Mrs Andrea Quirk

# Drayton House

**Inspection report**

50 West Allington ,Bridport, DT6 5BH
Tel: 01308 422835

Date of inspection visit: 13 and 16 March 2015
Date of publication: 03/06/2015

## Ratings

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

## Overall summary

The inspection was unannounced and took place on 13 and 16 March 2015.

The service provides personal care and accommodation for up to 19 older people, including people living with dementia. Accommodation is provided over two floors accessible by a passenger lift and stair lift. The service is located within walking distance of the local town. At the time of inspection there were 13 people living at the home, including one person staying for respite care.

There was a registered manager in place, however at the time of inspection as they were due to leave their post, they were handing over to the owner, who would be applying to become the registered manager. The owner was previously the registered manager six years ago. 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.

The service was last inspected on 21 February 2014 and was found not meeting the standard relating to people's consent to their care and the standard for how the quality of the service was assessed and monitored. There was also concern about the standard of cleanliness and hygiene. The registered manager sent us an action plan detailing how and when the issues would be addressed. At this inspection we found the service had completed the actions and made improvements. We found a strong

# Summary of findings

ethos of choice had been developed for people who lived at the home, as well as formal consideration of people's 'best interests', in accordance with the guidance and principles of the Mental Capacity Act 2005 (MCA).

An improvement plan for the redecoration and refurbishment of specific areas of the building had been completed. The cleanliness of the home was checked regularly and arrangements were in place to prevent the spread of infection. People told us they felt safe in the home and we saw they were supported to receive care safely. People benefitted from a safe and hygienic building.

The staff worked as a team to coordinate care and delivered the service based on an individual assessment of needs and a written and up to date care plan. Resources were in place to provide occupation and activities for people who chose this. Regular involvement with the local community was encouraged and facilitated for people who wanted this. Staff and management demonstrated care and concern for people's mental, physical and emotional well-being.

One person who was unable to walk independently told us when they called staff, they came within one or two minutes and that the staff were, "a good crowd and very kind. Their care is fantastic." Staff knew and understood people's needs. People told us they were satisfied with the service. We observed people being consulted about all aspects of their care, being given explanations in a way they could understand and staff noticing when people wanted attention and offering this in an unhurried manner. One relative told us, "everyone is very happy and friendly, you can't ask for more. The staff go out of their way to give people what they want."

Where people had complex needs, the service engaged the relevant external professional such as the community nurse, the GP or the dietician, to ensure people's care was managed appropriately.

Food was freshly prepared with choices offered for all meals. People were encouraged to express their likes and to try different tastes. People all told us they enjoyed the meals and we observed people were supported to eat a well-balanced diet.

Staff were positive about the service and told us they felt well supported and trained to carry out their duties effectively and safely. There were enough staff to meet people's needs. Staff were recruited safely and provided with an induction into the service before taking on all the duties. More experienced members of staff supported less experienced members of staff and staff were regularly supervised.

There were no formal complaints recorded for the service. The service had recently given questionnaires to people's representatives to get their feedback. Relatives commented on how accessible the registered manager was and how they felt they could approach them with questions or comments. Family and community involvement in the home was sought via events put on with invitations or through local events in the town, where people were helped to attend if they wished. Regular meetings were held with staff where issues and up to date guidance were discussed helping staff work as a team and share ideas about service improvements.

# 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

People told us they felt safe and staff demonstrated an understanding of abuse and how to report any concerns.

Risk assessments were used effectively to promote a balance between safe care and respecting people's autonomy.

There were sufficient staff to provide the service people required.

The environment was hygienic and well maintained. Any hazards were effectively managed. Medicines were administered safely.

**Is the service effective?**

Good

The service worked within the formal framework of the Mental Capacity Act 2005 and people's rights were protected.

Staff were trained and supported to provide care for people effectively.

A well balanced diet was provided and people were supported to have enough to eat and drink.

**Is the service caring?**

Good

People and relatives told us they felt the service was caring and commented on the caring attitude of staff.

People were given time to express their needs and treated with respect and dignity.

People were supported at the end of their life to be comfortable and pain free.

**Is the service responsive?**

Good

Detailed care plans were reviewed regularly and gave personalised information about people's care and their preferences.

Staff worked as a team and used dedicated resources inside and outside the home to ensure people had meaningful activity and occupation which promoted their wellbeing.

Individual care was discussed with relatives so they could be kept informed about any changes. This helped them to feel involved with the care. Their feedback had been recently sought through a questionnaire.

**Is the service well-led?**

Good

The service was well-led and promoted compassionate, personalised care.

Managers spent time with people and their families and were available to support and guide staff.

There were systems in place to monitor and check the quality of care.

# Drayton House

**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.

This inspection took place on 13 and 16 March 2015 and was unannounced. A single inspector carried out the inspection. We did not ask the provider to complete a Provider Information Return (PIR) before the inspection. A PIR is a form that asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make. However we gathered information from various sources including statutory notifications about the service relating to incidents and feedback from other agencies. We looked at information relating to one safeguarding incident in May 2014 and a contract monitoring report from the local authority. We spoke with the owner and the registered manager for the service to give them the opportunity to tell us about what the service does well and planned improvements.

We spoke with seven people and three relatives and observed their care. We looked at five care plans and three staff records. We spoke with three healthcare professionals who had provided healthcare services to people at the home recently and we spoke with six members of staff.

Good

# Is the service safe?

## Our findings

All the people we spoke with told us they felt safe with the service. People told us they felt safe in the home. Staff could tell us about signs of abuse and what to do if they had safeguarding concerns. All the staff were able to tell us how they would report their concerns. Staff had confidence in the management of the home, but were able to tell us what they would do if they thought service was not protecting people. The provider had a whistleblowing policy which staff were aware of.. They also mentioned which agencies they would contact, such as the safeguarding team, CQC or the Police. The service had been involved in a safeguarding investigation since the last inspection concerning incidents within the home. We saw that appropriate actions were put in place to protect people from the risk of repeat events.

Risks to people's welfare were managed in a way which was balanced with their freedom to exercise choice. We observed a positive approach was taken to support people, recognising people's wish to have freedom of movement around the home and local community, by making sure their mobility was risk assessed. For example, people were assisted to go out into the local town when they expressed a choice. An individual plan of support had been compiled to help people, accompanied by staff, to be safe when out and about, for example travelling to the shops in the local town. Other risks such as nutrition, behaviour and social isolation had been assessed and written plans put in place for the safe management of these risks. Staff demonstrated that they referred to and followed these plans when supporting people.

Staff knew how to respond to behaviour which was challenging. They described the importance of understanding the person, respecting their circumstances, their autonomy and right to make choices, working with the advice of other professionals, and working as a team. This helped to ensure that people's behaviour did not escalate and any risks to people and staff were minimised. We spoke with community health care staff who confirmed that the service had managed risks safely for one person which had enabled them to live with less restriction since they had moved into the home.

There were sufficient members of staff on duty to provide a safe service. We observed that staff were present at all times of the day throughout the home. Staff worked as a team to ensure they responded to those people who remained in their rooms most of the day, or to check on anyone who was cared for in bed. We observed regular checks on one person being carried out, as stated in their care plan, as they were unable to call for help due to their condition. When we asked another person how long it took for someone to attend if they used their call bell, they told us it was one or two minutes. Where agency staff were used this was a stable arrangement with staff who knew the home. An information folder was compiled for any agency staff that came on duty so they could have a written as well as a verbal handover. This helped to ensure people received continuity of care.

Staff had been trained to support people and understand how to meet the needs of each person. There was a mix of very experienced and less experienced staff. Staff were clear about their responsibilities and which tasks they were trained to undertake. For example, staff explained to us who was competent to administer medicines or who was trained to use specific risk management tools to assess nutrition and skin condition. Staff all told us they felt supported to deliver a safe service.

Staff had been recruited safely. The staff files showed a process was followed for selection of candidates using application, interview and assessment of staff, including obtaining appropriate references. This showed background and suitability was taken into account when assessing a candidate's suitability for working in the service. The service used the Disclosure and Barring Service (DBS) to make further checks on people's suitability for employment within the service.

Medicines were handled safely. There were suitable arrangements for the ordering, handling and storage of medicines for people living in the home. Delivery of medicines was checked in accordance with the policy of the service. One senior member of staff took the lead for medicines in the home. They demonstrated understanding of the safe handling of medicines and administration. They showed us how they maintained weekly oversight of individual medicines records and stock as a way of checking safe practice. Each person's prescription was recorded on an individual chart with their photograph, and a note of any allergies was clearly marked. We observed medicines administered by staff and saw staff followed safe

Good

# Is the service safe?

procedures. Staff were observed asking people about their medicines, for example, “Are you in any pain? Would you like your medicine?” and offering support in a discreet and respectful way.

The premises and equipment were maintained safely. We saw electrical and fire assessment checks were up to date and there were established arrangements for the regular testing of appliances. The registered manager took the lead in identifying health and safety issues, carrying out monthly observations and checks of the environment or noticing issues as they arose. Records showed specific repairs or refurbishment were undertaken when hazards were identified. For example, we saw one area in the kitchen which was identified recently as a possible hazard and this was repaired and addressed promptly.

People, and their relatives, told us they found the home clean. The home smelt fresh and looked visibly clean in all areas. The kitchen had been refurbished which allowed more effective cleaning to take place. We observed staff routinely used personal protective equipment such as aprons and gloves and told us how they prevented any risks of cross contamination. The service had managed a recent outbreak of illness affecting a number of people and staff about which we were notified. We saw that appropriate measures had been taken to control and reduce the spread of infection.

Good

# Is the service effective?

## Our findings

At the last inspection in February 2014, the service was not meeting the standard for consent to care and treatment. At this inspection we found there had been improvements. The home had considered on an individual basis whether people had the capacity to consent to their care arrangements in the home or whether due to their lack of mental capacity, safeguards needed to be put in place to protect people's rights. We saw that the service had followed a formal procedure to comply with the Deprivation of Liberty Safeguards (DoLs), part of the Mental Capacity Act 2005 (MCA). These safeguards aim to ensure that the liberty of those who are residing in care homes is not being restricted unlawfully. Applications had been made to the local authority for appropriate consideration in respect of six people. Ten of 16 staff had received training in DoLS in the last two years, including senior staff who last received training in this topic in 2014. Staff understood that people's care needed to be provided in the least restrictive way.

Consent to care and treatment was sought in line with legislation and guidance. The home had followed a process for considering and recording best interest decisions for people who could not give valid consent due to mental impairment. For example, for one person their bed rails had been considered as a best interest decision and in another care record we saw evidence of medicines being considered as a best interest decision where the person could not give their valid consent. We observed staff offered choice at all times. For example, one member of staff told us how although someone's room had to be cleaned for hygiene purposes, this was always done sensitively, "you cannot override someone's decision." They explained how they had reached an agreement with the person to carry out what needed to be done in a way which suited them but also met the needs of the service.

People were supported to eat a balanced diet. We observed people either eating meals in their room or enjoying conversation with each other and staff, including the cook, at lunch. There was regular feedback between people, staff and the cook which enabled the staff team to get to know people's likes and dislikes. People's feedback was used to plan the shopping and the menu. Food was mostly sourced from local suppliers and some people were enabled to accompany staff to the shops to be involved in grocery shopping. Some of the activities in the home involved food tasting, for example, herbs or spices. Staff told us this helped to stimulate people's taste and appetite. One person told us they had tried various fruit and vegetables they had previously never eaten. A person, who needed specially prepared food and drink to reduce any risk of choking due to swallowing difficulties, had clear guidelines in their care plan for this. We asked all members of staff how their drink and food should be prepared and all were able to demonstrate correct knowledge of the instructions. All staff demonstrated awareness of the need to consult a specialist for an assessment should people have swallowing difficulties.

People were supported by staff that understood their needs and knew how to care for them. All the staff we spoke with were familiar with the content of the care plans and how to meet the diverse range of needs. An induction was provided for new staff and staff told us they felt supported to develop their knowledge through training and supervision. Training was provided through a combination of online, workbook and face to face methods. Two members of staff told us they preferred online methods as this gave them a flexible way of meeting their learning and development needs, alongside supervision from senior staff. One told us, "I had no background in care but I found it easier than I thought. You do get a lot of support and you are not left on your own." Another member of staff told us, "Everyone here is different, you work as a team, you read the care plan and know what to do, and the information is there that I need."

A record of training was provided which showed all staff had received training in medicines, health and safety, food hygiene, equality and diversity, infection control and fire safety and safeguarding. Both the registered manager and owner told us they were committed to supporting training for all staff as the basis for effective care. Staff were supported to develop professionally. For example, all staff were qualified either in level two, three or five of the nationally recognised qualifications in care, or working towards one of these levels.

People were supported to receive healthcare as they required. Staff liaised with local healthcare services to arrange appointments and assessments with people, for example in relation to their dental and eye health and screening for long term conditions. We spoke with a specialist nurse who reported that staff worked effectively

Good

# Is the service effective?

with someone who showed behaviour which challenged, stating that they followed advice which had resulted in the person making a successful transition from their own home into the care home, with the least restriction on their freedom.

The home was arranged in a way which allowed people to move around freely. People had space for their belongings and rooms had been arranged to maximise people's comfort, for example in the positioning of furniture and the provision of special beds. Some people could not use the bathroom due to their disability. The registered manager told us that discussions had been held with the owner in relation to the provision of suitable bathing/ showering facilities to enable safe access for all people using the service to a bath or shower.

Good

# Is the service caring?

## Our findings

People had positive and caring relationships with staff. The atmosphere was welcoming and accepting for people and their visitors. We saw one person who, although found it difficult to mix easily with others, demonstrated care and concern for other people, reflecting an atmosphere of mutual support. One person told us, “I like it here because it is small.” We observed friendships had developed between people which they found comforting, supportive and stimulating and that the service had encouraged friendships to form. Some people spent time together either at meals or in the lounge areas. One person told us, “if it wasn’t for these staff I wouldn’t be here. Their care is fantastic. A relative told us, “my relative has been as happy as anything since she’s been here.”

People who were anxious or found socialising or communal living difficult, received patient support and encouragement from staff to express themselves and be able to communicate. Two members of staff told us how they had spent over a year getting to know and understand someone due to their condition and ways of communication, very gradually building and developing trust. Another member of staff told us in relation to someone with dementia, “The way you speak and your tone of voice makes a massive difference.” Staff demonstrated compassion and tolerance for people and their circumstances. Where people spoke about particular subjects with staff members, for example, politics, this was noted in their daily records, so all staff could be aware of particular topics which interested individuals. One person told us, “ it is important to still have your own life and here you are helped to do that.” Another person told us, “here they (the staff) try to find out what you like or what interests you and provide it.”

People’s privacy was respected. Discussions with people in communal areas were held discreetly and we observed staff knocked on doors and waited for a reply before they entered people’s bedrooms, unless they were unable to reply.

People were given opportunities to make choices about their care and be involved in the home and the wider community. Efforts were made to promote people’s active involvement in their care and in the wider community. Where people expressed a wish to be involved in local events this was facilitated by staff. People’s views about their care, including any areas of risk, were clearly recorded as a key element of their care plan. For example, one person who was at risk of self-harm had their views recorded about how staff could best support them to avoid this. Where people did not want to take their medicine on any particular day, staff were instructed to record that the person had declined rather than refused, emphasising the consent element of the care.

People were supported to be comfortable at the end of their life through appropriate staffing, sensitive arrangements around their bedside, such as particular music or lighting and a comfortable, calm environment. Staff demonstrated confidence, awareness and sensitivity in meeting people’s physical and psychological needs. Training and experience in end of life care had been arranged for some members of the staff team. A community nurse told us they were impressed with the quality of care being given to a person who was receiving end of life care, evidenced in their peaceful demeanour and by the quality of their skincare and general appearance and comfort.

Good

# Is the service responsive?

## Our findings

People were supported to live their life the way they chose. Care plans detailed how people liked to be supported. People told us how they could choose their routine for the day. For example if they wanted to come into the dining area in their dressing gown for breakfast, the registered manager explained, this was their home and they were encouraged to feel free to do that. We observed people who chose who remain in their rooms and were at risk of social isolation. However this was mitigated as staff interacted with people, actively engaging them in conversation on a regular basis. We observed this was received positively. A member of staff told us how the ethos of the service was to accept people for who they were and support them in their chosen lifestyle. All members of care, management and support staff were able to give us practical examples of how they achieved this in relation to the people living at the home.

People and their relative's involvement influenced how care was given. Care plans had records of involvement with relatives and recorded the views of people about how they liked to receive their care. Consideration had been given in each of the plans we looked at and for the people we observed as to how their independence was maximised. For example, where someone was at risk of low mood, guidance was recorded about how they could be kept informed about daily events. A member of staff told us how they observed one person who closed their eyes when their relatives visited and they then talked to the relative about how their visits might be affecting them.

People experienced care that was in line with their needs because changes were noted and acted upon. Reviews of care plans included, where relevant, updating of weight charts and updated risk management tools, for example, to monitor skin and nutrition. Care plans had been updated with changes and events which had occurred as part of the regular monthly review for each person.

People were offered opportunities during their day to participate in meaningful activity. People's daily activities were recorded with information about what they had enjoyed. This guided staff about how to plan the service. There were a range of activities on offer through the week and weekend, which some people were able to tell us about. For example, one person who took part in a poetry session wanted to share this and showed their enjoyment of this activity. Activities ranged from arranging of special meals, for example to celebrate particular occasions, entertainment, animal visitors, and trips out, exercise activities, stories and poems. We observed people had been involved in crafts and arts as some of this was displayed in the home. Three people had regular days at local centres. This helped to promote people's health and wellbeing.

Events were held from time to time to which invitations were extended to people's families and members of the community as appropriate. We noted that where people had less family involvement, this was noted by the registered manager who ensured that on special days such as birthdays and Christmas, they, or a member of staff, were present to offer particular attention to the person. Where one person who had come in for respite care was going home alone, they were encouraged and supported in making links with the community to ease their transition.

The registered manager told us there had been no complaints made about the service. A recent survey had obtained feedback from relatives about the service. Some of the responses were available and reflected people's satisfaction, with some very positive comments about the service and staff. Three relatives told us they were kept informed at all times of any changes in their relative's condition and they felt they could approach the staff with questions and comments. We were not shown any specific evidence of how people's experiences and views were used to develop the service, however were given examples of how people's individual background and wishes were taken into account in planning activities and care for that person. People told us they knew who the staff were and all the people we spoke with could tell us the names of staff. They all told us they would go to the manager if they weren't happy about something.

Good

# Is the service well-led?

## Our findings

The service was well led. People, relatives and staff all spoke positively about the service and described an ethos of respect and compassion for people. Senior staff were frequently present with people, enquiring how they were. The registered manager and senior staff modelled compassion for people by noticing people's needs, spending one to one time with people, and being available to respond to incidents and events during the day. For example, during our inspection, we observed the registered manager's communication with ambulance and hospital services and how they ensured one person received the care and treatment they needed.

Staff told us they worked as a team. Senior staff told us they looked for effective ways to relay best practice and remind each other to follow policy. For example, they told us about their staff meetings, where we saw recorded that the same issues were repeated over several months. Staff told us communication between staff was carried out in the meetings but also through daily handovers between shifts, use of daily notes for each person, a diary, a 'jobs list' and a staff notice board. This helped to ensure overall continuity of care. One member of staff told us that changes and events were well communicated in the home through all these methods, "We communicate all the time, this is how we know what is going on." We noted that staff used the care plans and knew about the contents. All the care plans and reviews we looked at were up to date. A training session was booked for staff on the care planning system.

The service was audited and checked by the registered manager using records filled in by staff about the service and using templates for collecting information, such as reviews of care plans. Records showed that staff were reminded of the importance and relevance of these records in staff meetings. Information was recorded and analysed about incidents and accidents, risk assessments, the environment, and training due. The checks and reviews ensured that the registered manager kept an overview of the service, how it was being delivered and any quality issues. Issues identified during the environmental audit were recorded and acted upon or communicated to the owner for action. We saw an example of how the service looked at the circumstances of an incident which occurred during the inspection, when one person slipped in the bathroom. The moving and handling risk assessment was reviewed, taking account of the person's condition, their anxiety and the environment and how this could be prevented in future.

There was a vision for the service expressed verbally however we not shown any specific plan. The owner of the service was due to apply for the position of registered manager. They told us their vision for the service was to continue to provide a 'home from home' for people, using the advantage of the small home atmosphere to ensure people and relatives felt welcome at all times. They also wished to enhance links with the local community for the benefit of people, to promote wellbeing and reduce the risk of social isolation. We observed that these elements of the service had been developed by the outgoing registered manager. The owner told us they recognised the changing needs of people who came into residential care as being generally more complex, and wished to adapt the service and the environment accordingly, for example, in the provision of an accessible bathroom. We saw evidence of gradual adaptation of the home through refurbishments which had taken place since the last inspection. The owner also expressed the commitment to on-going training for the workforce as being a key influencing factor in quality. This included components of specialist training in areas such as dementia and Parkinson's Disease. We saw evidence of training and professional development for all staff.