take their medicine and staff were gentle and encouraging. Staff considered people's medical needs and arranged medical reviews where needed. For example, one person was not sleeping well at night and options for night sedation were being considered. The person's GP was involved in a medicines review and staff were mindful of the person's other health needs such as their mobility which might be affected by a change. Some people received their medicine covertly. For example, in their tea. The correct procedures had been followed that authorised this and ensured the person's rights were protected. Staff maintained and updated their medicines knowledge through the internet, care journals and medicine management group letters.

People were protected by staff who managed and controlled the prevention of infection well. A dedicated cleaning team and laundry assistant were employed. All areas of the home were clean and smelled fresh and staff told us they had new equipment to support them in keeping the home clean. Staff understood their role, used protective equipment for personal care and followed policies and procedures that reflected current guidance on keeping people safe. Staff explained to us how they had managed a recent infection control outbreak. Staff had promptly put in place barrier nursing to reduce the likelihood of cross infection. Barrier nursing is a technique used to help reduce the risk of infection spreading within the home. Staff told us they were trained in infection control and when an outbreak occurred would use "barrier nursing, disinfectant wipes, sterilisation and people would have their own clinical waste which was disposed of promptly."

Good

Is the service effective?

Our findings

People, their relatives and health care professionals were supported by well trained staff who effectively met their needs. Healthcare professionals were positive regarding the care and support people received at Drake Nursing Home.

Staff confirmed they received a thorough induction programme and on-going training to develop their knowledge and skills. They told us this gave them confidence in their role and helped enable them to follow best practice and effectively meet people's needs. Newly appointed staff shadowed other experienced members of staff until they and the registered manager felt they were competent in their role. The registered manager told us, staff could openly discuss and request additional training and would be supported to achieve their goals.

The registered manager confirmed they were aware of the new care certificate, recommended following the 'Cavendish Review' and were implementing this for all new and existing staff. The aim of the care certificate is to improve consistency in the sector specific training health care assistants and support workers receive in social care settings. Staff confirmed they had been supported by the registered manager and owner to improve their skills and obtain qualifications. Staff told us this gave them a sense of achievement and helped them to meet people's needs.

Staff had been encouraged to complete essential training. The PIR indicated 29 of the 43 staff in post held healthcare qualifications in areas such as end of life care, epilepsy management, stroke and wheelchair safety. Staff were clearly able to explain how they would respond to different clinical situations. For example, if they found a person with skin damage or discovered someone had fallen. Staff used a variety of approaches to interact and engage with people when verbal communication had not been successful. For example, when one person struggled to hear and understand staff, pictures were used to help explain what staff were saying to aid the person's understanding. Staff had been trained to hold lead roles in in key areas such as continence care, manual handling, end of life care and tissue viability. Knowledge was then shared with the staff team through presentations by these staff. Other learning was on-going from care journals, books regarding dementia care, staff attendance at local care forums and national conferences and links with key projects such as the Archie Project in Somerset which aims to improve activities for people living with dementia.

Staff training and development needs were identified through formal one to one meetings (supervision), informal discussions, observation of care, staff meetings and where improvement had been identified following previous incidents. These mechanisms were seen as important to share learning, knowledge and good practice and support staff new to care work. Supervisions were undertaken every two or three months and staff received an annual appraisal to enable reflection of their performance over the past year. Open discussion provided staff the opportunity to highlight areas of good practice, identify where support was needed and raise ideas on how the service could improve. Staff felt supported by these processes.

Staff thought creatively about how they met people's diverse needs and learned new techniques for communicating effectively with people. For example, we heard from staff about one person from a different culture whose first language was not English.. At the time two staff spoke the person's language so when they were on duty they cared for the person but at other times staff used the internet to learn words and phrases so they were able to communicate effectively. Staff told us "We used google translator to communicate and we had a good outcome."

The service had links with organisations such as the National Activity Provider Association (NAPA), a charity devoted to exploring high quality activities for older people and links with the Archie Project in Somerset which supports improvement in dementia care, reminiscence and activities for older people. Research from Stirling University was used to ensure best practice guidance was followed and we saw the service was using research regarding dementia friendly environments for example new, circular tables had been purchased in the dining area to support people to have a more social dining experience. These organisational links were used to support staff to have the skills they needed to ensure people received effective care. For example recent developments at the home included a new sensory room. This room was used for someone who was restless or agitated to help soothe them. Staff completed questionnaires about a person's mental state before and after they had used the room, to note improvement and what they liked or did not enjoy. Staff

learning was shared in staff meetings. For example, one staff member attended hearing loss training to learn about communication and assisted technology and then presented this back to the staff team.

Links with a local school which had a special interest in dementia care had been developed. They had been asked to be part of the programme to redesign the lounge area, and make it more stimulating to support people's needs. Different themed areas were being considered with the support of the school and students spent time with the activities staff so they understood the environmental changes required to meet people's needs. These were mutual learning sessions to ultimately help ensure people received the best outcomes and a good quality of life at Drake Nursing Home. Staff also had links with the local university and had been invited to talk to students about life in a nursing home and share their knowledge and expertise.

People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. Care records showed where DoLS applications had been made and evidenced the correct processes had been followed. Health and social care professionals and family had appropriately been involved in the decision. The decision was clearly recorded to inform staff. This enabled staff to adhere to the person's legal status and helped protect their rights. The registered manager had a good knowledge of their responsibilities under the legislation and had undertaken training in this area.

Staff showed a good understanding of the main principles of the MCA. Staff were aware of when people who lacked capacity could be supported to make everyday decisions. Staff knew when to involve others who had the legal responsibility to make decisions on people's behalf. We heard staff discuss more complex situations where other professionals might need to be involved in deciding what was in a person's "best interests". Staff told us they gave people time and encouraged people to make simple day to day decisions. For example, what a person liked to wear or drink. However, when it came to more complex decisions such as a do not resuscitate order or where the person should live, a health care professional or, if applicable, a person's lasting power of attorney in health and welfare was consulted. Where appropriate, Independent Mental Capacity Advocates (IMCAs) were also used to support decision making to ensure people's right were protected. This helped to ensure actions were carried out in line with legislation and in the person's best interests.

People and their relatives were involved in discussions and decisions about what people liked to eat and drink. Care records identified what food people disliked or enjoyed and listed what the staff could do to help each person maintain a healthy, balanced diet. People were encouraged to say what foods they wished to have made available to them. We saw lunch and tea were social experiences where possible. Food was appetizing, where pureed the different foods were done separately so there were distinct colours so people could identify the different foods on their plate. Where people ate more with their fingers, this was encouraged. People ate in a relaxed environment and chatted to their friends and staff. Staff were readily available to encourage those who required additional support and took time to ensure people received a good nutritional intake. Family members were encouraged to share a meal with people if they wished.

People were protected from the risk of poor nutrition and dehydration by staff who regularly monitored and reviewed people's needs. Care records identified where people had specific health conditions which might impact on their dietary needs such as diabetes. Adapted and bright, coloured crockery was used to help support people's dietary intake and keep them safe such as beakers which changed colour when they were hot. People's nutritional needs were discussed in the weekly team meetings where there were concerns or improvement seen. For example, staff noted one person had been quite sleepy recently and they needed reminding to eat. Another person had not been eating well. Staff shared that they had noticed the person did not like coloured foods and consequently had been picking out the herbs in their food. This information was to be shared with kitchen staff to improve their dietary intake. If people were active and spent a lot of time walking around the home, staff encouraged the additional snacks they required to help ensure they maintained their weight. Information was shared which might help a person to

sustain a healthy diet. For example, staff shared that one person took time to wake up in the morning so their breakfast needed to be given when they were more alert and interested in food. Staff had noticed another person ate better when facing and looking at the fish tank, they opened and closed their mouth as the fish did. Staff now moved them to the fish tank for meals and their dietary intake had improved. Audits and staff feedback had meant the time of the main meal had been changed following staff noticing people were more alert for afternoon activities when they had a lighter lunch. Audits and observation had noted the change to the main meal in the evening had also reduced the number of falls as people were more settled.

People were weighed regularly and weight changes monitored closely. Staff liaised promptly with family and people's doctors if there were concerns. Some people had been referred to the Speech and Language Team (SALT) for assessments where there were concerns their health needs impacted on their diet. Staff were aware of those people who required a soft or pureed diet and followed guidance given by the healthcare professionals involved.

People's day to day needs were met by staff who monitored, discussed and reviewed people's health needs frequently. Care records ensured monthly reviews occurred of people's nutritional status and skin care needs, this enabled changes over time to be noticed and the appropriate action taken. Behaviour charts monitored people's individual needs where this was necessary. A weekly clinical team meeting reviewed all people living at the home, discussed any health concerns / improvements, referrals to other professionals needed or upcoming hospital reviews. A range of external health professionals supported people's health needs such as GPs, opticians, dentists, chiropodists, physiotherapists and mental health professionals. When positive changes were made to people's health and they no longer required the level of care Drake Nursing Home provided, they ensured prompt referrals were made to support people to more independent living.

People experienced care and support to make their lives more meaningful and comfortable. For example one person was identified at risk of pressure damage to their skin and also had poor posture. Staff made huge efforts to secure funding to enable him to have a specialist chair. The new chair gave better support so the person was able to sit upright, have his legs elevated and be comfortable eating. Another person was identified as liking to draw, staff purchased an easel for his table so he could draw in comfort.

Under new ownership the design and decoration of the service was being improved to meet people's needs. Bedroom furnishings and equipment were being purchased to improve people's comfort such as waterproof duvets and new beds. People and their families were involved in making people's rooms personalised as bedrooms underwent refurbishment. Flooring was being replaced in areas which made the environment easier to clean and more aesthetically appealing. A wet room (shower) had been created for people to be able to choose whether they had a bath or shower. Areas of the home were being re-designed to provide more stimulation such as the sensory room, a sensory garden and a 1940's retro area. Improved signage within the home supported people to find their way more easily and promote their independence. Large noticeboards were a visual aid for people and contained important information such as birthdays, what season it was, the date and what activities were on. This helped orientate people to time and place.

Good

Is the service caring?

Our findings

People and those who mattered to them were exceptionally positive about the caring nature of the staff. Everyone spoke highly of the quality of the care and confirmed they were treated with compassion. Staff were respectful to people, cheerful and positive in their interactions, listened and were very kind. Comments from family included "Whatever role the staff are in they take a real interest in the residents and their well-being"; "Staff are always friendly and caring"; "Thank you for all the lovely care you gave my father"; "At times it has been a rocky road but because you all took so much trouble to make life easier, it also made our lives easier"; "They made her time happy and comfortable in difficult circumstances."

One person who had recently moved to the service commented, "The staff are so nice and I am settling in well." Their relative confirmed how pleased they were. Health care professionals commented staff were warm, friendly and caring. The registered manager told us the aim of the service was to develop "an excellent rapport with people" and staff said "We're all really friendly, we talk to residents and each other, we engage people through talking, films, music and walks in the garden" and "We're person-centred, we're like one big family and we have a sunny outlook."

Staff showed concern for people's wellbeing in a meaningful way. There was a strong person-centred culture and staff were exceptional in the way they helped people. Staff were clear it was a partnership and invested time building relationships with people. Staff interacted with people in a caring, supportive manner and took practical action to relieve people's distress and / or anxiety. For example, one person was confused when they were offered some cake. Several staff took time to verbally reassure the person the cake was for them to eat. This wasn't successful so they fetched a book with pictures in to explain to the person the cake was for them. This reassured the person and given time they ate their cake. Another person was trying to move furniture. Staff approached the person and supported them to move the furniture where they wished it to go.

During the SOFI we observed all levels of staff and management spent time with people and used verbal and non-verbal ways to communicate and engage people. For example, some people responded to staff talking to them and engaged them in conversation. Staff also used non-verbal communication such as touch and facial expressions such as a smile to make their interaction meaningful for the person. Staff were observant and noticed when people tried to move that were unstable on their feet. For example, staff tried to encourage one person to take a seat to minimise the risk of them falling. When the person expressed they did not want to sit, staff held their hand and safely guided them on their journey around the lounge, until they found a place where they did wish to rest. We saw staff guide people to tables at tea and introduce people to support friendship. Staff observed people's body language and noticed when people were in pain. For example, one person was bending down holding their side indicating they were in pain. All staff made time to stop, talk and engage with people at every opportunity.

Staff were versatile and worked as a team to meet people's needs. For example one person engaged only with the domestic team and had built a special relationship with two of the cleaning staff. These staff were used creatively to support this person's personal care and activity needs so they were able to continue to go to the park, visit the chiropodist and go to the hairdresser. There were flexible boundaries amongst the staff roles to meet people's needs for example the management team, care staff and kitchen staff alike supported people with meals.

Staff had an in-depth knowledge of the people they cared for commenting "We talk to them about their care, we have daily discussions about their choices and preferences." We heard staff talk about important things which mattered to people such as their like of certain music and how they used this information to support their care. For example, one person liked Elvis music, headphones had been purchased to enable them to listen to their personal choice in private. People told us of their interests which matched what was recorded in their individual care records. During the afternoon there was a music session. We had heard earlier one person did not like this and noticed before the music commenced, they were moved to a quieter area of the home. Those who did not like to come downstairs or who needed to remain in bed had activities brought to them to enjoy. For example, the birds of prey visited people in their rooms so they were able to participate.

Conversations with people, relatives and health and social care professionals during the assessment process helped staff know and understand people's unique preferences and personal histories. Life story books were given to family

Good

Is the service caring?

to complete where people were unable to share their own information and past experiences. This supported people's care. For example, one person who had previously been a plumber, had plastic piping bought for them to tinker with. We observed another person who had previously liked DIY enjoyed using a wooden tool box which had been purchased for them.

Personalised rummage boxes were available in people's rooms to provide stimulation and occupation, and creative ideas such as U Tube videos were being used to help engage people in topics of conversation. Further information was gathered about people through the use of memory boxes and reminiscence work which aided conversation. For example, staff used past time memorabilia such as a tea cosy, bicycle clips and ration books, to facilitate discussions with people. These activities helped build relationships between people and staff and meant they could respond to people's needs because they knew them well. Creative use of memorabilia, music and items such as dolls and handbags helped to trigger treasured memories of childhood, opened up a window of meaningful conversation, communication and connection, entertained and amused. People were noted by staff to visibly relax. Benefits included a sense of well-being, reduced agitation, anxiety and apathy. The service understood the evidence base behind these interventions which included enhanced social skills, cognitive stimulation, tactile awareness, hand-eye co-ordination and motor skills. People benefitted from a sense of achievement.

People and their relatives were given information and explanations about support when needed, so they could be involved in making decisions about their care. Staff knew people's individual communication needs, and were skilled at responding to people appropriately. For example, some people at the home had difficulty understanding information. Staff knew who these people were and told us they kept sentences short, used pictures or wrote questions down for them to read. Explanations were brief and clear to aid people's understanding. Choices were limited so not to create confusion. For example, a choice of two of their favourite named drinks. Staff said they also prompted people who sometimes got lost mid-sentence to help them remember their train of thought.

People and their relatives told us people's privacy, dignity needs and human rights were respected by staff. One person's behaviour meant they kept removing their curtain, this meant their privacy and dignity could have been compromised. Staff discussed this and sourced a frosted panel for the lower part of the window, this meant they had privacy but could still have a view from their window. Staff attended the dignity in care forum to remain up to date with best practice in this area. Some people had shared rooms and a curtain across the room allowed people privacy if they wished. Care records emphasised the importance of supporting people to preserve their dignity if they were unable to do this themselves. For example, staff ensured people wore the appropriate clothing for the weather conditions and prompted people when they needed to get changed if their clothes were not clean.

Staff promoted respectful care; they noticed when people needed help after lunch to remove food particles from their faces. Staff discussed ideas to support people from having their clothes damaged by food stains and debated why this might be happening for certain people. For example one person often feel asleep shortly after eating, their mouth would fall open and this then caused their clothing to become stained. Staff noticed when people's shoelaces were undone and promptly addressed this. Friendly interactions were observed by staff at all levels. People greeted familiar staff arriving on duty with warmth, genuine affection and pleasure. Staff reciprocated the welcoming. We observed staff to be upbeat and happy which in turn created an atmosphere in the home which felt positive and caring. People were asked what they wanted to be called. For example, did they mind their first name being used. This helped ensure staff addressed people in the manner they preferred and which respected them. People's information was kept securely and confidentially. A privacy and dignity policy supported staff in this area.

People's cultural needs were met by staff who considered creative ways to overcome language barriers if they didn't speak English. People's religious needs were supported by links with two local ministers who visited regularly.

Friends and relatives were able to visit without unnecessary restriction. Relatives told us they were always made to feel welcome and could visit at any time. Staff were concerned about the welfare of relatives too and ensured they were involved and supported where necessary inviting family for meals and offering phone and one to one contact where required.

Good

Is the service responsive?

Our findings

Care records contained detailed information about people's health and social care needs. They were written using the person's preferred name and reflected how people wished to receive their care. People's personal preferences were known. For example, which sports programmes people liked such as cricket and what people didn't like such as dental visits. The registered manager told us further improvements were being made with regards to making the records even more personalised with the development of individualised audits for all residents including any safeguarding risks, falls history, people's nutritional score and their body mass index. People and where appropriate, those who mattered to them were involved in the process to help ensure their views were recorded, known and respected by all staff.

People, family and health professionals contributed to a pre-assessment to ensure the service was able to meet people's needs. The people currently living in the home was always considered to ensure new people's placement was appropriate and would be successful. Staff used their communication skills such as listening and observing to understand people's individual needs and develop personalised care plans.

The activity staff also contributed to the assessment process through their one to one work with people and through the group activities. This meant a holistic overview was obtained including people's social skills. The progress people made in their one to one activity time was shared with staff and fed back to family.

People's needs were regularly reviewed through the clinical team meetings, staff handovers and the doctor visited weekly. Arrangements were made for health and social care staff to review people frequently or as their needs changed. Prompt referrals were made to support people's need for additional equipment such as specialised chairs or referrals to external agencies due to on-going assessment at the service. All staff confirmed they had time to read people's care records so they knew their strengths and levels of independence.

People and care records confirmed people were supported to follow their interests. There were areas of the home where they could relax or enjoy pastime memories such as the 1940's retro area, the soothing sounds and visions of the fish tank and a newly created sensory room. The registered manager informed us they were looking to develop the activities programme and provide external activities. People were supported through use of one to one time to have personalised activity that met their needs. External entertainment was provided such as music and dancing. People also enjoyed visits from a grey hound and other animals which visited the home. For example, a visit from "Zoolab", a company who brought in giant snails, a rat and a snake.

People were encouraged to take part in the social activities organised by the staff to reduce the risk of social and community isolation. At Christmas the staff had put on a Cinderella pantomime for residents which we were told by people, relatives and staff was thoroughly enjoyed. Coffee and family mornings were arranged to support people to maintain relationships with those who were important to them and encouraged family's involvement in people's care. Fetes and fundraising ideas such as car washes supported the activity programme. Local business and schools were encouraged to be involved so Drake Nursing Home was part of the local community.

The service had a policy and procedure in place for dealing with any concerns or complaints. The registered provider and registered manager, clinical team lead and nurses on duty were visible and approachable in the home and there was an open door policy. The policy was clearly displayed in areas of the home and in people's rooms we visited. People and those who mattered to them knew who to contact if they needed to raise a concern or make a complaint. People and family said they would be comfortable raising a concern or complaint. People did not have any concerns and felt confident to raise any issues with staff, manager or their family if they did. People's relatives commented "No complaints but if I did staff would listen and help." We reviewed two complaints made in the previous seven months. Both complaints made had been thoroughly investigated in line with the service's policy and feedback given to the complainant. Neither complaint had been upheld.

Good

Is the service well-led?

Our findings

The new owner (registered provider), registered manager and clinical team (nurses and senior management) lead took an active role running and improving the service and had good knowledge of the people and the staff who lived at Drake Nursing Home. There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

People, friends and family, and staff all described the management of the home to be approachable, open and supportive. Staff told us "oh he's lovely (referring to the new owner); he's all for the patients and he's made a lot of good changes. He listens to staff and a lot of things we've asked for he's got for the home"; "I get all the support I need from the management"; "Great outlook (referring to management team), the sensory room is great and gives people a better quality of life, I feel involved in service improvement."

The registered manager told us their philosophy of individualised care, respect and choice and how through their leadership these values were shared amongst the staff team. They explained they involved everyone in decision making, listened, showed appreciation and made it fun. Staff were encouraged and challenged to find creative ways to enhance the service they provided for example a staff noticeboard shared new information, poems and individual learning. The registered manager recognised the importance of staff having knowledge in specific areas, for example there were tissue viability links, end of life champions and continence care leads who attended updates and shared learning with the staff team. Staff told us they felt empowered to have a voice and share their opinions and ideas they had through supervision meetings (one to one's) and staff meetings. Staff felt concerns were listened to and the management team (registered manager and registered provider / owner) were approachable and they had confidence in the senior management team. A family atmosphere was evident during the inspection where colleagues supported each other and enjoyed their jobs.

The registered manager explained they were encouraged and motivated by the owner to improve the service. A plan was in place for refurbishment within the home and service improvement to improve the care of people. For example, plans were afoot for an improved lounge area and an on-going programme in place for replacing essential furniture. People, family, local schools and research were being used to develop these ideas.

The service inspired staff to provide a quality service. Staff told us they were happy in their work, understood what was expected of them and were keen to provide and maintain a high standard of care. The registered manager informed us a process of self-review and learning from health and social care colleagues, training, attendance at conferences such as the Dementia conference and linking with dementia care projects such as The Archie Project in Somerset.

The registered manager told us one of their core values was to have an open and transparent service. The provider sought feedback from people and those who mattered to them in order to enhance their service. Questionnaires were conducted that encouraged people to be involved and staff were encouraged to raise ideas that could be implemented into practice. For example, one staff member felt changes were required to a reminiscence form to support their work and they felt empowered to develop this to accurately record and monitor the work they were undertaking with people.

Staff meetings for clinical staff (nurses and senior management), catering and domestic staff were regularly held to provide a forum for open communication. Staff told us they were encouraged and supported to question practice and action had been taken. For example, staff had raised concerns that one carpet which was quite old had become "ruffled". This was seen as a potential tripping hazard if not replaced in the short term. It was decided that a non-slip flooring was best. The management sourced a good, new, non-slip floor surface which was safer and provided a homely feel. Open discussions were held regarding the priorities for refurbishment changes, for example who was in most need of a new bed.

The staff worked in partnership with key organisations to support care provision. Health and social care professionals who had involvement with the home confirmed to us, communication was good. They told us the staff worked in partnership with them, followed advice and provided good support. The local authority informed us the service had been receptive to previous safeguarding issues raised and taken action to remedy the concerns.

Good

Is the service well-led?

The registered manager told us people were at the heart of what they were striving to achieve. They had developed a culture within the service of a desire for all staff at all levels to continually improve. For example, the staff worked in partnership with the local schools and colleges with knowledge of dementia to learn and improve. Conferences and relevant research in the area of dementia was considered, appropriate care journals read and local and national forums attended. Drake Nursing Home was receptive to improvements identified by the local authority such as the development of a children's safeguarding policy for visiting families. The service held a locally recognised award, the Dementia Quality Mark and healthcare professionals had asked the registered manager to share their work in this area to other local homes.

The service had an up to date whistle-blowers policy which supported staff to question practice. It clearly defined how staff that raised concerns would be protected. Staff confirmed they felt protected, would not hesitate to raise concerns to the registered manager, and were confident they would act on them appropriately.

There was an effective quality assurance system in place to drive continuous improvement within the service. Audits were carried out in line with policies and procedures. Areas of concern had been identified and changes made so that the quality of care was not compromised. For example, a falls audit had identified that people were at greater risk of falls in the evening. As a result of the audit, additional staff were now on duty during this period and falls had reduced. An "at a glance dashboard" of audits and areas to be improved was being developed. Spot checks were regular to monitor the quality of care. Performance issues were promptly addressed and recorded.

We reviewed many questionnaires and thank you cards the service had received. All comments were highly positive. Relative feedback was encouraged through the "open door" philosophy of Drake Nursing Home and the regular coffee meetings the home held.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.