CareQuality Commission

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Drakelow House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 18, 19 and 20 April 2017.
We last inspected the service on 14 July 2016 when we rated the service as Requires Improvement overall.

At that time we found the service was in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to governance, the safe and proper management of medicines, care workers, risk assessments, infection control and meeting people's psychological and social needs.

Following the inspection the provider sent us an action plan detailing how the identified breaches would be addressed. At this inspection we found that the provider was now meeting all of the requirements of these regulations. This inspection was to check improvements had been made following the last inspection and to review the ratings.

Drakelow Residential Care Home is registered with the Care Quality Commission (CQC) to provide residential care and support for up to 18 older people. A small number of people who were using the service were living with the early stages of dementia. The home provides permanent and short stay care residential services. Accommodation is provided over two floors and the first floor can be accessed via a passenger lift. All bedrooms are single occupancy with nine having en-suite facilities. The home is a detached building set in its own grounds and is located in Heaton Moor, Stockport. At the time of the inspection 12 people were using the service.

A registered manager was in place at the time of the inspection. 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 registered manager is also the registered provider and owner of Drakelow House.

We saw many positive and caring interactions between care workers and people who used the service to make sure people's wellbeing was promoted.

People who used the service and their relatives were complimentary and positive about the support provided and attitude of the care workers team and management. They felt the overall care provided was very good and the environment was homely.

During both days of the inspection we saw people were supported by sufficient numbers of care workers. Care workers we spoke with told us they had undergone a thorough recruitment process and had undertaken employee induction and training appropriate to the work. This helped to make sure the care provided was safe and responsive to meet people's identified needs.

Care workers confirmed they had received safeguarding and whistleblowing training (raising a concern about a wrong doing in the workplace) and knew who to report concerns to if they suspected or witnessed abuse or poor practice. We saw records to show care workers received regular supervision to help make sure they were carrying out their duties safely and effectively.

We saw written evidence that people and their relatives were involved in the decision making process at the initial assessment stage and during their care needs review.

Care records were in place which reflected peoples identified health care and support needs. Information about how people wanted to be supported and their dietary requirements were also included in the care records we examined.

Systems to make sure the safekeeping and administration of medicines were followed and monitored were in place and reviewed regularly. Medicines were stored safely and administered by designated trained care workers. Any specific requirements or risks in relation to people taking particular medicines were clearly documented.

Complaints were addressed by the registered manager. People who used the service and their relatives told us they knew how to make a complaint and felt confident to approach any member of the care workers team if they needed to.

Systems were in place to monitor the quality of the service. People using the service and their relatives had been provided with surveys to ascertain their views and opinions about their satisfaction of the service provided. Any feedback received was noted and used to make improvements to the service and the care and support provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Safeguarding policies and procedures were in place and care workers knew how to protect people from the risk of harm.

Risks to people were identified and detailed in their care records. Written information showed how to mitigate any risks to people.

Systems were in place to make sure medicines were stored and administered safely by suitably trained care workers.

Is the service effective?

Good

The service was effective.

Care workers received an employment induction, regular supervision and training to help make sure people were provided with care and support that met their needs.

People had access to external healthcare professionals, such as hospital consultants, specialist nurses and General Practitioner's.

Food options and refreshments were available throughout the day.
People's nutrition and hydration was monitored to ensure their nutritional needs were being met.

Is the service caring?

Good

The service was caring.

People received care and support from care workers who knew them well.

We observed positive interactions between care workers and people who used the service.

People's care records were stored securely to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to them receiving a service. Care records identified risks to people's physical health, mental health and well-being.

People's health care reviews were held annually or more frequently if necessary. Specialist guidance was included in people's care records where necessary.

People told us they felt confident in raising concerns or complaints with the registered manager or care workers.

Is the service well-led?

Good

The service was well-led

People who used the service; their relatives and care workers spoke positively about the management team.

The registered manager promoted a person centred approach to help make sure people's needs and preferences were met.

Systems in place in order to monitor the quality of the service were fully utilised.

Care Quality Commission

Drakelow House Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on the 18, 19 and 20 April 2017 and the first day was unannounced. The inspection was carried out by one adult social care inspector.

Prior to the inspection we reviewed information we held about the service. This included notifications the provider is required to send us in relation to safeguarding, serious injuries and other significant events that occur within the service. We reviewed the previous inspection report and the registered provider/manager action plan and any information shared with us about the service through our contact centre.

We sought feedback from the local authority quality assurance team, the clinical commissioning group (CCG) medicines management team, Stockport Healthwatch and the local authority health protection nurse. We received feedback from the quality assurance team and CCG medicines management team and no concerns were raised. We used the information received to help plan our inspection.

The provider was not requested on this occasion to provide a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with four people who used the service, a visiting relative, a visiting hairdresser the registered manager, the deputy manager, a visiting district nurse, a visiting health and safety officer and three care workers. We also spoke via telephone with a manager from the water treatment company the home commissioned to gain an update about a routine legionella inspection at the home.

We looked at the care records that belonged to three people who used the service, three care worker personnel files, records relating to how the service was being managed such as safety audits, records of training and supervision, records of maintenance servicing and quality assurance.

Good

Is the service safe?

Our findings

At our last inspection in July 2016 we found there were not enough care workers on duty to meet the needs of 18 people living at the home. At this inspection we saw care worker levels had not increased since our previous inspection. Care workers were still responsible for the housekeeping tasks, such as meal preparation, cooking, laundering, ironing and cleaning in addition to their daily care tasks. However when we looked at care worker arrangements for the following two weeks we found that whilst care worker levels were unchanged the ratio of care workers to service users was sufficient to safely meet the needs of the 12 people living at the home. This was confirmed when we checked the staff roster. The registered provider/manager told us they would increase the care worker hours and in addition to this they would recruit a cook and laundry assistant when service user numbers increased. They told us that any increase in care worker hours would be determined on the needs and dependency levels of people who used the service. At the time of the inspection 11 people using the service were able to manage their own personal care safely and required no assistance with their mobility. Risk assessments were in place for people who were at risk of falls. Only one person required assistance with their personal care and mobility and required minimal care worker assistance. People we spoke with and a visiting relative told us they felt there were currently enough care workers to meet people's needs.

At our last inspection in July 2016 we found the registered provider/manager had not taken action to rectify some areas in connection with risk assessments, Legionella checks, fire safety and infection control. At this inspection we found the registered provider/manager had made improvements in these areas. We found that checks on water and related equipment such as for hot and cold outlet temperature and weekly flushing of the water system and shower head sterilisation checks were being completed and recorded. During the inspection we telephoned the water treatment safety contractor who confirmed that that a completed Legionella risk assessment had been finalised and the current water system risk assessment score had reduced the risk level from high to medium and was confirmed via an email to the registered provider/manager. They told us this was within acceptable limits due to the size and function of the building. This meant the risk of people contracting legionella disease was reduced.

At our last inspection in July 2016 we identified concerns in relation to cross infection. At this inspection we saw that the registered provider/manager had made improvements in this area. We saw care workers had access to personal protective equipment (PPE) to help reduce the risk of cross infection and was being used when providing personal care to people. Care workers we spoke with told us about the importance of good hand hygiene and they knew to use disposable gloves and aprons provided for them. This helped to protect them and people using the service from the risk of cross infection whilst delivering care. They were aware of the need to make sure they used the protective equipment available and confirmed to us there was always plenty of PPE available for staff to use.

The deputy manager was responsible for making sure health and safety audits were carried out on a regular basis for areas such as doors, lighting and heating. Records indicated that fire equipment checks and fire drills were carried out frequently. We examined records that showed regular checks had been undertaken for electrical appliances and portable appliance testing. We saw environmental risk assessments had been

undertaken using a system for documenting and recording any maintenance work required.

We found that a new toilet stand aid had replaced one which was rusty. Risk assessments for windows and steps leading to the garden had been carried out. All reachable windows in the home were fitted with secure window locks and a hand rail was fitted to the garden steps to provide additional safety measures for people using the service. We visited the laundry area located in the cellar and saw that the laundry door had been fitted with a key coded lock. We saw that the laundry room and the food storage room had been redecorated; all walls were damp/mould free, new washable shelving was in place to store food and people's clean laundry in each room and flooring in both rooms had been painted with washable impermeable paint. All rooms were fitted with a key coded lock, this included a cellar room used to store a filing cabinet which housed archived records. We saw health and safety audits were carried out on a regular basis and a designated care worker carried out regular checks on windows, doors, lighting and heating. Records indicated that fire equipment checks and fire drills were carried out frequently. We examined records that showed regular checks had been undertaken for electrical appliances and portable appliance testing. Environmental risk assessments had been undertaken using a system for documenting and recording any maintenance work required. During the inspection a visiting health and safety officer carried out a health and safety inspection and was satisfied these areas had been made safe and risks to people were minimised.

When we visited the kitchen we found that the large storage cupboards were still being used to store people's records and other information in relation to the homes policies and procedures. However the registered provider/manager told us that whilst these cupboards had always been used to store paper records, this area of the kitchen was not at any time used to prepare food. We saw that an adjoining kitchen was used for meal preparation and cooking food and this did not pose a risk of cross infection or food contamination to people. When we spoke to care workers they confirmed that food was always prepared and cooked in the adjoining kitchen whilst crockery and cutlery were always washed in a sink located at the far side of the kitchen away from the cupboard that stored people's records. When we walked around the building we saw that cleaning fluids and cleaning equipment were stored within a locked cupboard that could only be accessed by an authorised key holder. Mops, buckets and floor brushes were colour coded to make sure such equipment was only used in identified colour coded areas in the home. This system helped to prevent cross contamination during the cleaning process and formed part of the care workers training programme.

At our last inspection in July 2016 we identified concerns in relation to the safe storage of excess medicines which were being stored on shelving inside a locked office. At this inspection we found the registered provider/manager had made improvements in these areas. We saw that any excess medicines were stored in a second medicines trolley that was kept locked in a locked office. We examined the systems in place to monitor the way medicines were being managed at the home and to ensure people received their medicines safely. We saw records to show medicines delivered to the home were checked by two care workers, one being the deputy manager and prescriptions were checked before being dispensed. We saw medicines, skin creams and medicines prescribed to be taken as and when required medicines had been appropriately recorded on individual medication administration records (MAR) and there were no missing signatures. An up to date list of authorised medicine handlers (care workers) was in place and had been signed by designated care workers. The deputy manager carried out care workers medicine administration spot checks and we saw records to show all care workers designated to administer medicines had undertaken a medicines competency assessment. This meant risks associated to the management of medicines were reduced. A medicines policy was in place to provide guidance and help to ensure the safekeeping and administration of medicines. This had been monitored and reviewed and included information about supporting people to self administer their own medicine. We saw instructions for care

workers to observe the person whilst they self-administered their insulin via injection. A risk assessment to identify any risks associated with this particular activity, a care worker observational record chart, signed medication administration records (MAR) and a body map chart to record any skin changes were in place. Three people who used the service confirmed their medicines were administered on time and this was confirmed when we observed a medicines round being undertaken in the home.

We saw systems to help protect people from the risk of abuse were in place. The service had a safeguarding policy and procedure which was in line with the local authority's 'safeguarding adults at risk multi-agency policy'. This provided guidance on identifying and responding to the signs and allegations of abuse. We looked at records that showed the registered provider/manager had suitable procedures to help make sure any concerns about people's safety were appropriately reported. The registered provider/manager, deputy manager and care workers spoken with were knowledgeable and confident about the services safeguarding procedures. They were able to give a good account of the risks associated to vulnerable adults, the safeguards in place to minimise these risks and explain how they would be vigilant about poor practice in order to recognise and report suspected abuse. They confirmed they had received safeguarding and whistleblowing training and shared their understanding of the service's whistleblowing policy (the reporting of unsafe and or poor practice by care workers) They told us they would contact the registered provider/ manager or deputy manager to inform them about any concerns. Care workers training records showed they had received training in both topic areas.

An accident and incident policy and procedure were in place. Records of any accidents and incidents were recorded, reported appropriately to the Care Quality Commission and the local authority adult social care team and analysed to check if there were any reoccurring themes. Records to show all of the people living at Drakelow House had a Personal Emergency Evacuation Plan (PEEP) were in place. These plans detailed the level of support a person would require in an emergency evacuation situation such as a fire evacuation. We saw records to show that all care workers had undertaken fire safety training at regular intervals.

A recruitment and selection procedure was in. We looked at three care worker personnel files and found that they had been recruited in line with the regulations including the completion of a disclosure and barring service (DBS) pre-employment check and at least two recent references from previous employers. Such checks help the registered provider/ manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable adults. All care workers were issued with an employee handbook which contained information about Drakelow House policies, procedures and the organisational expectations of care workers. We spoke with three care workers who described their recruitment to the service. They told us that after completing an employee application form, they were invited to attend a face to face interview to assess their suitability for the job. Following a successful interview the registered provider/manager carried out the necessary pre-employment checks which included proof of the employee's identification (ID) and two references, one from a recent employer. When we examined three care worker recruitment records we saw evidence that care workers were not assigned any work until the appropriate ID, references and clearance from the DBS had been received and found to be satisfactory.

We examined the care records that belonged to three people. The care records showed that risks to people's health and well-being had been identified. Risk management plans in relation to people's daily living routines were also in place and were linked to the person's care plan. For example, where there was a high risk of dehydration to a person their risk management plan clearly showed the factors which might increase the likelihood of the risk occurring and the action care workers should take to reduce the risk. Care workers spoken with understood their role in relation to people's identified risks and what to do should the risk occur.

Good

Is the service effective?

Our findings

At our last inspection in July 2016 we found there was a lack of evidence that care workers training, supervision and appraisals were taking place. At this inspection we found the registered provider/manager had made improvements in this area and was meeting the requirements of the regulation. We saw there was an ongoing annual care workers appraisal and supervision system in place. Care workers we spoke with confirmed they received supervision at least every four months and an annual appraisal. Care workers supervision records examined detailed a record of notes taken and the dates for individual supervision sessions had taken place. Care workers we spoke with told us during their supervision session they spoke about the care provided to people and planned training. This provided care workers with the opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. They told us they had undertaken a full employment induction before starting work at Drakelow House and they told us they were given a five day mandatory induction that covered topics such as fire evacuation, safeguarding, food hygiene and infection control. This induction was followed by a five day period of shadowing (working under the supervision of an experienced care worker) within the home. This gave the new care worker the opportunity to get to know the people who used the service. A probationary period of four weeks could be extended if the care workers performance did not meet expectations or the care worker felt they required additional time to develop their skills.

The registered manager/ provider told us that National Vocational training in Health and Social care and induction training provided via the Care Certificate would be put in place and undertaken by new care workers at the home. We saw training certificates to show existing care workers had received training appropriate to their role. This helped to make sure people received safe and effective care. The Care Certificate is a professional qualification that aims to equip health and social care workers with the knowledge and skills they need to provide safe and compassionate care.

The registered provider/ manager told us that training would be arranged for care workers where it was identified particular skills and knowledge would help them to meet people's specific health and wellbeing needs. This was confirmed when we examined three care worker training records which showed they had undertaken training in dementia awareness which helped to support people who were in the early stages of dementia. Care workers we spoke with said, "The refresher training has been good since the last CQC inspection. We've had refresher training in infection control, fire awareness and moving and handling". When we spoke with people who used the service they were complementary about the care workers and their ability to provide them with the care and support required. One person said, "It's a lovely place. The care workers know what they are doing".

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care

homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered provider/manager told us that DoLS were not required for any person currently living at the home, and therefore no DoLS applications had been submitted. We saw the care workers learning and development plan had identified where care workers required refresher training in this topic and dates were planned for this training to be undertaken. The registered manager and care workers were knowledgeable about the MCA and the need to carry out mental capacity assessments for people who required them.

The service supported people with varying levels of support needs ranging from people being able to mobilise around the home unsupported to one person who required support to mobilise using a walking frame. Care workers we spoke with had a good understanding of how and why consent must be sought to make decisions about specific aspects of people's care and support. A care worker said, "We always ask the residents how they want us to help them. We never assume we always ask". The registered provider/manager told us that where consent from people could not be sought they would always approach the person's relative where a lasting power of attorney (LPA) was in place or arrange for a meeting to be held with appropriate professionals in attendance. LPA is a legal document that lets the person appoint one or more people (attorneys) to help make decisions on their behalf. Types of LPA can relate to health, welfare, property and financial affairs.

We saw people had choices about what they wanted to eat and where required they were assisted or supported to eat their meals with prompts from care workers. Dining tables were set for each meal time and where people preferred to eat in their rooms they were supported to do so. We examined the menu and saw that a variety of meal options were available at different times of the day. We saw the meals served were well presented, looked appetising and nutritionally balanced. Care records and daily records we examined showed attention was paid to people's dietary requirements and what they ate and drank. We examined a person's weight record which indicated the type and amount of food they had eaten. This meant people's nutrition and hydration was monitored to ensure their nutritional needs were being met. People we spoke with told us that they enjoyed the meals served. They said, "The food is very nice, we can have what we want and there's always enough" and "There's always plenty of drinks, tea and juice and the food is excellent".

Care records showed people had access to external healthcare professionals, such as hospital consultants, specialist nurses and general practitioners (GPs). Notes of such visits were included in people's care plans. Other care files showed attention was paid to people's general physical and mental well-being, including risk assessments to identify where people were at risk of for example, developing pressure sores. Care records that recorded people's weight, dental and optical checks were also in place and reflected the care being provided to people.

When we walked around the home we saw the design and layout of the home were suitable to accommodate the number of people using the service. There was sufficient suitable equipment in place to promote people's mobility such as handrails and wheelchairs. Shared toilets, showers, bathrooms and lounge areas had signage which assisted people to navigate around the home safely. Appropriate raised seating was provided and pressure relieving cushions were well maintained and in good condition. Corridors were clutter free and wide enough for wheelchairs and other mobility aids to manoeuvre adequately. At the time of the inspection nobody required the use of a wheelchair inside the home. However a small number of wheelchairs were available for people who had been assessed to use them, with support from their relatives when outside of the home. The service maintained a homely environment to enable people's planned activities and routines to be supported effectively by care workers.

Good

Is the service caring?

Our findings

People who use the service told us they were happy living at Drakelow House and felt they were receiving good care and support from the care workers. When we spoke with four people they collectively made positive comments about the care workers team, their approach and their attitude towards them. They said, "The care workers are wonderful and if you've got to be in a place, this place is wonderful" and "The care workers are lovely here. It's just like home from home. You couldn't get any finer" and "You never see care workers in an angry way, they always say 'let's talk about it' and "The care workers are pleasant, kind and polite, they have pride. [Care workers] has a presence about her. Watching her is like poetry in motion".

We saw care workers had developed a good rapport and understanding of the people who used the service and treated the people and their belongings with respect. Care workers understood people's particular communication styles and how to interact positively with them. Where one person had difficulty communicating we saw that care workers remained patient and took time to listen to them in a respectful way which helped promote the persons dignity. We observed good interpersonal relationships between care workers and people who used the service. For example during our observations over lunch time we saw care workers showing warmth and empathy towards people and when they were serving meals, always asking if people were enjoying their food and if they had eaten enough. Care workers interacted with people well, they shared friendly conversation with people and we observed them laughing and joking with people whilst escorting them to their appointment to see the visiting hairdresser. On their return from the hairdressers we heard care workers make complimentary and flattering comments about people's hair styles.

Care records showed and we observed that people were encouraged to remain as independent as possible, and care workers supported people to manage tasks such as maintaining personal care and mobilising around the home within their capabilities. Care records examined had been written with empathy and understanding of people's individual needs. For example one care record described why a person preferred to spend time in their room. Another care plan described that a person required 'gentle support' to mobilise using of their walking frame. Throughout our inspection we saw evidence within people's care records that there was a culture of promoting and maintaining people's independence wherever this was possible. When we spoke with three care workers about people's identified needs they were able to show they knew people very well and gave examples of how people preferred their care and support to be given. We saw these details had been accurately reflected in people's care plans which showed the care workers had a good understanding of individualised care.

The registered provider/manager and care worker team were aware of how to link in with a local advocacy service to ensure that people who did not have any relatives living nearby had someone they could turn to for independent advice and support when needed. An advocate is a person who represents people independently of any government body. They are able to assist people in ways such as, writing letters for them, acting on their behalf at meetings and/or accessing information for them.

The registered provider/manager told us that whilst nobody living at Drakelow House was currently receiving End of Life (EoL) care they would always contact the National Health Service (NHS) EoL

coordinator who specialised in palliative care (care for the terminally ill and their families) when necessary. We saw records that confirmed care workers had undertaken training in this topic and the registered manager/provider was awaiting confirmation of refresher training for care workers. We looked at the home's end of life care policy and procedure which was person centred and geared towards helping the person, and their relatives to have full control about decisions relating to the person's future care and end of life needs. A visiting district nurse said, "We haven't been involved in EoL at Drakelow House for about four years. At that time the person remained at this home and the staff were very supportive in making sure the person stayed here until the end of their life. That was what the person wanted. We have an EoL coordinator who is scheduled to provide refresher training in this subject and how staff can recognise the stages of decline".

Records showed and people's relatives we spoke with told us they were involved in decisions about the person's care. We saw that peoples care records were reviewed frequently and where possible had been signed by the person living in the home or their relative where a Lasting Power of Attorney (LPA) was in place. This showed they had been involved in the decision making process about the care provided. LPA is a legal document that lets the person appoint one or more people (attorneys) to help make decisions on their behalf. Types of LPA can relate to health, welfare, property and financial affairs.

We saw that all records and documents were kept securely in locked cupboards accessible only by designated key holders and no personal information was on display. This ensured that confidentiality of information was maintained.

Good

Is the service responsive?

Our findings

At the last inspection in July 2016 we found there was not always access to meaningful activities to support people's social and psychological wellbeing. At this inspection we found the registered provider/manager had made improvements in this area and was meeting the requirements of the regulation. We saw a timetable of daily activities was displayed on the home's notice board and available for people to access. Activity topics such as afternoon tea, armchair exercise and classic films were listed. Activities were led by the care workers and people could choose to take up their own activities and interests not listed on the timetable if they chose to do so. During the inspection we saw that all of the 12 people living at Drakelow House had chosen not to be involved in the activities available at the time of the inspection, a discussion group about current and previous lives, family work, pets and current affairs. We saw some people leaving the home with their relatives and other people were visited by relatives and friends at the time an activity was taking place. We saw that people were enabled to use the services of the visiting hairdresser in preparation for their planned activity out of the home. All of the people we spoke with indicated they were satisfied with the activities that were being provided. However when we spoke with three people about their choice of activities they said, "Sometimes there's an entertainer, but I never stay to watch. I like staying in my room, watching the TV or reading a newspaper. My daughter visits regularly and we go out for a run in the car" and "I like to stay in my room, it's lovely. I have everything that I need in here. There's always somebody to talk to if I want to" and "This is home from home. You couldn't get any finer. I'm ok just resting and I can talk to the girls [care workers] they're lovely". The deputy manager said, "It can be quite a task getting people involved in the activities we provide. People prefer to rest, read or they go out with their relatives. Not all people want to take part, so we encourage them where possible". We saw where people had taken part in activities inside and away from the home this information was recorded in their care records.

A visiting relative said, "When [Person's name] moved in to Drakelow House they were in physical decline. [Person's name] is ok here. Their mobility has improved because the staff very kindly push [person's name] to stay independent and mobile. They [care workers] are great. They observe [person's name] when [person's name] is taking their insulin. [Person's name] won't take part in the activities, they love their room, it's a large room with an ensuite, they're very comfortable. Staff know him well and [person's name] is settled here".

People's needs had been assessed before they moved into Drakelow House. The needs assessment was used to complete the care plan which enabled the person to be cared for in a person centred way. Records showed care workers used the information to develop detailed care plans and any support records that would identify people's abilities and the support required to maintain their independence. Assessments showed people and their relatives had been included and involved in the assessment process wherever possible. Care plans were reviewed annually or more frequently if the person experienced any health changes. They contained a detailed personal history and gave clear guidance for care workers to follow. For example instructions for care workers to observe a person whilst they self-administered their insulin via injection responded to the person's immediate health care needs and helped to maintain their daily routine and independence. We saw a risk assessment to identify any risks associated with this particular activity, a care worker observational record chart, signed medication administration records (MAR) and a body map

chart to record any skin changes were in place. In addition to this we saw emergency instructions for care workers to follow should the person experience hypoglycaemia. Hypoglycaemia occurs when the level of glucose present in the blood falls below a set point. The person was also supported by the district nurse who carried out regular injection site skin checks to ensure the person maintained good skin integrity. Notes taken at each skin check were recorded in the district nurse's records which were then recorded in the persons care records by care workers.

We examined four care records which contained clear information about each person and sufficient detail to guide care workers on the care and support to be provided. They contained relevant information about people's health diagnosis and associated needs such as nutrition and hydration assessments. Care records included information about people's mobility, moving and handling, tissue viability and social values. They included the person's emergency contact details such as their next of kin, and General Practitioner (GP) their current support needs, the care to be provided and the desired outcome following the care provided. People's weights were recorded monthly if necessary and a body map to record and highlight any bruising or injuries sustained, was kept in the persons care record. This meant care workers could respond appropriately to help make sure people's health and wellbeing were being appropriately responded to and maintained.

Person centred care reviews were held annually or more frequently if necessary and involved the person who used the service, their relatives, a health / social care professional and a care worker. Where issues were identified such as changes to the person's care these were noted and follow up action recorded. Care workers spoken with were aware of the importance of the care review system and understood information about the person was reviewed to make sure it fully reflected their current support needs. A relative of a person who used the service said, "I visit [person's name] a few times a week and take them to their hospital appointments. They [care workers] tell us everything we need to know about [person's name] and this helps us feel involved in their care". Care workers we spoke with said, "This home has a lovely atmosphere and we try our best to meet people's needs", and "You've got to like this kind of work and we all do", and "We want our own parents to be treated the way we treat the people who live here at Drakelow House" and "I enjoy coming to work it's a fulfilling job".

When we spoke with the visiting district nurse they told us about the care provided to people and said, "I've been coming here for 10 years. Most people here are fully self-caring and mobile. Nobody requires the use of a hoist to mobilise. The residents are always clean and tidy and well-presented and the ladies always have their hair done. There are always drinks available whenever people want them. The staff are very quick to contact us if there are any issues they are concerned about. Such as somebody acquiring a skin tear. The staff meet people's needs very well".

A complaints policy was in place. People spoken with told us they knew how to make a complaint if they needed to and guidance telling people how to make a complaint was displayed on the notice board in the vestibule of the home. The complaints policy in place allowed for a full investigation into the complaint and for all complaints to be taken seriously. The policy allowed complaints to be escalated to the local government ombudsman if the complainant remained dissatisfied with the outcome. We reviewed a selection of complaints the service had received over the previous 12 months and noted that a complaint about a missing item of clothing had been addressed immediately by the registered provider/manager who had followed the services complaints process. Actions had been recorded and the complaint resolved to the person's satisfaction.

Good

Is the service well-led?

Our findings

A registered manager was in place at the time of our inspection. 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 registered manager who is also the registered provider was present during both days of the inspection.

At the last inspection in July 2016 we found we found that quality assurance needed to be improved and there was no recorded evidence of the provider's oversight and management of the service. Records and audits had not been kept up to date for the safe and proper management of medicines, staff training and supervision, infection control and Legionella water checks. At this inspection we found the registered provider/manager had made improvements in this area and was meeting the requirements of the regulation.

We saw completed records were now in place to monitor the competency of care workers responsible for administering medicines. Since the last inspection the deputy manager had carried out care worker medicine administration spot checks. We saw records to show that care workers designated to administer medicines had undergone a medicines competency assessment which was carried out by the deputy manager. The registered provider/manager and deputy manager had planned to undertake a medicines competency assessment on each other before the end of April. This meant risks associated to the management of medicines were reduced.

We saw that a care worker learning and development matrix was in place. The matrix identified what training care workers had undertaken and the training topics scheduled for the coming months. We saw that all care workers had been listed to receive refresher training in end of life care and infection control by the end of January and April 2017. However the training provider had cancelled both planned training session and the provider was awaiting confirmation dates from the local authority end of life coordinator. The deputy manager said, "This training will probably be better because the EoL coordinator is a specialist in this area". This meant the registered provider/ manager had identified areas where additional training was required, and had taken steps to ensure training that met specific learning needs was provided.

Following our last inspection in July 2016 it was apparent that the management oversight of the service had been improved. The registered provider/manager was part of the working staff team and worked at the home most weekends and some evenings. They and the deputy manager had introduced systems to oversee that good practice and quality of the service was maintained. Action had been taken to address the breaches found at the last inspection and the provider was now meeting the requirements of these regulations.

We saw recent audits on reporting systems such as accident and incident reporting and environmental risk assessments were in place. These showed where improvements were needed and what action had been taken to address any identified issues. This helped to ensure any trends or patterns which might emerge

were identified and addressed. We examined these records which showed there had been no identifiable patterns in the last 12 months. We saw records that showed health and safety audits were carried out on a regular basis were up to date and complete. These systems helped to protect care workers and people who used the service from the risk of cross infections.

Staff meetings were held infrequently due to there being a small staff team and a lack of care worker availability at the same time. However the staff team utilised a communications book to share information and a thorough care worker duty handover system was in place. This meant care workers were responsible to ensure their communication was effective and supported the sharing of pertinent information and instruction between themselves about the service they provide to people.

Meetings for people and their relatives had been reinstated and were planned in advance. However the deputy manager told us that these meetings had not been well attended and therefore they had sought to gather people's views and opinions using different methods such as individual discussions during people's care reviews/ care interventions and chatting to people at mealtimes. We saw that notes of these discussions were recorded in people's care records.

At the time of the inspection the deputy manager was in the process of receiving completed quality assurance questionnaires from people and their relatives. They told us this was an ongoing process and they addressed any comments immediately with the respondent. We saw a 2015 summary of comments and compliments had been collated. A comment made by a visiting relative suggested the home should consider setting up a website as this would be helpful. The registered provider/manager told us they were considering this along with investing in new information technology for the service. Following the inspection the deputy manager informed us that the home had purchased a new laptop and were now looking into a creating a website for the service.

Care workers we spoke with told us they had confidence in the management team and found the registered provider/manager to be very approachable and supportive. They said, "If you have a problem [registered provider/manager] will help you", and "The deputy manager is excellent, they're efficient and they try their best" and "We're like a family here". People who used the service and their relatives spoke highly of the registered provider/manager, the deputy manager and the care workers. People said, "If I had any problems I would go to the manager without fear or favour, there's no better" and "The manager has a presence about her, they know what they're doing" and "I can't find fault with any of them [management]. It's wonderful. A relative spoken with said, "I really can't fault the managers, anything I want to know they will tell me. The management team are very approachable".

Before this inspection we checked our records to see if appropriate action had been taken by management to ensure people were kept safe. We saw that the registered manager had made appropriate notifications to the Care Quality Commission as required.