Embrace (UK) Limited

Dovecote Nursing 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?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This was an unannounced inspection carried out on 27 October 2015.

We last inspected Dovecote Nursing Home in October 2014. At that inspection we found the service was meeting all its legal requirements in force at the time.

Dovecote Nursing Home is a 61 bed care home that provides personal and nursing care to older people, including people who live with dementia or a dementia related condition.

A registered manager was not in post. A peripateteic manager was managing the home until the new manager started in January 2016. 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

People said they felt safe. We had concerns however that there were not enough staff on duty to provide safe and individual care to people.

People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Staff undertook risk assessments where required and people were routinely assessed against a range of potential risks, such as falls, mobility, skin damage and nutrition. People received a varied and balanced diet. People had access to health care professionals to make sure they received appropriate care and treatment.

Staff received training and supervision to give them some knowledge and insight into people's care and support needs. Regular staff knew people's care and support needs. However, bank and agency staff did not always receive an induction to inform them about people's care and support needs.

People said staff were kind and caring. However, we saw staff did not always interact and talk with people. There was an emphasis on task centred care.

Not all areas of the home were well maintained for the comfort of people who used the service.

People and their relatives had the opportunity to give their views about the service. A complaints procedure was available. The home had a quality assurance programme to check the quality of care provided, however the audits were not always effective.

Dovecote Nursing Home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment

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?

Requires improvement

Not all aspects of the service were safe.

People told us they felt safe. However staffing levels were not sufficient to ensure people were looked after in a safe and timely way.

Staff were aware of different forms of abuse and they said they would report any concerns they may have to ensure people were protected.

People received their medicines in a safe manner.

Checks were carried out regularly to ensure the building was safe and fit for purpose.

Is the service effective?

Requires improvement

The service was not always effective.

The environment was showing signs of wear and tear in some areas of the home.

Staff were supported to carry out their role and they received the training they needed.

Best interest decisions were made appropriately on behalf of people, when they were unable to give consent to their care and treatment.

People received a varied and balanced diet to meet their nutritional needs.

Is the service caring?

Requires improvement

Not all aspects of the service were caring.

We saw there was an emphasis on task centred care with people as staff did not have time to spend talking with people or engaging with them.

People we spoke with were on the whole complimentary about the care and support provided to people.

Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy.

There was a system for people to use if they wanted the support of an advocate. Advocates can represent the views of people who are not able to express their wishes.

Is the service responsive?

Requires improvement

The service was not always responsive.

Staff were knowledgeable about people's needs and wishes. Records reflected the care and support provided by staff.

Summary of findings

Staff did not have time to engage and interact with people except when they provided care and support. There were limited activities available for people on the top floor.

People had information to help them complain.

Is the service well-led?

Not all aspects of the service were well-led.

A registered manager was not in place but one was due to begin in January 2016. A relief manager was in place. Staff and relatives told us the manager was supportive and could be approached at any time for advice and information.

People who lived at the home and their relatives told us the atmosphere was good.

The home had a quality assurance programme to check on the quality of care provided. However, we had concerns the audits did not highlight deficits in some aspects of care people received.

Requires improvement

Dovecote 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 inspection took place on 27 October 2015 and was unannounced. The inspection team consisted of an adult social care inspector, a specialist nursing advisor 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 for older people. The specialist advisor helped us to gather evidence about the quality of nursing care provided.

Before the inspection we reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service. We received information of concern from these agencies. CQC also received information of concern directly.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us.

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 14 people who lived at Dovecote Nursing Home, eight relatives, the peripatetic manager, two registered nurses, seven support workers including one senior support worker, the activities organiser, a domestic person, a member of catering staff and a visiting health care professional. We observed care and support in communal areas and looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, recruitment, training and induction records for four staff, six people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the acting manager had completed.

Requires improvement

Is the service safe?

Our findings

People said they felt safe and they could speak to staff. However, they commented there were not enough staff. Comments included, "Very short of staff, never enough on," "They're stretched a bit for staff sometimes," and, "Staff come when I call not so quick sometimes, but they are busy." Relatives' comments included, "It was chaos earlier this year when (Name) was in for respite care, but it's better this time," "There are lots of agency staff lately but some days its like the Marie Celeste when you walk in," "It's a worry, I think (relative) is safe here though communication isn't very good as the girls don't seem to know shift by shift what happened in the last one." A health professional commented, "Care is as we ask, no problem there." A staff member commented, "Generally people are safe, the staff on duty know the residents and know when something is wrong."

Although people said they felt safe we had concerns there were not enough staff to meet people's needs in a safe and timely manner and to ensure they received the care they required.

The peripatetic manager told us there were 54 people who lived at the home. We were told daily staffing levels were two nurses, two seniors and seven support workers.

On the day of inspection on the top floor one nurse and four support workers including one senior support worker provided care to 27 people who lived with dementia or a dementia related condition. Three support workers were available until lunchtime, 12:45pm, when an agency support worker came on duty to replace the fourth support worker who was absent. Staff told us three people were confined to bed and they required two staff to assist with all their care and support needs. 12 people required more staff support because of their behavioural needs. Eight people required full assistance with all their care and support needs. At least one person also received more supervision as they were at "high risk of falls." This meant people required more staff assistance due to their level of need and when four staff members were assisting any two people who may need two members of staff each to support them, other people were left unsupervised or had to wait for assistance. We had concerns there were not enough staff to provide care to people in a safe, effective and timely way that promoted people's dignity and individuality. We observed staff did not have time to assist some people with their continence needs in a timely manner and as a result some people became distressed. People were left unsupervised as staff were busy attending to people in their rooms. The nurse was unavailable to provide direct care at all times as they dealt with other duties such as medicines, clinical interventions and liaised with professionals involved in the person's care.

On the ground floor one nurse and four support staff including one senior support worker provided care to 27 people from 7:30am-7:30pm. We were told 12 people were supported in their bedroom and required two staff for their moving and assisting needs. Staff also told us the majority of people on this floor required two staff for their moving and assisting needs. Observations at the lunch time meal showed there were insufficient staff to provide care and support to people to ensure their nutritional needs were monitored and met. A nurse was in charge of the mealtime, as they served, two staff members assisted people in the dining room, whilst the two other staff members assisted people in their rooms. It was observed on a few occasions the dining room was unsupervised and we considered this to be unsafe in case any person was at risk of choking.

Our observations and staffing rosters showed there were not enough staff to meet people's needs. The peripatetic manager told us staffing levels were determined by the number of people using the service and their needs. Our findings did not support that people's dependency levels had been taken into account to ensure sufficient staff over the 24 hour period. Two nurses commented when asked about how staffing levels were decided, "I don't know what the dependency tool is," and, "The last manager said we had the right ratio of staff to residents. I know it should be needs-led." Feedback from a health care professional before the inspection included, "There have been lots of bank staff and a high staff turnover." We were also told by staff there had been six agency staff working on the Saturday. On the day of inspection an agency nurse was on duty on the ground floor as the provider had vacancies and was recruiting permanent nursing staff. Staff were asked about staff turnover. Their comments included, "Qualified staff is a nightmare, they come and go and don't turn up for interview," "We have some good carers that have been here for a while," "We need some stabilty in relation to staff and some continuity," "Staffing needs addressing upstairs, its is quite challenging, upstairs is a forgotten entity," "We have one full time member of qualified on days and there's one on nights, we're waiting for vetting checks," "There's a

Is the service safe?

knock on effect on staff morale and sickness. However, the Company never say no to agency staff." The peripatetic manager told us there were two long term support worker vacancies and two short term vacancies and staff were being recruited. They said they were recruiting qualified staff and one nurse was due to start in three weeks and one in four weeks.

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

The complaints and safeguarding logs provided evidence of incidents, for example, some incidents of aggression that had taken place between people when staff members had not been available to provide supervision to people. We viewed the log and found concerns had been logged appropriately. 17 safeguarding alerts had been raised with the local authority between July 2015 and August 2015. They had been investigated and resolved.

Staff had an understanding of safeguarding and knew how to report any concerns. They were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse and they knew the lines of reporting within the organisation. They told us they would report any concerns to the manager. Comments from staff included, "Resident on resident incidents, physical attack, medicine errors and any suggestion of abuse I'd ring social services and fill in an incident report, and, "I contact Social Care direct, speak to the social worker, contact next of kin and the General Practitioner and behavioural team if necessary."

Risk assessments were in place that were regularly reviewed and evaluated in order to ensure they remained relevant, reduced risk and to keep people safe. They included risks specific to the person such as for falls, pressure area care and nutrition. Records contained information for staff on how to reduce identified risks, whilst avoiding undue restrictions. For example, a falls risk assessment included measures to minimise the risk of falls.

Records showed that there was minimal use of medicines to manage behaviours thay may challenge staff. We saw care plans for distressed behaviour were in place and they provided guidance for staff about the actions that should be taken when the person became agitated and distressed. Written information was available that included what might trigger the distressed behaviour and the staff interventions required. Staff told us they received advice and support from the behavioural team if required.

Medicines were given to people as prescribed. We observed a medicines round. We saw staff who administered medicines checked people's medicines on the medicine administration records (MAR) and medicine labels to ensure people were receiving the correct medicine. They explained to people what medicine they were taking and why. People were given their medicine and they were offered a drink to take with their tablets and the nurse remained with the person to ensure they had swallowed their medicines.

Medicines records were accurate and supported the safe administration of medicines. There were no gaps in signatures and all medicines were signed for after administration. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines that may be at risk of misuse.

Staff members who administered medicines told us they would be given outside of the normal medicines round time if the medicine was required. We saw written guidance was in place for the use of some "when required" medicines, and when and how these should be administered to people. Such as for pain relief or for agitation and distress to ensure a consistent approach by staff.

Records showed that where people lacked mental capacity to be involved in their own decision making, the correct process was used. For example with regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). We saw 'best interest' decision making adhered to the National Institute for Health and Care Excellence (NICE) guidelines as a best interest meeting had taken place with the relevant people. NICE guidelines state, "A best interest meeting involving care home staff, the health professional prescribing the medicine(s), pharmacist and family member or advocate to agree whether administering medicines without the resident knowing (covertly) is in the resident's best interests." We saw records for people who received covert medication and a staff member told us, "A best interest meeting is

Requires improvement

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planned with the pharmacist and other relevant people to discuss whether it is in (Name)'s 'best interests' to administer their medicine this way after we offer it to them and they refuse it."

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plan was reviewed monthly to ensure it was up to date. This was for if the building needed to be evacuated in an emergency.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of checks with the Nursing and Midwifery Council to check nurses' registration status were also available and up to date. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

We saw from records that the provider had arrangements in place for the on-going maintenance of the building and a maintenance person was employed. Routine safety checks and repairs were carried out, such as checking the fire alarm and water temperatures. External contractors carried out regular inspections and servicing of, for example, fire safety equipment, electrical installations and gas appliances. There were records in place to report any repairs that were required and this showed that these were dealt with. We also saw records to show that equipment used at the home was regularly checked and serviced, for example, the passenger lift, hoists and specialist baths.

Requires improvement

Is the service effective?

Our findings

We had concerns not all areas of the home were well-maintained for the comfort of people who lived there. Areas of the building especially upstairs was showing signs of wear and tear. The furniture in the lounge such as the armchairs were worn. There was a malodour on the top floor. Paintwork was scuffed and chipped on skirting boards, handrails and doorways in some areas including corridors and bedrooms. The office carpet on the top floor was stained and some bedroom walls and carpets were marked. The kitchen floor and walls and some kitchen food containers that stored dried goods were marked. Lavatory and bathroom floors and the hallway floor covering to the top floor were marked and discoloured. The peripatetic manager told us a programme of refurbishment was planned. We noted the top floor became very hot during the day and at times the temperature was 79 degrees Farenheit. Some people complained they were too hot but other people didn't want windows opened. The peripatetic manager told us as it was milder outside the thermostat had not been adjusted to take into account the warmer temperature outside the building.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found some areas of the premises were 'enabling' to promote people's involvement and independence. The communal areas and hallways had some decorations and pictures of interest, there were displays and themed areas on the top floor corridor to stimulate people as they sat or walked along the corridors, however they were worn and showing signs of wear and tear. There was appropriate signage and doors such as lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence.

Staff had some opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments included, "We do 'on line' training and face to face training," "There are a list of 46 courses available and some are quite interesting," "I've done National Vocational Qualifications (NVQ) (now called Diploma in health and social care) at levels two and three," "There are opportunities for training," "The company has an internal trainer to deliver some of the training," "Invariably I book a course and then have to work so I've not done my certification of death course," and, "My mandatory training is up-to-date but I need syringe driver training."

The staff training records showed regular staff were kept up-to-date with safe working practices. The peripetetic manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Staff training courses included, dementia care, positive behaviour support, medicines management, conflict resolution, mental capacity, deprivation of liberty safeguards and equality and diversity. However, the staff training matrix and comments from staff about training in the most recent provider's staff survey showed staff wanted some training to give them more understanding of some specialist conditions of people and aspects of care delivery. For example, training in areas such as dignity in care, mental health awareness and nutrition and hydration.

Staff were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. Staff comments included, "I supervise new starters," "My supervision is due this month,"I've had three supervisions including a group supervision, it was quite useful," "I've had four supervisons this year and we have discussed staffing." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs. A staff member commented, "I have an appraisal annually."

Staff members were able to describe their role and responsibilities. Some staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. This ensured they had the basic knowledge needed to begin work. One staff member told us, "I had a full induction and it lasted over a week and then I was signed off over a six week period." We spoke with two agency workers during the inspection to ask them if they had received an induction when they started to work at the home. One of the workers told us they had and one had not received an induction. We found that not all agency and bank staff had received induction or

Is the service effective?

information about people's care and support needs. This meant that they may not have been effective in knowing how people needed their care and support delivered. The peripatetic manager told us this would be addressed.

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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

People can only be deprived of their libery 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 are called the Deprivation of Liberty Safeguards (DoLS). Dovecote records showed 48 people were legally authorised and six applications were waiting for assessment by the local authority.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. Staff received advice and guidance when needed from specialists such as, a community nurse, a dietician, a psychiatrist and General Practitioners(GPs). Records were kept of visits and any changes and advice was reflected in people's care plans. One person received a visist from a specialist nurse during the inspection which we were told was part of an ongoing treatmen plan. We were told by a health care professional. we contacted before the inspection that a weekly surgery used to take place until recently. However, since the GP had retired the clinic no longer took place at the home. The clinic had been run by the General Practitioner and a specialist nurse. The clinic was held to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital. We were told an approach was to be made to the local surgery to start another clinic.

Relatives were kept informed by the staff about their family member's health and the care they received. Relative's comments included, "They (Staff) tell us everything," "My other relative goes to review meetings and we get asked about everything," "We're kept up to date, (Name) has had a few falls, but it's not the staff's fault, the hospital has let us down," "The staff do their best they always speak to us and keep us informed," and, "We did the care plan with staff." Another relative told us, "(Name) has been here for two and a half years and they still haven't got the right contact numbers down. I went on holiday recently and left contact numbers for two other family members and they still rang me in the middle of the Atlantic to ask permission for (Name)'s flu jab, I'm going to have to speak to them about that today." We discussed this with the manager who said it would be addressed.

People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so that staff were aware of the current state of health and well-being of people. Staff members comments included, "Communication is good," "Handover is a brief synopsis of each person and what happened on shift, it lasts 20-25 minutes," and, "There's a handover from day and night shift." A relative spoke of their concerns at the lack of communication amongst staff which they thought had an effect on their relative's care. They commented, "I wish there was some communication amonst staff because there obviously isn't, my relative's teeth went missing about three months ago, no one seems to tell anyone. When you ask staff, they say,"Oh are (Name)'s teeth missing. The dentist came but (Name) can't tolerate having impressions done now." We discussed this with the peripatetic manager who said it would be addressed.

We were told and saw a written handover record was also used. It contained information about people's health, mood, behaviour, appetite and activities that they had ben engaged in. This meant detailed written information was available about people's current health and well-being when different staff came on duty to care for people.

We checked how people's nutritional needs were met. Care plans were in place that recorded people's food likes and dislikes and any support required to help them eat. For example, a care plan for nutrition stated, "Preferred hot drink is coffee with milk and two sugars, preferred cold drink is 'Appletiser,' (Name) likes fish and chips." We spoke with the chef who was aware of people's different nutritional needs and special diets were catered for. The chef told us they received information from nursing staff when people required a specialised diet. They explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they would be offered milkshakes, butter, cream and full fat milk

Requires improvement

Is the service effective?

as part of their diet. We looked around the kitchen and saw it was well stocked with fresh, frozen, home baked and tinned produce. We saw food was well presented and looked appetising. People were positive about the food saying they had enough to eat. People's comments included, "The food is okay but I'm used to my own cooking," "The food is alright," It's always the same no changes," "The food's okay could be better," and, "The food is good." Hot and cold drinks were available throughout the day.

There were systems to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. People were routinely assessed against the risk of poor nutrition using a recognised tool Malnutrition Universal Screening Tool (MUST). This included monitoring people's weight and recording any incidence of weight loss. Where people had been identified as at risk of poor nutrition staff completed daily 'food and fluid balance' charts.

Requires improvement

Is the service caring?

Our findings

People who used the service and relatives we spoke with were positive about the care and support provided. Peoples' comments included, "The girls (staff) are great, they take great care of us," "The staff treat me with respect," "The girls are good to me," "It's very nice here they look after me well," "I've been here a long time and the girls are nice to me, they are so kind," and, "Staff are lovely." Relatives' comments included, "We are very happy with (Name)'s care, staff have been brilliant," "The staff do their best, we have never seen anything wrong, (Name) is happy here, they respond well to most carers," and, "The staff are nice to (Name), they interact well," "(Name)'s clothes always look clean which we know can be difficult to maintain," "(Name) is always well groomed," "Staff know us by name, and they are always so helpful," and, "We're really happy with it all." A relative commented, "I'm happy enough with the care but it's the little things like toenails not being cut or (Name) being in the wrong clothes, some things have gone missing, like (Name)'s watch. We know they can't help some things but it's a bit poor really." We discussed this with the peripatetic manager who was aware of the concerns and told us the watch had been reported as missing and other issues were being addressed.

We had concerns however about some aspects of care people received.

From our observations we considered improvements were needed to ensure that all staff interacted with people at all times, and not only when they carried out care and support with the person. Although staff had limited time to interact with people their conversation was meaningful when they did as they supported them. There was a lack of conversation or attempts at conversation by the agency staff with people.

We observed the lunch time meals on all floors of the home. The dining experience was not well organised in all the dining rooms. We saw dining tables were set with tablecloths, condiments, cutlery and any specialist eating equipment people needed. A menu was available in the downstairs dining room but no written or pictorial menus were available upstairs to help people select their food. Staff did not see when someone poured juice onto their meal as they weren't sure what to do so we intervened. We observed some people who were ambulant left the dining room before they had finished their meal and staff did not know what they had eaten. Some people may have continued to eat their meal with encouragement from staff if they had been available to supervise them.

Upstairs we saw people in one dining room waited over 45 minutes for their meal as the other dining room was served first. People were sitting at the table waiting and three people kept asking for a drink and a drink was not served when they asked until we intervened. In the upstairs dining rooms we observed that staff did not show people two plates of food to help them make a choice to decide what to eat. There was limited staff available in all dining rooms to support people with tasks such as cutting their food up, supporting people with eating and prompting them to eat their food. Where staff did have the time they did this in a quiet and unhurried manner, sitting next to the person and assisting them to eat.

In the downstairs dining room conversation was lively when staff were present but it then became silent again when staff left the dining room to answer call bells or deliver meals to bedrooms. Although staff were supportive when they were available assisting people with meals, there were not enough staff to help all people who required encouragement. At least two people had left before they were offered a drink or a pudding. Six people were assisted to eat in their bedroom and four people were assisted to eat in the dining room. Six people also required encouragement and prompts to eat their food. We saw there were not enough staff available to provide the necessary support and guidance to people who required it.

On the top floor which provided care and support to people who lived with dementia, or dementia related conditions we saw no pictorial aids or orientation aids, such as an activity board to advertise activities and entertainment, menus and calendars, newspapers, magazines or books to help remind people of the date and time. This meant people were not helped, by their environment, to be mentally stimulated and remain involved.

People said their dignity was respected. However, we observed although some people were well groomed, others wore clothing stained with food that remained unchanged all day. A relative was heard to say, "What have they done to your hair, where's your brush. I'll have to find it you can't stay like that."

Requires improvement

Is the service caring?

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were observed to be respectful in their approach with people. They called people by their preferred name. Staff we spoke with were able to clearly explain how they would preserve people's privacy, for example when providing personal care.

Throughout the visit, the interactions we observed between staff and people who used the service were friendly, supportive and encouraging. Staff asked the person's permission before they carried out any intervention. Staff explained what they were doing as they assisted people, for example as they assisted them in the hoist transfer and they met their needs in a sensitive and patient manner.

Staff we spoke with had a good knowledge of the people they supported. They were able to give us information about people's needs and preferences which showed they knew people well. They described how they supported people who did not express their views verbally. They gave examples of asking families for information and showing two items of clothing so people could choose what they would like to wear. This encouraged the person to maintain some involvement and control in their care. Staff also observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain.

Most records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision themselves. For example, emergency health care plans were in place for people that showed a "best interest" meeting had taken place with the person's family and the GP, to anticipate any emergency health care problems. Where people had made advanced decisions on receiving care and treatment we saw the correct forms were used. The care plan detailed the "do not attempt resuscitation" (DNAR) directive that was in place for the person. We discussed with the manager one's person's DNAR directive that did not show that it had been signed by all the appropriate people with a 'best interest' meeting taking place. The manager told us they would speak to the district nurse attached to the home to address this and check other people's forms. This was necessary to ensure up to date and valid healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

We were told the service used advocates as required but most people had relatives. Advocates can represent the views for people who are not able to express their wishes. We were told two people had the involvement of an advocate

Requires improvement

Is the service responsive?

Our findings

Some people confirmed they had a choice about getting involved in activities. Comments included, "I do gardening in the grounds. I talked to the 'gaffer' (Manager)and me and the activities staff do the flower beds, we got third prize," and, "I've got my television and my things and they bring me things to do but I don't go anywhere." A relative commented, "There's a book with all the activity photographs in it.(Name) is in them enjoying themselves, so (Name) does do things."

We saw a number of planned activities advertised on the notice board downstairs that included, flower arranging, bingo, pamper sessions, balloon therapy, 'Oomph' exercises, baking, hairdressing, church services, charity events, visiting entertainers and planned seasonal parties. The activities person told us, "I'm on care duties today, we are short of staff with sickness and such, so I help out wherever I can. We do exercises and pamper sessions, and all the girls (staff) join in if they can, if they're not busy. With us being short staffed it will depend on what time I have and what I can get round to. When there's enough staff on we do all sorts."

We had concerns people who lived with more severe dementia or a dementia related condition were not stimulated. Staff did not have time to carry out activities with people when the activities person was not available.

On the top floor which accommodated some people who lived with more severe dementia or cognitive impairment, there were no activities available to stimulate people. We observed staff on the unit only had time to engage and interact with people when they were carrying out a task with a person. For example, when they offered a person a drink, or when they helped people to mobilise. We saw people sat sleeping in the lounge for most of the day whilst a television showed day time television which we saw no one was watching. The volume was low so people would be unable to hear unless they were sitting close to the television. In other areas of the home people sat without music or television and many sat sleeping. Some people also remained in their bedrooms without stimulation and staff did not spend time with them except when they took meals and carried out tasks with them. Care was task centred rather than person centred. This meant support workers carried out tasks with people rather than attending to them at a time they may choose and spending time sitting interacting with them.

Records showed people's needs were assessed before they moved into the home to ensure that staff could meet their needs and that the home had the necessary equipment to ensure their safety and comfort. Up-to-date written information was available for staff to respond to people's changing needs. Records showed that monthly assessments of people's needs took place with evidence of regular evaluation that reflected any changes that had taken place. For example, with regard to nutrition, wound care, mobility and falls and personal hygiene.

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in people's needs. A tissue viability nurse had been involved to assess some peoples' skin condition and to give advice about what pressure relieving equipment was required to minimise any risk to the person. Care plans reflected the advice and guidance provided by them and other external health and social care professionals. For example, a person's care plan for pressure area care stated, "Remains on two hourly positional changes, continually nursed in bed on airflow mattress."

Staff completed a daily report for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording when staff turned a person in bed, where it was identified a person was at risk of developing pressure areas. These records were necessary to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

The care plans gave staff specific information about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. They detailed what the person was able to do to take part in their care and to maintain some independence. For example, a care plan for personal hygiene stated,

Requires improvement

Is the service responsive?

"(Name) will participate in their personal hygiene but requires some assistance from staff," "Name is able to wash themselves and brush their teeth with prompts and encouragement from staff." A care plan for moving and assisting stated, "Two staff to assist (Name) offering reassurance and step by step explanations of actions." Care plans were up-to-date and they were reviewed monthly and on a more regular basis, if a person's needs changed. Staff told us they were responsible for updating designated people's care plans. One person's care plan had been reviewed due to a change in their needs, "Due to this deterioration care plan to be re-evaluated and updated over the next four weeks."

Information was available to help staff provide care and support when a person was no longer able to tell staff themselves how they wanted to be cared for. People's care records contained information which had been collected from their families about their life history and likes and dislikes which gave staff some insight into people's previous interests and hobbies when people could no longer communicate this themselves. Information was available with regard to peoples' wishes for care when they were physically ill and recorded their spiritual wishes or funeral requirements. For example, a care plan stated, "(Name) is Church of England, but doesn't practice any more." This information was important as well as the health care information that was available about people's wishes at this important time in their lives. We saw a weekly religious service was advertised to take place each Sunday. Large print communion sheets were available from the local parish church for people to use if they wished or if they had any visual impairment.

Regular meetings were held with people who used the service and their relatives. The peripatetic manager was also available to speak to relatives and people individually. The dates for forthcoming meetings were advertised so people had notice of when they were to take place in case they wanted to attend. We saw some meeting minutes that recorded the meeting had not taken place as relatives had not attended. Resident meeting minutes showed people were consulted about menus, availability of drinks during the day, cleanliness of the building and activities and entertainment. The peripatetic manager told us about the possible formation of a resident committee if people who lived in the home were interested. We spoke with some people during the inspection who would have been able to give their views and suggestions.

People said they knew how to complain. The complaints procedure was on display in the entrance to the home. People also had a copy of the complaints procedure that was available in the information pack they received when they moved into the home. A record of complaints was maintained and we saw one complaint had been logged by the by the home since the last inspection. The complaints log did not include the complaints and concerns the CQC had received and had asked the home to investigate about the staffing levels and some aspects of care provided to people. The need to record these, and any others received by other agencies and referred to the home to investigate, in the complaints log was discussed with the peripatetic manager.

Requires improvement

Is the service well-led?

Our findings

A permanent manager was not in post but one had been appointed and was due to start at the service in January 2016. A manager for Dovecote Nursing Home was therefore not registered with the CQC. A peripatetic manager was managing the home and had been in position since the previous manager left in July 2015. The peripatetic manager understood their role and responsibilities to ensure notifiable incidents such as safeguarding and serious injuries were reported to the appropriate authorities.

We were told regular analysis of incidents and accidents took place. The peripatetic manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. Records showed a person who had fallen more than twice was referred to the falls clinic. We had concerns however regarding some of the safeguarding notifications we had received. These had shown repeat behaviours had taken place on four occasions involving the same person. CQC had needed to intervene to ensure people were kept safe and were not at risk. Other incidents had involved people having altercations with each other as staff were not around. Monthly accident records also showed there were several unobserved accidents each month when people had fallen and they were 'found on the floor' either in the lounge or their bedrooms as staff were not available to supervise people. This was discussed with the peripatetic manager and we were told it would be addressed.

Records showed audits were carried out regularly and updated as required. Audits included checks on, documentation, staff training, medicines management, accidents and incidents, finances, nutrition, skin integrity and falls and mobility. Daily, weekly and monthly audits were carried out for health and safety, medicines management, laundry and maintenance of the environment. We had concerns however, although audits were carried out such as for accidents, incidents and safeguarding they had not highlighted deficits in certain aspects of care to ensure people received safe and timely care. Audits had also not identified deficits in some areas of the environment and people's poor dining experience.

An infection control, care planning, pressure care and medicines audit was carried out three monthly. The peripatetic manager told us monthly visits were carried out by the area manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans and staff files. These checks were carried out to ensure the care and safety of people who used the service and to check appropriate action was taken as required.

Staff told us and meeting minutes showed meetings took place approximately monthly. They were held to keep staff updated with any changes within the home and to discuss any issues. Meeting minutes showed recent meetings had discussed policies and procedures such as safeguarding, staff performance, staff morale and absenteeism, infection control, people's care and record keeping. A health and safety calendar was available that identified tasks that had to be completed each month with regard to health and safety in the home. Health and safety meetings took place with staff.

Managers' meetings were also held with other managers in the organisation, to discuss any changes to be implemented to enhance the running of the homes and consistency within the organisation. We saw the improved record keeping and how records were accurately reflecting the care provided by staff as a result of the monthly audits. A financial audit was carried out by a representative from head office annually.

The registered provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to staff and people who used the service. Findings were available from a recent survey that had been sent to staff and people who used the service. We saw some of the findings were varied. They were less positive with regard to the environment and training. We were told these were areas that were being addressed.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had not ensured staffing levels were sufficient to provide safe and person centred care to people at all times.** **Regulation 18 (1)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The registered person had not ensured, in relation to the premises, that they were properly maintained.** Regulation 15 (1)(e)

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 registered person had not ensured that service users' care and treatment was designed to meet all their needs and that they received person- centred care.** Regulation 9 (1)(3)(b)(d)