Drake Court Health Care Limited

Drake Court Residential Home

Inspection report

Drake Close
Bloxwich
Walsall
West Midlands
WS3 3LW
Tel: 01922 476060
Website:

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Ratings

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

Overall summary

We carried out an unannounced inspection on 14 October 2014. During our last inspection on 11 September 2013, we did not identify any concerns.

Drake Court provides accommodation and support for up to 29 people who may also have a dementia related condition. At the time of our inspection, 26 people used the service.

There was a registered manager at Drake Court. 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.

Summary of findings

Some parts of the home had not been suitably maintained to ensure the environment was safe. We needed to inform the registered person to provide immediate work to the office area during our inspection to ensure the building was safe. The provider had not taken action previously, although they were aware of the concern.

The home had not been adapted to meet the needs of people with dementia or people who had a visual impairment. This meant some people needed support from the staff to move around the home to keep safe.

Recruitment checks were carried out to ensure staff were suitable to work with people who used the service. We saw there were sufficient staff to meet people's assessed needs and systems were in place to ensure additional staff were available to cover annual leave or sickness.

People who used the service were able to make decisions about their care. The staff had received training and demonstrated a good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty safeguards (DoLS). This would ensure that where people were no longer able to make decisions, these would be made in their best interests. Nobody who used the service was subject to any restraint or were being deprived of their liberty.

Staff received training although we saw this was not always effective. We saw people were not always supported to move safely.

Staff cared for people respectfully. People told us the staff were kind and supported them in a dignified manner. People were satisfied with the care they received and how this was delivered.

People were provided with opportunities to engage in activities in the home and the community according to their interests. People were supported to attend religious services at their usual place of worship.

People were able to raise concerns and were confident that suitable action would be taken.

You can see what action we told the provider to take at the back of the full version of the report.

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?
This service was not consistently safe.

Parts of the home had not been maintained to ensure people were not placed at risk.

The environment had not been adapted to meet the specific needs of people with dementia or visual impairment to support their independence

There were sufficient staff to meet people's identified needs.

Requires Improvement

Is the service effective?
The service was not always effective.

The staff did not always receive the training necessary to support people with moving and handling.

People's health and wellbeing was and monitored and staff worked with other professionals to ensure people received the care they wanted.

People were able to make decisions and were not subject to any restrictions.

Requires Improvement

Is the service caring?
The service was caring.

Care was provided with kindness and compassion. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well. Staff took an interest in people and their families to provide individual personal care.

Good

Is the service responsive?
The service was responsive.

People were able to engage in hobbies and interests of their choosing in the home and the community.

People were supported to practice their religious beliefs and attend places of worship.

People knew how to complain and any complaint was responded to appropriately.

Good

Is the service well-led?
The service was not always safe.

Requires Improvement

Summary of findings

The provider did not have systems in place to identify environmental concerns or to take necessary action.

Audits were completed for care provision which identified concerns and changes to people's care were made to reduce any risk.

People told us the manager was approachable and listened to any concerns an their views about the service.

Drake Court 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 October 2014 and was unannounced.

The inspection team consisted of two inspectors and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who used this type of care service. The expert had experience of caring for older people within people's own home and within a residential care setting.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also checked the information we held about the service and the provider. This included the notifications that the provider had sent to us about the care and information we had received from the public and the local authority. We used this information to formulate our inspection plan.

We spoke with 12 people who used the service and three relatives. We also spoke with two nurses, four members of care staff, the cook, the registered manager and operational manager. We carried out an observation of care practices over the lunch time period and shared a meal with people who used the service.

We looked at four people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, health and safety checks, staff rotas, training records, three staff recruitment files and questionnaires that had been sent to people who used the service and stakeholders.

Requires Improvement

Is the service safe?

Our findings

When we arrived at the service there was water dripping from the ceiling of the office and down the walls. The damage to the office indicated this had been a long standing concern and the staff confirmed this. We were concerned about the safety of people, as water could be seen dripping by electrical cables and sockets. To ensure people's safety the registered manager agreed to contact the provider and an electrician was contacted to visit that day. We also saw the floor within the lift was uneven and the rubber flooring was torn causing a potential hazard to people. The staff confirmed the provider was aware of the concerns within the environment but had not taken action to make the improvements needed.

This meant there had been a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Adequate maintenance had not been carried out in the home by the provider to protect them against the risks of an unsafe or unsuitable premises.

The home accommodated some people who had dementia related conditions. The bedroom doors were of the same colour and design with people's name written on them and the building was not designed to help people orientate themselves around the home. We saw people walking along the corridor and staff had to show them which room was their bedroom. Some people had a visual impairment and they told us one person liked to remain as independent as possible. We saw they needed to be supported to their room to ensure their safety as the environment had not been adapted to meet the needs of people with a visual impairment with tactile aids to guide the person.

The main lounge was divided into three seating areas, each with a television. It was difficult to speak with some people as the televisions were loud. One person told us, "It's worse at night when we watch different things. We do try and turn it off when no one is watching so it's a bit better." One relative told us that the way the lounge was organised, "Encouraged people to interact." Another relative said, "I like the set up as it encourages people to interact." We spoke with staff who told us, "Sometimes it does get difficult. It's better when we have the main screen and show films as everyone watches the same screen. We also have the new small lounge. If people want a quieter area, we encourage people to use that room instead."

We observed one member of staff administering people's medicines. People were given a drink and time to take their medicines, whilst the staff member stayed with them to ensure these had been taken before recording this. People we spoke with told us they were confident they received their medicines as prescribed. One person told us, "I know I have my tablets twice a day and what they're for. They never forget about me."

A new medication system had been introduced the month prior to our inspection. The medication administration records (MAR) included a picture of the medicine to help staff identify each tablet within the blister pack. We saw there were no gaps in the MARs which matched the medicines dispensed from the blister pack. For two of the medicines, people only required half of the dispensed tablet. The staff told us that they broke these in half and replaced the unused tablet back in the strip. This meant this was no longer sterile and was not stored safely. The staff agreed to review the dispensing of these tablets.

The staff told us they were made aware of changes to care and we saw assessments of risks were reviewed each month with people who used the service. One person we spoke with told us, "I sit down with the staff and we read through everything. They always ask if everything is okay and if it's what I want."

We saw that where people were involved in any accident these were monitored on a monthly basis. One person had a high number of falls in one month and this concern had been identified through the audit. A referral was made to the falls prevention team to support the person and reduce further risk of harm. One member of staff told us, "We always look at what we can do to help people when we see they keep falling."

The people we spoke with said they were happy with the care and support they were receiving and the staff were responsive to their needs. We saw one member of staff was available in the communal part of the home to ensure people were supervised and remained safe. One person told us, "The staff are always around here. They're always asking us if were okay and if we want anything. The staff here are lovely." Another person we spoke with told us, "I feel safe because the staff care for you. They never see you alone." The staffing levels were sufficient for the number of people living in the home which allowed staff to provide personal care in a timely and unhurried way.

Requires Improvement

Is the service safe?

We looked at the recruitment checks that were carried out for staff that had been recently recruited to the service. We saw that there was a system in place that ensured staff were suitable to work at the service. Staff told us that they had visited the service and underwent an interview to assess their suitability to work with people before checks, including checking references and a Disclosure and Barring Check (DBS). One member of staff told us, "I started working after I had my papers back. I knew I had to wait to make sure everything was okay before I started here."

We talked with staff about how they would raise concerns about risks to people and poor practice in the service. Staff told us they were aware of the whistleblowing procedure and they would not hesitate to report any concerns they had about care practices. One member of staff told us, "I've done it before and wouldn't hesitate to do it again. You can't do this job if you close your eyes to what's happening." The staff told us they had also received training to recognise harm or abuse and felt they would be supported by the management team in raising any safeguarding concerns. One member of staff told us, "We have all the details in the office, who to contact and what to do. We wouldn't wait to report anything we felt should be reported."

Requires Improvement

Is the service effective?

Our findings

We saw two examples where people were moved using a moving and handling belt. This equipment was used to support people to transfer from their wheelchair to a chair. We saw one person was placed on the edge of the seat because there was insufficient room to manoeuvre them with the equipment used. Another person had difficulty moving their feet and the transfer did not support them to continue to weight bear. Staff we spoke with told us training was provided through 'distant learning' courses or from other members of staff. Some staff we spoke with told us they were not confident they were delivering the care according to the most recent best practice guidance. One member of staff told us, "We have had training and we sometimes have to do the best we can as there's not enough room. We do our best." This meant there had been a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. People had not been protected against the risks of receiving care that was inappropriate or unsafe.

The care records contained information about health concerns and how these were being met. One person told us, "They don't mess around here. If you're ill, the doctor visits. They never make you feel like you're putting them out." One relative told us, "The always let you know when something is happening. The staff know I like to go to appointments with my mum. It's good that we are still involved."

We saw the staff completed records to help them to identify changes in people's health and wellbeing. One person needed a detailed record to be kept of what they drank and ate to ensure they were not at risk of malnutrition. We saw a record was maintained and reviewed by the staff and health care professionals. We spoke with a community matron who told us, "I can't fault the staff. They record everything about what's been eaten and drunk so we can review the care plan. They follow instructions and never hesitate to call if they're worried about anything. We have a very good relationship."

We shared lunch with people who used the service and observed how people were supported. Staff were attentive to how much people ate and ensured they were offered drinks throughout the meal. One person we spoke with told us they had diabetes. They told us, "The staff know what I should and shouldn't eat and they never forget." Another person had a visual impairment and was provided with equipment to eat independently. The person was not informed where food was placed on their plate and said, "I thought I was eating parsnips but its carrots." We spoke to the registered manager about how the person could be supported, and aids and adaptations that could be used to promote their independence and enhance the quality of care provided.

People we spoke with told us they were happy with the standard of the food. There was a menu displayed in the dining room which people told us they could see to read. People told us they liked the food that was prepared. One person said, "Whatever they cook is always nice. I've never had to complain. I couldn't cook better myself."

The registered manager and staff told us that people who used the service were able to make decisions about their own care and were aware of how to respond where people no longer had capacity to make decisions. The Mental Capacity Act 2005 (MCA) sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. There were no persons who were unlawfully subjected to any restraint or deprived of their liberty. The MCA Deprivation of Liberty Safeguards (DoLS) sets out how applications are to be made and individual orders include conditions that providers must follow to ensure people receive effective agreed care. The staff had received training in this area and could explain what this Act meant for people who used the service. One member of staff told us, "Just because people have dementia doesn't mean people can't make decisions. When we do people's reviews, we read things with them and ask about everything so we know they understand and it's what they want."

One person had a do not attempt to resuscitate order in place (DNAR). A community matron and staff confirmed the person had capacity to make this decision. The guidance for completing the form gave clear instructions on how to proceed where people had capacity although there was evidence of others views rather than the person with capacity. The DNAR form recorded that the decision was not to be reviewed. Best practice guidance from The British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing recommends that decisions should be reviewed with appropriate frequency and when circumstances change.

Requires Improvement

Is the service effective?

We recommend that the provider reviews DNAR decisions in line with guidance from The British Medical Association, The Resuscitation Council (UK) and the Royal College of Nursing.

Good

Is the service caring?

Our findings

People we spoke with told us they were happy with the care provided and one person told us, "The care here is good, very good. Nothing is too much trouble for the staff." A relative told us, "It's very good. All the staff know [person who used the service] and their ways." Another relative told us, "I've a good feeling about the place. The staff are friendly, open and welcoming. [Person who used the service] was comfortable as soon as they came here." We saw that staff had good relationships with people who used the service and people were relaxed in the presence of staff.

We observed interaction between staff and people who used the service. We saw staff were kind and sensitive. One member of staff spoke with a person and commented that they looked tired that day and asked if anything was wrong. We saw they spoke about how they felt and what they could do to support them. We later spoke with this person who told us, "They always notice the little things and always want to make sure we're alright."

A rapid response nurse contacted us to speak about the care provided by the staff. They told us, "The care is absolutely super and first class." They told us the people they visited were well cared for and the staff also supported the family. They told us during their visits, they saw that people were happy and well cared for and care was provided appropriately.

People told us that staff respected their privacy and dignity and provided sensitive care. We saw staff speaking discreetly to people when asking about personal care needs. One person told us, "The staff give me the time I need to look after myself. They don't treat me like a child and do everything for me. I still get to wash myself and the staff give me the time. I haven't got to the stage where I need them to do everything for me. It's good they let me carry on whilst I can."

Care records contained life histories which gave details about the person's background and people important to them. One member of staff told us, "It's important we do these and it's so interesting. We like to know about people and it's good to know about people's lives. We talk to people about this whenever we can."

People were able to make choices about how they spent their time and what they did. One example we saw was a member of staff encouraged a person to sit in a different chair that would be more comfortable for them. The person told the staff member that they wanted to stay where they were. We saw the staff respected the person's decision to stay in that chair but fetched a cushion to give some support and help them to sit more comfortably.

We saw that people were given choices. For example, one person was asked if they would like to eat with a spoon or a fork; another person was asked if they wanted to sit out in their chair or stay in their bed. We saw that the choices people made were respected by the staff.

Staff spoke respectfully with people and used the preferred names of people. One person told us, "The staff know I don't use my first name. I've never been known by [first name]. Everyone has always called me [preferred name] and that's what the staff do too. I like it that way." One member of staff told us, "It's important people feel at home here. I just think how would I like my parents to be cared for here. I treat people like I would want a family member to be treated. It's what people deserve."

Good

Is the service responsive?

Our findings

Information in people's care records included people's preferences on how they wanted to be supported. The staff told us, "We sit with people in their room and discuss what's in their care plan. We always ask if they are still happy with what we are doing and can change things." One person who used the service told us, "I know they write down what we want because we talk about it and all the staff do what I want them to. It's good because I don't have to keep telling them, they just know."

People told us their family continued to play an important part in their life and could visit at any time. One person told us, I still love going shopping and going out with my daughter. Nothing has changed, she pops round and if I want to go out, I just go. There are no problems." Another person told us, "My family are always made to feel welcome. It's better now we have the new lounge as we can go there and it's quieter."

A programme to support people to engage in their hobbies and interests was prepared each month and each person had a copy. People told us they could choose whether to be involved. One person told us, "A lot of us just like chatting and are not too bothered in what's going on." We saw the staff supported people to engage in chair exercises and people enjoyed the ball games and laughed with each other. The staff explained what each activity was and adapted the game to each person's abilities. People we spoke with told us that they enjoyed this activity. One person said, "That was fun."

People told us they had recently been out for a meal with some friends. One person told us, "We often go out for a meal. It's nice to go out somewhere different." Another person said, "If we want anything we go and get it. The staff help us to the shops so we can buy what we want." The provider also operated a 'mini shop' on a trolley which had popular items of toiletries and confectionary for people to buy. We saw people retained control of their money and purchased items independently. One person told us, "It's handy having the shop. I don't always want to go out."

People were supported to continue to practice their faith. A representative from a local place of worship visited the home and conducted a Christian ceremony. Other people were supported to attend a favourite place of worship. The staff told us friends supported people to go to their usual place of worship. One member of staff told us, "For some people it is important to go to and worship with their friends and family. People are welcome to join in the service here but if they want to go somewhere in particular then we will make these arrangements. If it's important to them then it's important to us." The staff we spoke with were knowledgeable about the different religious faiths people practiced and recognised the differences so they could support people's diverse needs.

People knew who to speak with if they wanted to raise a concern and there were processes in place for responding to complaints. People we spoke with told us they were happy with the service provided and how staff provided their support. One person told us, "What is there to complain about? I landed on my feet when I came here." Another person told us, "The staff listen to whatever is on your mind. They're always asking if we are alright and if they can do anything. I'd just speak up and tell them if anything was bothering me."

Is the service well-led?

Our findings

The manager completed a PIR prior to our inspection. This document gave us some key information about the service, although it did not focus on what the service did well for people and improvements they planned to make. We identified that the provider had not taken suitable action to make improvements to the environment to ensure people were safe and ensure it was suitable to meet the diverse needs of people who used the service.

All the staff we spoke with told us that the registered manager was approachable and supportive and worked alongside them when providing support to people. One member of staff told us, "The manager is excellent. She's always there when you need her and we can talk to her about anything." A relative told us, "Nothing is too much trouble. Se lets you know important information and always makes sure [person using the service] is looked after. I don't have to worry about anything." We spoke with one community matron who told us the manager and staff alerted them to any concerns and carried out any instructions to support the health and well being of people.

The registered manager told us that staff received supervision although this was not carried out regularly. One member of staff we spoke with told us, "I meet with the manager and we get to talk about my work and what we do here. If there's any training I want to go on, I just let her know and she does what she can to arrange it." Another member of staff told us, "I haven't had supervision in a while. I know she's there if I need her." Staff received training to meet the needs of people using the service but they were not always observed to ensure they were competent in areas they had received training in. The manager agreed that regular supervisions and competency checks were needed to regularly assess and monitor the staff's knowledge and skills.

Systems were in place to monitor the service provision. We looked at how accidents and incidents were reported and saw that each month these were reviewed to help to identify concerns. We saw one person had a large number of falls over a short period of time. The registered manager had reviewed these incidents and sought support from the falls prevention team and reviewed the care provided. The number of falls had decreased and demonstrated this system was effective in identifying and monitoring accidents in the home.

The registered manager had notified us of any reportable events as required. We were informed of deaths that occurred at the service and incidents that resulted in a serious injury. This demonstrated they understood their responsibilities to notify us of significant events.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (10)(c)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **Adequate maintenance had not been carried out in the home by the provider to protect them against the risks of an unsafe or unsuitable premises.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.** **People had not been protected against the risks of receiving care that was inappropriate or unsafe.**