Mrs Wendy J Gilbert & Mr Mark J Gilbert

Dovehaven Nursing Home

Inspection report

9-11 Alexandra Road
Southport
Merseyside
PR9 0NB

Tel: 01704530121
Website: www.dovehavencarehomes.co.uk

Date of inspection visit:
19 July 2016

Date of publication:
21 September 2016

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service in March 2016 when two breaches of legal requirements were found. We found a breach in regulation regarding the safe management of medicines and we took enforcement action in respect of this breach. We served the provider with a statutory Warning Notice regarding medicines not being managed safely. We also found a breach of regulation as the service had not followed agreed local authority protocols for reporting an allegation of abuse to ensure people were protected. We asked the provider to take action to address these concerns.

After the comprehensive inspection, the provider wrote to us to tell us what they would do to meet legal requirements in relation to the breaches. We undertook a focused inspection on 19 July 2016 to check that they had they now met legal requirements. This report only covers our findings in relation to the specific area / breach of regulation. This covered one question we normally asked of services; whether they are 'safe'. The question 'was the service effective', 'was the service caring', 'was the service responsive' and 'was the service well led' were not assessed at this inspection.

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

Dovehaven Nursing Home provides nursing care and accommodation for up to forty elderly people. A registered manager was in post. 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.

At the previous inspection we had concerns regarding the administration of eye drops, the management of people taking warfarin, thickening agents in drinks and checks of controlled medicines. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs legislation. At this inspection our findings showed improvements had been made and medicines were now being managed safely. This breach had been met.

At the previous inspection we had concerns that the service had investigated a safeguarding incident (allegation of abuse) and had not followed agreed local authority protocols to ensure people were protected. At this inspection our findings showed staff were aware of the safeguarding procedure to follow and on-going training was provided around the safeguarding of adults (protecting people from abuse). This breach had been met.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found that action had been taken to ensure medicines were managed safely to meet legal requirements.

We found actions had been taken to ensure the service followed agreed protocols for reporting allegations of abuse to the local authority. Staff were aware of the safeguarding procedure to follow and on-going training was provided around the safeguarding of adults (protecting people from abuse)

While improvements had been made we have not revised the rating for this key question. To improve the rating to 'Good' would require a longer term track record of consistent good practice. We will review our rating for 'safe' at the next comprehensive inspection.

Dovehaven Nursing 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 focused inspection took place on 19 July 2016 and was unannounced. The inspection team consisted of an adult social care inspector and a pharmacy inspector to check that improvements to meet legal requirements identified after our comprehensive inspection on 21 & 22 March 2016 had been made. We inspected the service against one of the five questions we ask about services; is the service safe, this is because the service was not meeting legal requirements in relation to this question.

We looked at records in respect of the management of medicines including medicine administration sheets and audits and also the service's safeguarding procedures. We spoke with the registered manager, a registered nurse and regional manager. We contacted a commissioner of services prior to the inspection to seek feedback about the service.

Requires Improvement

Is the service safe?

Our findings

We previously visited this home in March 2016 and found you to be in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We took enforcement action in respect of this breach. We served the provider with a statutory Warning Notice regarding medicines not being managed safely.

We asked the provider to take action to address these concerns. The provider submitted a provider action report which told us the improvements they had made to meet this breach. On this inspection we checked to make sure requirements had been met and we found improvements had been made to meet necessary requirements. This breach had been met.

At this inspection we checked the medicines and records for seven people. We spoke with the manager of the home, a registered nurse and a regional manager. We found that all the records we looked at had photographs; two of the people did not have their allergies recorded on their medicines records. Having a photograph and having allergies recorded reduces the risk of medicines being given to the wrong person or to someone with an allergy.

One person had been admitted into the home after being discharged from hospital. The hospital had sent a copy of the ward prescription chart and a blister pack of medicines that the person went into hospital with. The directions on some of the medicines were different on the blister pack and the ward prescription chart. The home had hand written a Medicine Administration Record Sheet from the blister pack, but had not acknowledged the differing directions, which may have increased the risk of the person being given an incorrect dose. We raised this with the registered manager during the inspection who took action to address this.

At the previous inspection eye drops had not been dated when they had been opened and it was not always clear which eye(s) the drops should be applied to. Eye drops must be discarded after 28 days once opened and therefore it was unclear whether they were still safe to administer. At this inspection eye drops had clear directions to which eye(s) the drops should be applied to; and all eye drops had been dated once they had been opened.

At the previous inspection stock balances of warfarin could not be balanced and it was unclear of whether the correct dose of warfarin had been administered. Two of the seven people were taking warfarin and the balances were correct.

At the previous inspection, controlled drug balances (controlled drugs are medicines which are controlled under The Misuse of Drugs Act) had not been checked daily in accordance with the provider's medicines' policy. The home had now started daily balance checks for controlled drugs and the records showed that this was completed daily.

Where people were prescribed fluid thickeners to aid swallowing staff had not recorded to say what had

been used. The home had introduced a fluid balance chart for people on fluid thickeners to record the quantities of fluid taken each day. However, the chart did not indicate how much fluid thickener had been given to each person. The regional manager changed the fluid balance chart during our inspection when this was highlighted.

When we carried out the last comprehensive inspection in March 2016 we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the service had investigated a safeguarding incident (allegation of abuse) and had not followed agreed local authority protocol to ensure people were protected.

The provider submitted a provider action report which told us the improvements they had made to meet this breach. At this inspection we checked to make sure requirements had been met and we found improvements had been made to meet necessary requirements. This breach had been met.

At this inspection we discussed with the registered manager the safeguarding procedures in the home which included reporting incidents to the local authority and training for the staff around what constitutes abuse. Information was displayed for staff to refer to with regard to 'the definition of abuse', contact details for the local authority and also whistleblowing.

We saw training dates which showed staff had attended safeguarding (abuse) training, along with mental capacity and deprivation of liberty training. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Staff and managers were clear on their responsibilities with reporting and investigating allegations of abuse.