Four Seasons Homes No.4 Limited

Dove Court Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection took place over two days on 11 and 12 January 2017.

Dove Court Care Home is registered to provide residential and nursing care for up to 58 people, including people with dementia. At the time of this inspection there were 56 people living in the home.

There was a registered manager in post 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.

There were not always sufficient staff to meet the needs of people in a timely way and in some areas of the home staff did not have the time to interact with people outside of meeting people's basic care needs. People's experience of care and support differed depending on where they lived within the home. People in some areas of the home were not always able to access suitable levels of social interaction and activity.

Care plans were not always sufficiently person centred and detailed enough to provide staff with the information required to provide individualised care. People were not consistently involved in planning their care.

Appropriate systems or processes were not in place to assess, monitor and improve the quality and safety of the service. Quality assurances processes were not always effective at identifying shortfalls and where shortfalls were identified these were not always addressed in a sufficiently timely manner to minimise the impact on people.

People were supported to take their medicines as prescribed, however staff did not always follow the provider's policies and procedures when administering medicines. Records showed that medicines were obtained, administered and disposed of safely.

Recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service. Staff received induction to their role and training in areas that enabled them to understand and meet the care needs of each person.

People were supported to maintain good health and had access to healthcare services when needed; relevant health care professionals were appropriately involved in people's care. Staff supported people to have sufficient amounts to eat and drink to help maintain their health and well-being.

People felt safe in the home and relatives had no concerns about people's safety. Staff understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns. People received care from staff that were friendly, kind and thoughtful and their right to privacy and dignity

were respected.

People's consent was sought prior to care and support being delivered by staff. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

There were many opportunities for people and their families to share their experience of the home and the provider and manager actively sought feedback from people. Staff were aware of the importance of managing complaints promptly and in line with the provider's policy.

At this inspection we found the service to be in breach of three regulations of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. The actions we have taken are detailed at the end of this report.

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

The service was not always safe.

There was not always sufficient staff to meet people's needs in a timely way.

The information recorded regarding people's needs and potential risks was not always consistent.

Systems were in place to manage medicines in a safe way and people were supported to take their prescribed medicines; improvements were needed to ensure that staff followed the policies and procedures in place.

Safe recruitment practices were in place.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Is the service effective?

Good

The service was effective.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Staff received training and supervision to ensure they had the skills and knowledge to support people appropriately.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received the support they required to ensure that their nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staffing levels impacted upon the ability of staff to provide consistently caring support. Interaction between staff and

people living in the home was at times task focussed.

People were not routinely involved in planning and evaluating their care.

People's privacy and dignity were protected and promoted.

People received care from staff that were kind and thoughtful.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's experiences of social stimulation and activity differed depending on where they lived within the home.

People's individual plans of care were not always written in a person centred way.

People were assessed before they were admitted to the home to ensure that their needs could be met.

People using the service and their relatives knew how to raise a concern or
make a complaint and a system for managing complaints was in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People were not assured of a good quality service as there were insufficient systems and processes in place to effectively monitor the quality of people's care.

Where shortfalls in the quality of care provided had been identified the actions required to implement improvements had not been taken quickly enough.

People, their families and staff were encouraged to share their experience of the home to help drive improvements.

A registered manager was in post and they were active and visible in the home. They provided staff with regular support and guidance.

Dove Court Care 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 11 and 12 January 2017. The inspection was unannounced and was undertaken by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted the local health commissioners who help place and monitor the care of people living in the home.

During this inspection we visited the home and spoke with twenty two people who lived there and nine of their relatives. We also looked at care records relating to six people. In total we spoke with fifteen members of staff, including nursing staff, senior care staff, care staff, the cook, the registered manager, the acting deputy manager, a quality manager and the regional operations manager. We looked at six records in relation to staff recruitment and training, as well as records related to the quality monitoring of the service.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were not sufficient in all areas of the home to ensure that people received care and support when they needed it. People living on the nursing unit consistently told us that there were not enough staff on duty and that they had to wait for care and support. One person said "Staffing is a problem; I don't think there's enough of them, not as many as we need here really for all of us." Another said " You really do have to wait a long time to get up some days; I am not sure why but it must be the staff; it all depends who is about but you do have to wait for them to come". One person's relative said "The nursing care is good but the carers are under pressure." Staff working on this unit also told us that there were not enough staff available at times. Staff told us "It's difficult to get all of the checks done, we prioritise what is important for example re-positioning people and making sure they have food and drink."

People on this unit also told us that they sometimes had to wait a long time for staff support when they used their call bell. One person said "I have given up using my bell, waiting and waiting –now I just shout. I am lucky I am fairly near the nurse's office". Another person said "Usually it's between 15-20 minutes before they come, but it can be an hour or more it all depends what is going on, how busy they are". Staff told us that they went to people's rooms as soon as they could to ensure that they were safe; however if they were busy, they would tell the person they would return when they had finished what they were doing.

We spoke with the registered manager about the concerns raised and they told us that staffing levels were planned to meet the identified needs of people. They had undertaken a recent review of staffing numbers and deployment and had recognised that due to an increase in the care needs of people in some areas of the home, there was a need to increase the clinical staffing cover. These adjusted staffing levels and deployment had not yet been embedded as staff had not been recruited to fill all vacancies.

This constituted a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.

People's experience on the residential and dementia units was different. We observed that staff had more time to spend with people and no one was left waiting for support. People told us that they didn't have to wait for staff to help them and one person said "They look after me well here, always come when I need them". Staff said, at times they could do with more, for example at meal times, but generally felt they were able to meet people's needs.

There were systems in place to ensure that people received their prescribed medicines safely. Medicines administration records (MAR) contained were clear and detailed and staff had received training prior to taking responsibility for medicines administration. During our inspection we observed staff giving medicines; we saw that they were patient and offered each person the support they needed. However staff did not always follow the medicines policy and procedures; we observed two staff dispensing a controlled medicine together, but only one member of staff took the medicine to the person. This was discussed with the registered manager who recognised the risk involved and agreed to ensure that this practice did not continue in the home.

People could not be assured that the equipment in use to promote their health and well-being was used correctly as the provider did not have an effective system in place to ensure that people's pressure relieving equipment was set at the correct level. For example pressure relieving mattresses that were in place to protect people's skin were not consistently set to the weight of the person, this put people at risk of their skin breaking down. The acting deputy manager immediately reviewed the settings of all people's mattresses.

The information recorded regarding people's needs and potential risks was not always consistent. For example, during the inspection we observed that a number of people did not have access to a call bell. The registered manager explained that all people were checked hourly by staff and if people were unable to use a call bell this was recorded in their care plan. We checked a number of people's care plans and the information regarding call bells was not consistently recorded; records did reflect that all people were checked hourly. The registered manager arranged for an immediate review of people's needs.

People were assessed for other potential risks and their needs were regularly reviewed so that risks were identified and acted upon as their needs changed. For example where people's mobility had deteriorated their risk assessment reflected their changing needs. People's care plans provided instruction to staff on how to mitigate people's risks to ensure people's continued safety; for example how to support people to move safely.

People lived in an environment that was safe. There were environmental risk assessments in place and a list of emergency contact numbers was available to staff. Contingency plans were in place; each person had a Personal Emergency Evacuation Plan (PEEP) that provided information to staff and the emergency services on people's mobility needs in the event of an evacuation.

People were protected against the risks associated with the appointment of new staff. There were appropriate recruitment practices in place, taking into account staff's previous experience and employment histories. Records showed that staff had the appropriate criminal records checks and references in place.

Staff understood their roles and responsibilities in relation to keeping people safe. The provider's safeguarding policy was readily accessible to staff and provided them with the contact details of the local safeguarding team. Staff told us that if they had any concerns they would speak to the registered manager and if they were not satisfied with their response, they would report the incident to the safeguarding team directly. One member of staff told us "I would speak to the manager and if it wasn't taken seriously I would report it to the council".

Good

Is the service effective?

Our findings

People's needs were met by staff that had the required knowledge and skills to support them appropriately. New staff received an induction which included computer based learning, practical training and shadowing experienced members of the staff team. Staff did not work with people on their own until they had completed the provider's mandatory training and felt confident to undertake the role. The induction included key topics on moving and handling and health and safety. Newly recruited staff also undertook the Care Certificate; this is based on 15 standards that aim to give employers and people who receive care, the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff received mandatory training such as first aid and fire safety. Additional training relevant to the needs of the people they were supporting was also provided; this included training in dementia awareness. Staff were encouraged to do diplomas in health and social care, one member of staff said "Doing my Diploma really made a difference to how I do my job, it helped me to understand person centred care and that care should be built around the individual, when care isn't person centred, everyone gets the same". There was a plan in place for on-going training so that staff's knowledge could be regularly updated and refreshed.

People's needs were met by staff who were effectively supported and supervised. Staff were able to gain support and advice from the registered manager and nursing staff when necessary and regular supervision and appraisal meetings were available to all staff. The supervision meetings were used to assess staff performance and identify on-going support and training needs. One member of care staff said "I love supervision; I'm always learning different things."

People received care and support from staff who understood how to ensure that support provided was in people's best interest. 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 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).

We checked whether the service was working within the principles of the MCA. People's care plans contained assessments of their capacity to make decisions for themselves and consent to their care. Written records reflected that some of these assessments were not specific to one decision; however nursing staff were working through all the assessments in place to ensure that all assessments were decision specific. Care staff had received the training and guidance they needed in caring for people that may lack capacity to make some decisions for themselves. The registered manager and care staff were aware of, and understood their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

Staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST) and referred people to their GP and dietician when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely; for example where people had difficulty in swallowing, staff followed the health professionals advice to provide fluids that had been thickened. People's care plans contained detailed instructions about people's individual dietary needs, for example one person required a Lactose free diet and we saw that they were provided with this.

People received the support that they needed to eat and drink enough to help maintain their health and well-being. People were provided with a choice at mealtimes and an alternative if they did not like what was on the menu. One person said "The food is alright, for example we are supposed to have chicken casserole or fish pie today and then apple pie, but the cook will cook whatever you fancy if you ask twenty four hours before hand". Staff told us "We make sure people have enough to eat and drink, if someone doesn't want something we try offering different things".

People had access to health care support when they needed it. Records showed that staff had promptly contacted health professionals in response to any deterioration or sudden changes in people's health and acted on the instructions of the health professionals. We saw evidence of regular health checks taking place and people were supported to access a range of healthcare professionals such as the podiatrist, optician and community mental health team.

Requires Improvement

Is the service caring?

Our findings

People's experience of care was different depending on where they lived in the home. On the nursing unit, staff interactions with people were task focussed; the number of staff available had impacted on the staff's opportunity to spend time with people outside of providing personal care. One person said "The carers speak to me alright but I have to wait a very long time for them to come, I can't get up until they come and sometimes it's very late in the morning. I have no complaints regarding their kindness but there needs to be more staff to stop the waiting." We observed that in the main, staff only interacted with people when they were offering to do something for them; for example asking if someone wanted a drink.

The system in place to allow people and their representatives to contribute to their care plans and risk assessments was not effective and people were not consistently consulted about their care. People and relatives that we spoke to told us that they were not aware that they had a care plan and did not know how their care needs were evaluated and reviewed. The registered manager told us that people's care plans should be discussed with them and that they should be signed by the person or their representative to demonstrate their involvement and agreement with the information they contained. We viewed a number of people's care plans and they had not been signed. Therefore, people did not have the opportunity to make their wishes and views known regarding how they wanted to be supported; there was a risk that people would not receive support as they chose.

This constituted a breach of Regulation 9 (1) (3) (a) (b) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Person-centred care.

On the residential and dementia units staff had more time to spend with people. People and their relatives told us that they were happy with the way their care and support was provided. One person said "the carers are very, very good, really nice, they go beyond the call of duty, they really do; you can't fault them". Another person's relative said "I feel she is well cared for, they are kind and patient with her."

Staff supported people in a kind and caring way and involved them as much as possible in day to day choices and arrangements. Staff had good relationships with people; one person said. "I like it here very much, I like the way they care for me and look after me; they are very good". Another person said "It's good here; I couldn't ask for more and can't fault any of the staff." We observed that staff were caring and warm towards the people they were supporting, and interaction was sensitive and appropriate. We observed staff supporting one person with eating and drinking, the person was distracted and the member of staff was patient and gentle as they encouraged them with their meal. One member of staff told us "I'm always learning different things here, for example as you get to know people better; you understand how best to interact with them". The provider needs to ensure that there is a consistent experience for people across the home.

The registered manager was aware of how to access advocacy services on behalf of people and information about advocacy services was displayed in the home. Information was also available regarding people who had a lasting power of attorney or an advocate in place. No one currently living in the home required the

support of an advocate.

People's dignity and right to privacy was protected by staff. For example one member of staff said "When I'm helping someone with personal care I always make sure that the door is closed, I make sure I cover them with a towel". We also observed staff knocked on people's bedroom doors and waited to be invited in before entering the room. Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information without people's consent. One member of staff said ""It's important not to have personal conversations about people in front of others".

Requires Improvement

Is the service responsive?

Our findings

The information contained within people's individual plans of care was not always sufficiently detailed to ensure that people received personalised care and support. Some documentation gave good descriptions of how people should be supported and was clear in instructing of how staff should respond to people in particular situations. However, other care plans lacked detail; the language was generic and not person centred. Some people's care planning documentation gave an overview of the areas where people required support however, did not provide guidance for staff to follow as to how people liked their care to be delivered. For example, one person's care plan said that they required support with their personal care, however did not provide additional instruction to staff about how to provide this support. The home provides care and support to a number of people living with dementia who would be unable to reliably direct staff in providing their care and support and people were at risk of not having their care and support needs met consistently.

This constituted a breach of Regulation 17 (c) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance.

People's care and support needs were assessed before they came to live at the home. This assessment was thorough and covered areas such as medical history, mental health needs, consent and capacity and communication. Staff told us that they were provided with appropriate information regarding people's care needs. One member of staff said "The nurses tell us everything we need to know about people's care needs when they first come into the home."

We observed a staff handover meeting taking place between shifts; all areas of people's care and support needs were discussed, including their medical needs, personal care needs and planned activities. Staff were thoughtful when responding to people's needs; we observed staff discussing how they could support a person who was low in mood and the things they could do to help them feel better.

The assessment and care planning process did not always consider people's hobbies and past interests as well as their current support needs. At the time of inspection some people told us that they were not aware of the activities that were being provided as there was no timetable of planned activities available. This made it difficult for staff to ensure that people were included in activities of interest to them. However, the staff that we spoke to knew the people they supported well and often talked to them about their past life and interests. We observed activity staff supporting people to have a manicure and read poetry and one member of activity staff commented "Every person is different; we need to get to know them and what they want to do."

People's experience of activity provision differed dependent on where in the home they lived. People on the residential unit said that they had plenty to do, and enjoyed the activities; for example a regular tea party was organised. However people on the nursing unit said that they were bored and would like to do more. One person said "They will tell me if someone is in like a singer but it's rare we don't have bingo or quizzes up here; I read and I have my TV, nothing else." Another person said "Very, very limited activities, we do get

singers in from time to time –once every three months or so but day to day nothing happening." Two members of staff took the lead in organising activity and staffing provision for activities in the home had recently been increased, however this was not yet sufficiently embedded.

There was a complaints policy and procedure in place; complaints were logged and investigated by the registered manager, who understood the importance of reflecting on and learning from complaints. People and their relatives told us that they knew who to speak to if they were unhappy with any aspect of the service. Staff were knowledgeable about how to respond to complaints, one member of staff said "If anyone made a complaint to me I would report it to one of the nurses or the manager."

Requires Improvement

Is the service well-led?

Our findings

There was insufficient monitoring of the quality and safety of the service. A range of audits had been completed; however, these audits had not been effective at identifying or addressing shortfalls in a timely manner. For example, regular medicines audits had been carried out by nursing staff, but action had not been taken to ensure that staff consistently followed safe medicines practices. Procedures in place to ensure that people's pressure mattress settings were regularly monitored by staff were ineffective. We found people's mattresses were not consistently set to an appropriate setting for their weight.

Quality assurance processes were not consistently effective at ensuring the actions required to implement improvements were taken quickly enough. The provider had identified that staffing deployment and levels needed to improve. We saw that extra clinical staff had been recruited; however this measure had not been implemented quickly enough to ensure that people were supported by sufficient numbers of suitably skilled staff in all areas of the home. We received consistent feedback from people living in one area of the home that they had to wait too long for support from staff and that there was insufficient social stimulation and activity.

The provider had identified that people's individual plans of care were not always sufficiently personalised and that people were not consistently involved in the evaluation of their care needs. Sufficient action had not been taken to ensure that people's care plans were person centred, reflected their life history and interests, or that they were involved in planning their care.

Systems and processes were not effective in ensuring that staff consistently followed the provider's policies and procedures. Procedures in place required that physical observations such as temperature and respirations should be checked by nursing staff on a monthly basis; however records showed that this did not consistently happen. Potential risks to people's health and well-being may not be attended to in a timely manner.

Record keeping in some areas was inconsistent. The lack of specific records for individual mental capacity assessments had already been identified as a concern by the provider. However, sufficient action had not been taken to ensure that the records reflected the specific decision to be made and people were at risk of not being provided with appropriate support to make decisions. Not all people without access to a call bell had appropriate documentation in their care plan detailing why there was no call bell in place. People were at risk of not being able to access appropriate support from staff.

This constitutes a breach of Regulation 17 (1) (2) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good Governance.

There were other quality assurance processes in place, which were effective at addressing shortfalls in some areas. The registered manager carried out monthly audits covering areas such as health and safety as well as weekly analysis of falls, pressure ulcers and weight loss. We saw that actions required as a result of these audits were taken in a timely manner.

The culture of the service emphasised the importance of all staff's contribution; staff were involved in daily audits of the home and were encouraged to take action where shortfalls were found. Staff were engaged in discussions about the running of the home and regular staff meetings were held for them to discuss their views. We saw records of staff meetings where discussions had taken place regarding safeguarding, whistleblowing, training, care plans and correct completion of documentation.

The provider had an effective process in place to gather feedback from people, their relatives and staff through on-going surveys of their views. There was the facility on every unit for people, relatives and staff to provide feedback at any time. If the person completing the feedback wanted to speak to someone about their comments this was flagged up to the registered manager and regional manager and any negative feedback was also highlighted. Individual feedback could be responded to immediately and all feedback was analysed for trends monthly. Feedback from July 2016 until October 2016 had been analysed and was mainly positive. Residents and relatives were also invited to regular meetings and we saw minutes of these where people were provided with information and asked for their views of the care provided in the home.

Staff were confident in the managerial oversight and leadership of the registered manager and acting deputy manager; they found them to be approachable and friendly. Staff told us that they felt able to ask for support, advice and guidance about all aspects of their work. One member of staff said "The manager is lovely, she's always positive." Another said "I feel that [registered manager] listens to any suggestions I make."

Policies and procedures to guide staff were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies which underpinned their job role, such as safeguarding people and whistleblowing.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not meeting this regulation because: People or their representative were not involved in planning their care and people did not consistently receive person centred care and support. 9 (1) (3) (a) (b) (c) (d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider was not meeting this regulation because: The provider did not have sufficient arrangements in place to monitor the quality and safety of the care and support provided in the home. 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider was not meeting this regulation because: There were not sufficient numbers of staff deployed in all areas of the home to provide people with their care and support in a timely manner. 18 (1).