WCS Care Group Limited

Drayton Court

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service:
Drayton Court is a care home, providing personal care and accommodation for up to 45 people. It provides care to older frail people, some of whom are living with dementia. The care home also offers 'day-care' on specific days of the week, the day care lounge is separately staffed. Care is provided over three floors. Each floor has communal lounges, dining areas and a kitchenette. At the time of our inspection visit 37 people lived at the home.

What life is like for people using this service:
Risks were not consistently well managed because actions to mitigate some identified risks had not been taken. Risk management plans did not always give staff clear guidance on how they should support people. There were sufficient staff on duty during the day shift. A few staff felt night time staffing was too low and the new manager told us they would look at this.
People had their prescribed medicines available to them and were supported with these by trained staff. Staff did not consistently ensure people's medicines or prescribed items were stored securely which posed risks to people.

Staff received an induction, training and support from within the staff team, the provider's trainer and managers. Despite staff being told about the provider's values and vision, this was not embedded into the culture of the home as staff could not tell us what this was. Overall, the home was clean and tidy, and staff understood how to prevent risks of cross infection. There were some bedrooms with an offensive odour.

People had their needs assessed before they moved into the home. Overall, people had plans of care relevant to their needs. However, plans of care around pain management or future wishes for end of life care had not always been completed. Staff were trained to meet people's day to day needs and protect people from the risks of abuse.

We received mixed feedback from people about what it was like to live at the home. Those people who required less staff support experienced more positive outcomes. People had opportunities to engage in group activities, however, these largely took place in the day care lounge and meant people who chose to remain on their 'household' or in their bedroom were at risk of social isolation because there were limited opportunities to engage in activities or with staff.
People had access to healthcare when required. People were offered enough food and drink to meet their dietary requirements. However, people's mealtime experience was not always relaxed or enjoyable.

Some positive caring interactions took place between people and staff. However, some staff failed to follow the provider's policies which posed potential risks to people and did not consistently reflect a caring attitude.
People made day to day decisions about their care and were supported by staff who worked within the principles of the Mental Capacity Act 2005.

Staff did not consistently ensure people's private care records were stored securely or confidentially.

Overall, the provider's quality assurance system identified where improvements were needed, but this was inconsistent and did not always ensure quality and safety.

A new manager had started and was prioritising areas that required improvement.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 12 Regulated Activities Regulations 2014 – Safe care and treatment

Rating at last inspection: The service was rated outstanding. (The last report was published on 18 April 2016).

Why we inspected: This was a planned inspection based on the rating of the last inspection. The service is now rated as 'Requires Improvement' overall.
Enforcement: Action provider needs to take (refer to end of report).

Follow up: We will continue to monitor intelligence we receive about the service until we return to visit as per our inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Details are in our Safe findings below.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Details are in our Effective findings below.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Details are in our Caring findings below.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Details are in our Responsive findings below.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Details are in our Well Led findings below.

Drayton Court

Detailed findings

Background to this inspection

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

Inspection Team: Two inspectors, an inspection manager and an expert by experience carried out this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type: Drayton Court is a care home. People in care homes receive accommodation and personal care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission (CQC). A new manager had been appointed during May 2019 and was in the process of applying to become registered with us. A registered manager, as well as the owner and provider, are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection: The inspection visit took place on 25 June 2019 and was unannounced.

What we did when preparing for and carrying out this inspection:
We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as abuse. We also sought feedback from the local authority and professionals who work with the service. We assessed the information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During our inspection we spoke with 11 people and seven relatives. We spent time with people, who due to living with dementia could not give us their feedback, to see how staff supported them. We spoke with four care staff, the training co-ordinator, one care co-ordinator, one house-keeper, the head cook, the manager,

a service manager and the director of delivery. We gave night staff the opportunity to give us feedback by email.

We reviewed a range of records. This included six people's electronic care records, medication records, food and drink and skin care plans. We looked at multiple risk management plans. We also looked at records relating to the management of the home. These included systems for managing complaints, checks undertaken on the health and safety of the home and staff training records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question is now rated as Requires Improvement. This meant people were not always safe and were at potential risk from avoidable harm.

Assessing risk, safety monitoring and management. Learning lessons when things go wrong

- Risks were not always well managed. The provider had identified a risk of a person becoming entangled in the wire cord from their sensor mat plugged into their call bell point. We saw this person was in their bed and the wire cord was next to them. The provider had not considered ways to remove this risk.
- Alcohol was accessible to people in communal areas and in an unlocked care office. During May 2019, records showed there had been three incidents of behaviours that challenged following a person's high consumption of alcohol. Another person's care record stated they were allergic to alcohol and their wellbeing would be placed at risk if they consumed any. There was a risk people had access to alcohol without staff knowing.
- People were placed at risk of harm because staff did not consistently follow the provider's policy on the control of substances hazardous to health. For example, there were no staff present in a dining room kitchenette where we found a cupboard was unlocked and contained five bottles of surface cleaner and a box of dishwasher tablets. When we pointed this out to the care co-ordinator they took immediate action to lock the cupboard and assured us this was not usual practice.
- Individual risks were assessed, but risk management plans were not always up to date and lacked clear guidance to staff. For example, one person's moving and handling care plan did not tell staff in which situations the stand aid or the full body hoist should be used.
- Some people were identified as having or developing sore skin. Staff did not consistently reduce risks of people developing sore skin. For example, at 4.00pm we saw one person sitting in the ground floor dining room in their wheelchair, asleep at the table with their head in their arms. This person's care plan stated they should be supported to have bed rest during the afternoon, but staff had left them there since lunchtime. There were no staff in the communal dining room and we shared our concerns with the service manager. They told us this should not have happened and took immediate action.
- People had special equipment, such airflow mattresses on their beds, to reduce risks of developing sore skin. However, daily checks on airflow pump settings were not effective. For example, one person's airflow pump was set at 100kg and this was not their body weight and not in line with the guidance given for the setting. This meant people did not always receive the desired pressure relief from equipment.
- Staff knowledge of who was at risk of falls was inconsistent. For example, one staff member did not think there was anybody identified as 'at high risk of falls' in the home. However, the manager and care co-ordinator told us numerous people were.
- Learning did not always take place to reduce risks of reoccurrence of falls. There were 23 recorded falls during March 2019, ten of which occurred during the night time. Whilst there was some reduction in the number of falls recorded for May 2019 and the provider had acted to reduce risks through, for example, seeking guidance from the falls prevention team, the provider's actions had not included an assessment of

people's dependency needs to determine whether their staffing levels were sufficient to safely meet people's needs. The new manager told us they would be assessing people's dependency needs against staffing levels.

● There was a maintained fire alarm system and people had personal emergency evacuation plans. However, the provider has not assessed how night staff could safely move up to seven people, who required support, from their bed to a safe zone within the fire service's time guidance of less than two minutes.

Using medicines safely

● One person living with dementia had no pain management care plan. A visiting healthcare professional told us this person was likely to experience discomfort, and had grimaced, as a dressing was applied to their sore skin. There was no record of this person having been offered or given any pain relief because staff did not have the information they needed to determine how to assess whether this person was experiencing pain.

● People had their prescribed medicines available to them. Overall, staff administered medicines to people safely. However, staff did not consistently follow the provider's policy on the safe storage, handling and administration of medicines.

● A care office door had been left propped open by three crates containing prescribed items. Pots containing 'thickener' were accessible to people and the powder posed risks of choking. A bottle of prescribed medicine had been left on the desk. The medicines fridge was unlocked and contained people's medicines and an unlocked key cabinet contained keys to access people's medicines in their bedrooms.

● We found one incident when staff had not followed legal requirements relating to the safe administration and recording of a medicine.

The above concerns demonstrated a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● People's access to staff varied depending on the time of day. One staff member told us, "Mornings are always hectic, we could do with an extra staff member." The director of delivery told us about plans to create smaller 'households' which would mean staff were not covering a whole floor of the home. The director of delivery told us, "I will be discussing this aim to split each floor into a smaller 'household' with the manager. This would mean staff are deployed more effectively."

● There were three staff on shift at night-time covering the three floors in the home. Eleven of the 37 people living at the home required support from two staff, which included during the night-time. This meant staff left up to 16 people on one floor unattended whilst they gave support elsewhere. A staff member told us, "Night time staffing levels are not safe." Another staff member commented, "I've worked night shifts and think staffing should be increased for safety."

● The provider's system for recruiting staff ensured staff's suitability to work there.

Preventing and controlling infection

• Staff understood the importance of infection prevention. Staff wore Personal Protective Equipment (PPE) such as plastic aprons and gloves when needed.

• Overall, the home was clean and tidy. However, some bedrooms had an offensive odour. The director of delivery told us replacement flooring was on the July 2019 agenda for discussion as part of the refurbishment plans.

Systems and processes to safeguard people from the risk of abuse

● Staff were trained and knew about different types of abuse. They knew how to protect people from abuse

and when concerns should be raised with the manager and the provider. One staff member told us, "I would report any abuse straightaway" and added that if no action was taken, "I would go to CQC or the local authority."

● A staff member had raised a safeguarding incident following the company policy. The manager and provider had taken immediate action to ensure people's safety was maintained. Appropriate action had been taken because the manager and provider understood their responsibilities in reporting specific incidents to us and the local authority.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question is now rated as Requires Improvement. This meant people's outcomes were not consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance
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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- Staff followed the principles of the MCA. Staff sought consent, for example, when asking a person if they would like to be supported with personal care.
- 'Best interests' decisions had been made where people lacked capacity to make an informed choice as to whether to take their medicine. These had been signed by the person's GP. However, where people received their medicines 'covertly' (disguised in food or drink), there was no guidance as to how the medicine should be given or which medicines were covered by the 'best interests' decision.

Supporting people to eat and drink enough to maintain a balanced diet
- People's nutritional and hydration needs were met. Additional snacks were offered to people and the provider acted when people were at risk of malnourishment.
- The need for improvement in people's mealtime experience had been identified from people's feedback in November 2018. However, we found people's shared mealtime experience did not promote a relaxed or enjoyable experience. For example, music was playing, and people were seated tightly together because the dining area was too small for them on the Cedar household. Staff had not asked people if they wanted the television on over lunchtime, and no one was watching it.
- People were not consistently offered a choice of meal at the point of service in line with the manager's and provider's expectation. One relative told us, "Mealtimes need to be more organised. I've seen that it's inconsistent if people get a choice or not, it depends which staff are on."
- Records related to people's dietary intake were not always accurately completed. We saw one person was supported to have a nutritional milk-shake but their care record stated, "fruit juice". When we asked about this, a staff member told us this was because, "tasks were split" and staff supporting a person did not always complete the record. This posed potential risks of people's needs not being met because checks were not

made on what had or had not been consumed. The director of delivery told us it was their expectation that staff supporting a person with a task then completed the record. They assured us staff would be reminded of the importance of this.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

● People were supported to access healthcare professionals such as GPs, dentists and opticians. One person told us, "I've had my feet done." Referrals were made to speech and language therapists when risks of people choking were identified.

● Some people received visits from district nurses. During our inspection visit, we saw a district nurse supporting a person living with dementia. The district nurse had never met the person before and no home care staff were present. The manager told us they had identified improvement was needed in communication between Drayton Court's staff and visiting district nurses. They assured us immediate action would be taken to ensure a staff member was allocated to always be with people during their district nurse visit. This would ensure people were supported and guidance from healthcare professionals was received and recorded.

Staff support: induction, training, skills and experience

● Staff received an induction, during which the provider's trainer informed staff about the provider's values and vision. These were also displayed in the home. However, none of the care staff spoken with could tell us what the provider's values and vision were. For example, when we asked about 'Everyday well lived' one staff member told us they had never heard of it.

● Staff received training, regular support and supervision in which they could reflect on their practice and training needs.

● People and relatives felt staff had the training they needed. We saw some positive examples of staff putting skills into practice. For example, one staff member patiently supported one person to enjoy their meal in their bedroom, ensuring this was a positive experience for them. However, some staff did not follow training given and had not ensured people had things to hand they needed. For example, one person's water jug was empty, and staff did not replenish this and some people, with capacity, did not have their call bells to hand.

Adapting service, design, decoration to meet people's needs

● The provider responded to urgent repair needs. For example, heavy rain had caused a leak in the roof during the night and during our inspection visit, repair work was underway.

● Some areas of the home looked worn and tired. Relatives commented about worn furnishings and décor. The director of delivery told us an audit had been undertaken of their WCS care homes and a meeting with their Board of Trustees was planned for July 2019. Priorities and spending would be agreed upon for older homes, including Drayton Court, and a three-year refurbishment agreed.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had a pre-assessment before they came to live at the home to ensure their individual needs could be met. These assessments were used to formulate more detailed care plans for staff to follow.

● Our observations showed people were given choices about where they wished to spend their time. For example, some people chose to stay in their bedroom. Another person told us, "I like to come and see the school children who visit us here."

● During people's initial assessment they were given the opportunity to share information with the provider and staff to ensure there was no discrimination, including in relation to protected characteristics under the Equality Act (2010).

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question is now rated as Requires Improvement. This meant were not consistently supported or treated with dignity and respect; and involved as partners in their care.

Respecting and promoting people's privacy, dignity and independence

● People's personal information was not always kept securely. One staff member had left their electronic device used to store people's care records charging in an office with an open door. This information was accessible to anybody in the home to access as the session was not timed to expire for 180 minutes. The director of delivery assured us this was not their expected practice.

● Relatives told us staff were respectful of their relationship with their family member and encouraged them to maintain a caring role. For example, one relative told us, "I come at dinner time, it is not just sitting by the bed but I'm actually doing something for my family member. It is good for me and it is good for them."

● Staff knocked on people's bedroom doors and explained to people what was happening.

Ensuring people are well treated and supported; equality and diversity

● People felt well cared for. One person told us, "The care is good, if you need any help it is good." Another said, "They (staff) are very compassionate." Relatives made positive comments to us about staff and described them as, "Excellent, very good." "They are all very friendly, personable and diplomatic." One relative told us, "The girls (staff) come in and give my family member a hug."

● Some positive and caring interactions took place between people and staff. For example, one person told us they experienced pain and said, "The staff are very gentle with me, they know I'm in pain." However, our observations showed staff did not always take opportunities to engage with people, speak with them or acknowledge them.

● Some staff took care in their own actions to make sure their approach was caring toward people. We saw one housekeeper make sure the vacuum lead wire was placed close to the wall and they told us, "I'm always making sure what I do, doesn't put people in any danger otherwise that's not caring about them." However, staff did not consistently take this approach. During our inspection visit, we found numerous examples of staff not taking care to follow the provider's policies. For example, a staff member had left the sluice door unlocked. Such incidents posed potential risks to people and did not demonstrate staff consistently had a caring attitude toward people.

Supporting people to express their views and be involved in making decisions about their care

● People gave us examples of how staff involved them in making decisions about their day to day care. One person told us, "I can stay in my bedroom if I want to." And a relative told us, "If my relation says they don't want a shower, they listen and respect that."

● The provider gave relatives the opportunity to use their electronic 'Gateway' as a way to keep in touch and be involved in their relative's care. One relative told us, "I look at my family member's care everyday using

the 'gateway'."

● People and relatives gave mixed feedback about whether they had been involved in reviews about planned care. Overall, people could not recall being involved in reviews of their care plan. One relative told us, "I've not been invited to an official review but just a chat." Another relative did recall taking part in their family member's care review.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Outstanding. At this inspection this key question is now rated as Requires Improvement. This meant people's needs were not consistently met because due to lack of organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People's needs were assessed and they had individual plans of care. Overall, staff knew people and how to meet their needs and told us they could check people's electronic care plans. However, they did not consistently do this. For example, we were talking with one person and a staff member brought them a cup of tea (in a cup with a saucer). This person told the staff member, "I can't drink that, I need a beaker." This staff member apologised and went to fetch a beaker so the person could enjoy their drink.

● People's call bells were not always responded to in a timely way by staff. Whilst people told us staff responded to their call bells most of the time, on numerous occasions during our inspection visit, call bells went to the emergency setting because they had not been answered promptly. On one occasion, a call bell was ringing on one floor and staff, on that floor, were seen to be chatting together in the kitchenette and only responded went the call went to 'emergency'.

● We spoke to one person and they told us they had wanted to go to the toilet for some time. They told us, "I've got a thing (call bell) and I have pressed it, I don't know how many times." The person rang the bell again and staff responded to support this person to go the toilet.

● The manager told us they had noted the call bells sounding and reverting to 'emergency' and would be investigating why timely responses did not always happen.

● Some people experienced positive outcomes. For example, one person had been struggling with their mobility and staff had introduced them to group exercise sessions, which resulted in their confidence and strength increasing which had positively impacted on their mobility. Another person was supported to maintain their chess playing hobby. Another person told us, "I really like watching the (visiting) school children playing."

● Overall, people and their relatives felt staff knew how people liked to spend their time. For example, one relative told us, "Staff put on the Tour de France for my relation because they knew they liked cycling." However, another relative told us, "I don't think staff have much time to do activities with people."

● There was an inconsistency in people's experiences. Those people who were more able and perhaps did not need the same level of staff input or encouragement to engage clearly had much better outcomes than other people. Staff did not always support people to achieve the provider's vision of 'everyday well lived'. Some people were at risk of social isolation and staff did not always take opportunities to engage with people. For example, we saw one staff member just standing in a communal lounge, they did not interact with any of the people in the lounge.

● Most activities were limited to the day care lounge on the ground floor and those who attended gave positive feedback. However, we did not see any activities take place during the morning with people other than in the day care lounge. Staff told us it was the same people who went to join in activities, such as with local school children, in the day care lounge. One staff member told us, "When we have handover, we are

asked to do activities with people, but we don't really have time to do it." A staff member said, "We try and give everybody as much time as we can, but you think you aren't spending enough time with certain ones." Another staff member described the care as, "Alright but I do think it could be improved, some people could be interacted with better, especially those who stay in their bedroom."

● People's pastoral care needs were met. Staff had developed links with a local church and services were offered in the home for those people who wished to attend. The care co-ordinator told us if anyone had a different faith, links would be made with the relevant faith leader so visits could be arranged.

Complaints or concerns

● The provider displayed their complaints policy and people had the information they needed should they have cause to complain. Most people and their relatives did not have any current complaints about the services received.

● However, two people shared the concerns about their broken chairs which they were sitting on. One person told us, "This is my own chair, but it no longer reclines because staff broke it when they were taking it out of my bedroom to be cleaned. I'm no longer very comfortable." This person told us the accidental damage had occurred nine weeks ago and they had not been told when it would be repaired. The second person explained they could not recline their chair because the handle had been broken and were not comfortable and were waiting for a replacement chair but hadn't been informed when this was.

● One relative told us, "If I complained it wasn't being followed through, but with the new manager, I think things are already improving."

End of life care and support

● The home did not offer nursing care. However, the manager and provider aimed to support people's wishes to remain at the home for end of life whenever possible, with external healthcare professional support.

● Advance care plans, including end of life care, did not contain details about whether important information related to people's wishes had been discussed with them or their relatives. For example, most care plans looked at stated 'to be discussed'.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Outstanding. At this inspection this key question is now rated as Requires Improvement. The service was not consistently well managed and or well-led. Leaders and the culture they created did not promote high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility

- The provider had identified improvements were needed. The director of delivery explained their audits and checks had identified the leadership of the home was not strong and as a result staff were not being led or supported to deliver the standards of care expected by the provider. As a result a new manager had commenced their employment during May 2019 and was working with the provider's service manager and director of delivery to prioritise areas for improvement.
- The manager told us they were in the process of applying to become registered with us. In the short time they had been in post, they told us they had become aware numerous improvements were needed and were in the process of identifying and prioritising these. For example, they told us they had identified some people did not have 'when required' medicine protocols and had asked the deputy manager to prioritise these be written to ensure people received their medicines in a consistent way.
- Staff felt communication had improved since the new manager had been appointed because they were more responsive when issues were raised.
- The provider had systems and processes to check on the safety and quality of the service. However, these checks had not always ensured areas for improvement were identified or implemented in a timely way. For example, checks on people's plans of care had not identified where we found some needs had not been assessed and no care plan had been written.
- Overall, environmental checks ensured the home was safe for people to live in. However, we found one first-floor communal bathroom window opened beyond arms' length because there was no restrictor device fitted. The care co-ordinator assured us immediate action would be taken to make this window safe.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The provider offered opportunities to people and their relatives to give feedback. Some issues raised in November 2018 and rated the lowest areas were the same as those we found, which meant actions taken had not been sustained or were yet to be implemented.
- Staff told us they had staff meetings, and these were used as an opportunity to share their thoughts and views whilst receiving feedback and updates about the service.
- The rating from the provider's last inspection was displayed, as required, in the entrance area of the home.

Working in partnership with others

● The provider worked in partnership with others. For example, during November 2018, they had invited Age UK to visit the home, undertake checks and provide feedback on the services people received. A score of three out of a maximum of five had been awarded. Areas for improvement, including unpleasant musty odour, had been shared with the provider. Whilst environmental improvement was planned to be discussed, the provider had not acted to ensure issues were addressed in a timely way because unpleasant odours continued to be present.

Continuous learning and improving care

● The provider's home managers completed compliance assessment visits in one another's services.

● The provider had not always taken learning from their other homes to implement across all of their services. For example, some of the issues we identified on this inspection of Drayton Court, we had previously found and told the provider about, when we inspected one of their other homes twelve months ago.

● The provider had implemented an 'improvement journey' during February 2019, with the aim to improve, for example, people's mealtime experience. However, our observations of people's mealtime experience, across the three floors, showed improvements had either not yet taken place or were yet to be embedded in the staff team.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not always assess risks to the health and safety of service users. The provider did not always do all that is reasonably practicable to mitigate any such risks. The safe and proper management of medicines was not always adhered to.