

Drake Court Healthcare Limited

Drake Court Residential Home

Inspection report

Drake Close
Bloxwich
Walsall
West Midlands
WS3 3LW

Tel: 01922476060

Date of inspection visit:
20 October 2021
03 November 2021

Date of publication:
23 December 2021

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Drake Court is a residential care home providing personal care and accommodation for up to 29 people some of whom may live with dementia. The service was supporting 29 people at the time of the inspection in one adapted building.

People's experience of using this service and what we found

Although some improvements had been made since our last inspection, risks to people were still not consistently well managed and left people at potential risk of harm. Improvements were being made to the management of people's medicines. Mixed feedback was received about the staffing levels in place. Staff met people's core needs, but support was task-focused and staff did not appear to have quality time with people. Systems were in place to protect people from risk of abuse. We were somewhat assured with the measures in place to prevent the spread of infection.

People did not always have the equipment available to meet their needs. Improvements were still required to ensure records contained detailed information about people including their end of life wishes. People knew how to raise concerns and told us staff knew them well and were responsive to their needs. There were some opportunities for people to engage in activities although this could be improved for people that lived with dementia. Systems were in place to support people to maintain contact with their loved ones.

Although we saw improvements had been made in the areas we identified during our last inspection, we found further improvements were required. The systems in place to monitor the service were still not detailed enough to enable the management team to identify shortfalls.

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

Rating at last inspection and update: The last rating for this service was requires improvement (published 17 April 2019) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made or sustained, and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last six consecutive inspections.

Why we inspected

We received concerns in relation to care planning and staff not being responsive to people's care needs. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only. We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those

key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has not changed and remains as requires improvement. This is based on the findings at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvement. Please see the safe, and well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report. The provider had started to take action to mitigate the risks we had identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Drake Court on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to the management of risk and providing safe care, and the overall governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up

We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-Led findings below.

Requires Improvement ●

Drake Court Residential Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was undertaken by two inspectors.

Service and service type

Drake Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced.

Inspection activity started on 20 October and ended on 11 November 2021. We visited the service on 20 October and 03 November 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection

We spoke with seven people who used the service and five relatives about their experience of the care provided. We also spoke with nine staff which included care and domestic staff, a visiting healthcare professional, the provider and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of documents and records including the care records for seven people, three medicine records, three staff recruitment files. We also looked at records that related to the management and quality assurance of the service.

After the inspection

We continued to seek clarification from the registered manager to validate evidence found.

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 requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Using medicines safely

At our last inspection the provider had not ensured assessments of risks relating to the health safety and welfare of people were in place. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some improvements had been made in the areas we had identified, we found the provider was still in breach of regulation 12.

- On our last inspection we found some people were placed at risk of harm due to not being supported to have the required texture-modified diet. Their records also did not reflect their current needs in relation to this. We also observed staff not using the correct equipment when supporting people with a meal, or to move safely. On this inspection we found improvements had been made in these areas.
- At this inspection people were placed at potential risk of harm. There was a failure to assess risks to people and provide staff with guidance and direction on how to mitigate those risks. This included risks associated with people's medical conditions, mental health requirements, and skin integrity. Staff did not have clear, consistent guidance about these risks and how to mitigate them and support people.
- We reviewed the care of people at risk of sore skin. We found care plans and risk assessments did not always provide staff with detailed information on how to support people and the frequency required to provide pressure relief to prevent further deterioration of their skin. Where this information was provided, we found people did not always receive pressure relief in accordance with the frequency recorded to mitigate the risk of sore skin.
- We found some people were prescribed transdermal patches which were applied to their skin. For one person there were no records in place to indicate the location each patch had been applied. The manufacturer's instructions stated it was important to change the skin site every week, making sure at least three weeks pass before you reused the same site. The lack of records of where previous patches had been applied, meant we could not be assured the manufacturer instructions were being adhered to.
- Where people had medicines administered to reduce their distressed behaviours, the rationale for this and alternative methods that had been tried had not been recorded. We also found where people were receiving this medication on a frequent basis no action had been taken to ensure it was safe to do so.

The provider had not ensured of risks to people were managed effectively. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Once these concerns were shared with the registered manager they took action to address them.
- We reviewed how people's medicines were managed. Medicines records confirmed medication had been administered as prescribed. We counted the balance of a sample of the medicines in stock. These matched the medicines that had been administered and signed for.
- We reviewed the fire risk assessment which contained actions to address recommendations that had been made. The provider advised us action was being taken to complete the required work.

Staffing and recruitment

- At our last inspection we found employment gaps for new staff had not been explored as part of the recruitment processes in place. This had also been identified on previous inspections. On this inspection we continued to identify the same issues where gaps of employment had not been explored and addressed until we raised this with the registered manager.
- We found all other recruitment information had been obtained to ensure only suitable staff were recruited.
- We asked people if there were enough staff to meet their needs. Three of the seven people we spoke with told us there were. One person told us, "The staff are very busy. They don't have time to sit and have a chat with me." Another person told us, "They are very busy but when I need them, they come and support me."
- We received mixed feedback from staff on staffing levels at the service. Some staff felt there were enough staff to meet people's needs, whereas other staff told us an additional staff member at peak times would be beneficial.
- On the first day of our inspection site visit, we observed people's needs were not met in a timely manner. People were still being supported with personal care and their morning medication at lunchtime. The registered manager told us this was unusual. On day two we found people received their personal care and medication in a timely manner and the shift appeared more organised.
- Over both days we observed staff were busy and mainly task focused meeting people's core care needs.
- A dependency tool was in place and used to assess the number of staff required to meet people's needs. We shared the feedback we had received with the registered manager and provider who told us the dependency tool was regularly reviewed and observations would be undertaken to ensure the required staffing was available to support people.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe when supported by staff. One person said, "I do feel safe here, the staff are lovely and gentle when they support me."
- Relatives told us they had no concerns about the safety of their loved ones. One relative told us, "I have not been in the main home due to Covid, but I would know if something was wrong when I see [person] and they always look fine so I have no cause for concern."
- Staff we spoke with confirmed they had received training in relation to safeguarding people from abuse and knew the procedures to follow. One staff member told us, "I would report any concerns straight away to the manager or the provider. If needed, I would contact CQC or the local authority. I would make sure something is done."

Preventing and controlling infection

- We were somewhat assured that the provider was preventing visitors from catching and spreading infections. This was because the temperatures of visitors were not always consistently taken prior to entering the home.
- We were somewhat assured that the provider was meeting shielding and social distancing rules. This was

because people were not always able to socially distance in the main lounge area.

- We were somewhat assured that the provider was using PPE effectively and safely. This is because we observed occasions where face masks were being worn below the nose, and not always being worn when staff and the provider entered the home.
- We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. This is because we did observe some equipment and furniture was soiled.
- We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed. This is because of the issues we have identified above.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were somewhat assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

- We discussed with the registered manager the lessons learnt when the required records were not in place for a person who had been admitted into the home. The registered manager told us about the procedures now in place to mitigate the risk of this occurring in the future.
- We reviewed the systems in place to monitor incidents and accidents in the home. These were analysed on a monthly basis and action recorded, where needed, of how risks to people were to be mitigated. Improvements had been made since our last inspection and the records showed incidents were analysed for patterns and trends.

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 good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Prior to our inspection, information was shared with us by the local authority about the lack of records in place for a person who had been admitted into the home. The registered manager told us this was due to the expectation their electronic records would be transferred across from their previous care home. However, this did not happen. This meant staff did not have access to information and guidance about this person's care needs, history and preferences to ensure their needs could be consistently met. It also meant staff did not complete any records for this person for a period of time following their admission. Staff did receive verbal handovers, so they had knowledge of the person's core needs in order to provide daily support.
- We found some people did not have the equipment they needed to ensure their individual needs were met. For example, we observed a person consistently leaning over in the chair they were using. No action had been taken to assess this person's needs in order to find a suitable chair for them to use. We discussed our observations with the registered manager who acted and ordered a more suitable chair for the person.
- People told us they thought staff met their needs and they were consulted about their daily needs. One person said, "The staff know me and how I like to be supported so yes I think they meet my needs." Another person said, "When I am low in mood the staff support me during this time and talk to me and help lift my spirits."
- We observed staff being responsive when a person was unwell during our inspection and action was taken to seek medical intervention for the person.
- Relatives we spoke with confirmed they were kept up to date about their loved one's wellbeing and consulted where applicable about their needs. One relative said, "If [person] is not well or had an accident the staff are soon on the phone to tell me which is reassuring."

End of life care and support

- The registered manager advised us no-one was receiving end of life care at the time of the inspection.
- At our previous inspection it was identified there was limited information in people's care records to support their wishes about how they would like to be supported at the end of their life. We found improvements were still required in this area.
- Information was recorded where people had funeral arrangements, but individual wishes had not been considered and recorded to support their end of life care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We received mixed feedback about the provision of activities. One person told us, "I am bored, there isn't

much to do during the day and sometimes activities are provided on the evening, but I am too tired then." Another person said, "I go out regularly to places I like so I have an active social life."

- We saw an activities programme was in place which reflected a variety of activities were planned. Staff and a person living in the home were responsible for facilitating activities. However, we saw staff did not always have time to support people to engage in activities. ●

We observed an external entertainer visit on day one of our inspection, but this coincided with a visit from the GP so people's ability to enjoy this was compromised. We did not observe any other activities taking place and people were sat in the lounge with the television on.

- We also observed most of the people that lived with dementia sitting with no meaningful engagement or objects to occupy their minds such as therapy dolls or rummage boxes. We did observe one person was provided with a mitten to use to occupy their hands which they appeared to enjoy.

- We discussed our observations with the registered manager who told us they had advertised for an activities staff member to assist with the provision of activities within the home.

- In order to enable relatives and friends to see their loved ones during the Covid-19 pandemic, the provider had installed a visiting pod. This continues to be used by visitors. Relatives told us efforts were made to enable them to maintain contact with their loved ones when visits could not take place, using video calls, telephone calls and window visits.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Information about how people communicated was recorded in some of the records we reviewed.

Observations supported staff had an understanding about how each person communicated.

- The registered manager told us if needed information would be provided in alternative formats such as easy read, alternative languages, and large print. The registered manager advised us people living in the home did not currently require information in alternative formats.

Improving care quality in response to complaints or concerns

- People told us they knew how to raise any concerns and felt confident any issues would be addressed. One person said, "I have no complaints but if I did, I would tell the manager and I am sure I would be listened to."

- Systems were in place to record and respond to any concerns shared.

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 requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the provider had insufficient and inadequate systems in place to monitor and improve the service. This was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. In response to this we issued a warning notice.

At this inspection although we found improvements had been made in the previous areas we had identified we continued to identify shortfalls. Therefore, the provider remains in breach of regulation 17.

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- The provider has been rated as requires improvement for the last six consecutive inspections. We found issues that had previously been identified were addressed, but then we have found shortfalls in other areas which had not been identified by the provider's governance systems and processes. On this inspection we have considered the improvements that had been made since our last inspection to meet the requirements of the warning notice.
- Although audits were completed in several areas these were still not robust enough to identify the concerns we found during this inspection. For example, the medication audit was not comprehensive and therefore did not identify the shortfalls we found in relation to the management of people's medicines.
- Audits of care records completed by both the registered manager and nominated individual continued to fail to identify gaps in people's records and monitoring charts. Records still did not include all the required information to ensure people received person-centred care. They also did not always provide clear guidance for staff to follow to ensure people's needs and associated risks were met in a consistent way.
- We have identified shortfalls with the recruitment processes on two previous inspections, but the provider has failed to improve in this area and implement robust audits for staff recruitment files to ensure they contained all required information to support the employment of new staff.
- Systems and processes failed to ensure equipment used within the home was cleaned at regular intervals and records were in place to support this. They also failed to ensure night cleaning schedules were checked to ensure they were completed in full without gaps to support the cleaning undertaken at night.

- The systems in place failed to identify some people did not have the equipment they needed to support their wellbeing and take appropriate action to address this. For example, suitable chairs or ensuring people had foot stools to reduce the risks to their legs.

This is a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- In response to the feedback provided the provider told us they were considering employing a quality officer to assist with the monitoring of quality provided at the service.
- The provider had met their regulatory responsibility to ensure their current inspection rating was displayed within the home.
- The provider was aware of their legal responsibilities to report any notifiable incidents promptly to CQC.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager understood their responsibilities in relation to the duty of candour. Where incidents had occurred, the registered manager had informed the appropriate external professionals and people's loved ones.

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

- Systems were in place to seek feedback from people, their relatives and staff. Meetings were held with people and staff to gain their feedback and satisfaction surveys were sent out to relatives. Where recommendations had been made, information about how these had been addressed was recorded.
- People knew who the registered manager was and described her as caring, friendly, and supportive.
- Staff we spoke with felt supported in their role. One staff member said, "The manager is lovely, very approachable and supportive and she does her best for the people that live here. She is very caring. I feel listened to and supported."

Working in partnership with others

- The registered manager told us they worked in partnership with many agencies to ensure people's healthcare needs continued to be met, such as the local GP, enhanced care team, and district nurses.
- A visiting healthcare professional told us, "Staff here are responsive to any recommendations or suggestions we make. The staff are also pro-active in contacting us if there are any issues. They work well with us."
- The registered manager was working with the local authority and occupational therapist team to improve the care records and activities provided in the home. The registered manager had also worked with the Local Health Protection team to ensure feedback and recommendations in relation to preventing and managing Covid outbreaks had been implemented in a timely manner.

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 People were not protected from harm due to the lack of robust risk management processes within the service.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems were not robust or effective enough to monitor and improve the quality and safety of the service provided.