Dove's Nest Limited

Doves Nest 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 28 and 29 September 2017 and was unannounced.

Doves Nest Nursing Home provides accommodation and nursing care to up to 40 older and younger age adults. The service provides care to people with complex needs in relation to physical disabilities. Accommodation is located across three floors, with a passenger lift available between floors.

We last inspected Doves Nest Nursing Home on 08 and 09 March 2016 when we rated the service good overall. At that inspection we identified one breach of the regulations, which was in relation to the safe management of medicines. Following the inspection the provider sent us an action plan to tell us about the changes they would make to ensure they were meeting the requirements of the regulation. Whilst there was scope for further improvements to be made in relation to the safe management of medicines, we found the provider was now meeting the requirements of this regulation.
At this inspection we also identified additional breaches regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to providing safe care and treatment, good governance and requirements to display the service's performance rating. You can see what action we have told the provider to take at the back of the full version of this report.
We have also made two recommendations, which were in relation to the provider reviewing good practice guidance in relation to the implementation of the Mental Capacity Act 2005, and reviewing guidance and risk assessing the safety of the premises in relation to the needs of people living there.

People living at the home told us staff were kind and treated them with respect. We saw people were comfortable requesting support from staff, which was provided promptly. Staff knew the people they provided care and support to, including any preferences, likes and dislikes they had.

The chef was proactive in meeting people's preferences for meals. People provided us with positive feedback about the food on offer and we found their dietary requirements were met.

The home had made improvements to the way they managed medicines. We found protocols were now in place to inform staff when to administer when required medicines, and body maps were being used to help ensure the safe application of topical medicines such as creams. However, we found further improvements could be made. For example, quantities of medicines carried forward from previous months were not always recorded, which meant we were not able to work out if people had received their medicines as prescribed. One person was prescribed a 'when required' medicine and there was no plan or protocol in place to inform staff why and when to administer this medicine.

We found the provider had not fully considered potential risks to people's health safety and wellbeing arising from the management of the premises. For example, we found some people living at the home lacked capacity and were subject to authorised restrictive practices. There was no restriction on people leaving the home without staff being aware. Whilst the registered manager felt no one at the home was at

risk, there was no documented risk assessment. Not all windows had restrictors that met current guidance about their required standards. The registered manager did not feel these potential hazards posed a risk to anyone living at the home. However, this was not as a result of any formal risk assessment.

We found risk assessments were not consistently completed for all people living at the home. For example, we found one person did not have a bed-rail risk assessment, and none of the risk assessment tools had been completed for another person who had moved into the home over two months previously. This meant staff may not be fully aware of potential risks posed to these people's health and wellbeing or how to reduce such risks.

The environment at the home was clean, bright and spacious. The home was set in large, well-maintained gardens that were accessible to people living at the home. The home also had facilities such as a sensory room.

The registered manager had submitted deprivation of liberty safeguards (DoLS) applications to the local authority as required. Staff were aware of the principles of the Mental Capacity Act (MCA) and DoLS. However, we found some forms in people's care files suggested relatives were being asked to provide consent on their family member's behalf when they did not have lawful authority to do so.

Staff were mindful to support people in ways that respected their dignity and promoted their independence. We saw staff routinely offered people choices and supported people at a pace comfortable for them.

People had detailed care plans in place that were personalised to individuals' needs and preferences. Whilst care plans had been regularly reviewed, we found in a number of instances, they were not reflective of the care people were currently receiving.

A range of activities were provided and planned to meet the needs and preferences of people living at the home. However, we received mixed reports from people in relation to whether they felt sufficient activities were provided. There had been a reduction in the level of provided activities whilst the activity co-ordinator was covering care shifts for staff vacancies and leave.

The service had asked for feedback from people using the service. We saw this had been used to make improvements to the home, and to provide feedback to staff during supervisions.

There was a registered manager 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. Staff felt well supported by the registered manager and told us they were approachable.

We found shortfalls in the home's audit processes and record keeping. Audits of medicines had not taken place on a routine basis, and checks on the quality of care plans were limited in scope and had not identified the issues we found of care plans not reflecting people's current care. We found some records of care, such as repositioning for people at risk of pressure ulcers had not been maintained.

Whilst the provider was displaying the home's rating within the home, it was not displayed on the service's website, which is a legal requirement.

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 consistently safe.

The service had not always adequately identified nor assessed potential risks to people's health and safety.

Medicines were generally managed safely. However, there were not always clear plans in place to inform staff when to administer 'when required' medicines.

There had been no recent accidents at the home resulting in serious injuries. Staff were aware of how to identify and report potential safeguarding concerns.

Is the service effective?

Good

The service was effective

People enjoyed the food provided and were given a choice of meal. The service actively considered people's preferences and adopted the menus to meet them.

Staff received regular supervision that covered topics to help ensure they were competent and adequately supported.

The service had carried out best interests decisions where people were not able to make choices about their care themselves. We saw some forms in people's care files suggested others could make decisions on their behalf when they did not have legal authority to do so.

Is the service caring?

Good

The service was caring.

People told us staff were caring. Staff knew the people they provided care and support to well.

Staff interacted respectfully with people. They offered people choices and provided reassurance when needed.

Staff supported people to retain their independence and

respected people's privacy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were detailed and personalised to people's needs. However, they did not always accurately reflect the current care people were receiving.

There were a range of varied activities planned to meet people's social needs and provide stimulation. However, at the time of the inspection, the activities co-ordinator was covering care shifts, which had a negative impact on the provision of activities.

People were confident to raise any concerns or complaints they had. We saw complaints were investigated and responded to in a timely way.

Is the service well-led?

Requires Improvement

The home was not consistently well-led.

The home sought feedback from people living there and acted on this to make improvements.

Accurate and complete records of care provided were not consistently maintained. For example there were no records of repositioning when people required this support.

Checks that medicines had been managed safely had not been completed on a regular monthly basis as intended by the provider.

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

We brought this comprehensive inspection forward from the original planned date due to concerns that had been shared with us about how the service had managed a safeguarding incident and also how they managed risks of absconsion. Whilst we did not investigate the specific complaint raised, the inspection examined the service's performance in relation to these areas.

The inspection took place on 28 and 29 September 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors 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.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports and feedback received from one call to CQC raising a complaint about the service and one 'share your experience' webform submitted via the CQC website. We also reviewed any notifications the service had sent to us since our last inspection in relation to safeguarding, serious injuries or other significant events that had occurred.

As we brought this inspection forward, we had not asked the provider to complete a provider information return (PIR). A PIR is a form we ask providers to complete to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We contacted Manchester Healthwatch, Manchester City Council quality and contracts monitoring and the infection control teams and the Manchester clinical commissioning group (CCG), for feedback about the service. We did not receive any feedback.

During the inspection we spoke with nine people living at the home and four of their friends or relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight staff, including the registered manager, the operational lead, two care staff, the chef and three nurses.

We reviewed records relating to the care people were receiving. This included eight care files, daily records of care and medication administration records (MARs). We reviewed other records relating to the running of a care home including, four staff personnel files, records of training and staff supervision, records of servicing and maintenance and audits/checks carried out.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in March 2016 we found medicines were not being managed safely. There were no body maps in use to show staff where they should apply cream medicines, and there were no protocols to inform staff when they should administer 'when required' medicines. We found this to be a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, whilst there was scope for further improvements to be made, we found the provider was now meeting the requirements of this regulation.

We saw medicines were stored securely in a locked medicines trolley, fridge or controlled drugs cabinet as required. Controlled drugs are medicines that are subject to additional legal requirements in relation to their safe storage, administration and destruction due to the risk of their misuse. Two staff had signed the controlled drugs register when new stocks had been received, or when administering these medicines. We counted a sample of the stock and saw the amount remaining reconciled correctly with the amount recorded in the register. Staff monitored the temperatures of the clinic room and medicines fridge daily to help ensure medicines were stored at their recommended temperatures.

Since our last inspection, the service had started using body maps to indicate to staff where they should apply people's cream medicines. Staff recorded the administration of medicines on people's medication administration records (MARs). These records had been completed consistently without any unexplained gaps. However, it was not possible for us to verify that all medicines had been administered as recorded on people's MARs as staff had not always recorded the amount of medicines stock carried forward from the previous month on the MARs. This would also make it difficult for the provider to check medicines were being administered as prescribed on a consistent basis.

Some people living at the home were prescribed medicines to be taken 'when required' (PRN). We saw most people had PRN protocols in place in their care plans. The protocols provided staff with information about when these medicines should be administered and their intended effect. One person had been prescribed a PRN antihistamine medicine and there was no PRN protocol or reference to this medicine in this person's care plan. We spoke with a nurse on duty who was aware of the reasons this medicine was prescribed and of the signs that would indicate it might be required. However, the lack of clear, recorded direction would increase the risk that this medicine would not be provided at the times it was required, particularly if new or temporary staff were administering medicines.

We found appropriate servicing, maintenance and required checks had been carried out to help ensure the premises and equipment were safe. This included regular examinations of lifting equipment such as hoists, checking the temperature of hot and cold water outlets, servicing of the fire alarm system and checks of the electrical system and gas appliances.

The provider had risk assessments in place relating to fire safety and legionella. Legionella is a type of bacteria that can develop in water systems and cause Legionnaire's disease that can be dangerous, particularly to more vulnerable people such as older adults. However, we found shortfalls in the assessment

of risk in relation to other potential environmental hazards.

Prior to the inspection we received information of concern, including an allegation that staff had been preventing a person from leaving the home by using furniture to block access to the front door of the home. This concern was also reported to the local authority safeguarding team. Whilst we did not investigate this specific concern, we considered how the provider managed the potential risks of people leaving the home alone when they were not safe to do so.

Whilst the front door was locked to people coming into the home, we found there was unrestricted access for people to leave the home without staff being made aware. Whilst this would be the least restrictive arrangement for people living at the home, it is important that any potential risks of such an arrangement are considered. The registered manager told us there was no specific risk assessment in relation to the unlocked front door, but that they would carry out an individual risk assessment if they felt this was necessary for anyone living at the home. We asked the registered manager how they managed the risk that a person who lacked capacity and might be vulnerable would leave the home alone. They told us the majority of people living at the home would be unable to leave alone due to mobility impairments and said they would be unlikely to admit someone to the home whose needs required restrictions such as a locked front door. However, as people's needs change over time, it is important that such arrangements are regularly reviewed and risk assessed.

We found some windows in the home had window restrictors that could be disengaged without the use of a specialist tool. This is contrary to guidance issued by the Health and Safety Executive that window restrictors should be suitably robust and not able to be overridden without the use of special tools. The registered manager told us they did not think anyone would be at risk of falling from a window. However, there was no risk assessment in place to demonstrate the potential risk had been fully considered.

We recommend the provider reviews guidance from a reputable source in relation to managing the safety and security of care home premises, and that a competent person carries out regular risk assessment relating to use of window restrictors and access/egress arrangements.

Most people's care files contained risk assessments that considered potential risks to their health, safety and wellbeing arising from hazards such as falls, skin breakdown, malnutrition and moving and handling. Whilst there was no separate risk assessment tool used to assess risks relating to choking, we saw risks of choking or aspiration were highlighted in people's care plans. We found staff were aware of, and followed the advice of specialists such as speech and language therapists (SALTs) in relation to the support people need to eat and drink safely.

Staff had completed risk assessments for most people using bed rails. However, we found one person's bedrail risk assessment was blank. This meant the provider could not demonstrate that they had considered whether bedrails were safe and suitable to use for this person. We raised this with a member of nursing staff who told us they would complete the risk assessment.

We found other examples where staff had not completed risk assessments as required. We reviewed the care file of a person who had moved to the home July 2017. This person had a care plan that demonstrated some consideration of risks to their health and safety and how to reduce such risks. However, routine risk assessments such as those relating to falls, malnutrition, skin integrity and a personal emergency evacuation plan (PEEP) had not been completed since they had moved to the home 10 weeks previously. The nurse we spoke with told us this must have been an oversight and that risk assessments were usually in place within two to three days of admission. This person's care plan also indicated they were at risk of falls

and that staff needed to support and supervise them whilst using the stairs to ensure their safety. However, there were no specific details about what support it was that staff should provide to ensure this person's safety in their care documents,

The provider had not carried out adequate assessment of risks in relation to individuals' care and support. This was a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not notified the Care Quality Commission (CQC) of any serious injuries occurring at the service since our last inspection. Records of accidents confirmed there had been no recent serious injuries occurring at the service and this was also confirmed by the registered manager. Staff had completed accident forms for any minor injuries people had sustained. The forms showed staff had considered the cause of any accident and detailed any actions taken to reduce the likelihood of a reoccurrence. During the inspection we observed that staff supported people safely using equipment such as hoists when required. When people used mobility aids such as walking frames we saw these were left close by so people could reach them.

People told us there were always staff on hand to provide them with support when they needed it. Comments included, "I have not experienced anything that says there are not enough staff", "Staff are always passing by and always on the move, doing something for someone" and "I have never felt unsafe. If I want staff I just press the buzzer [call bell]." During our inspection we observed that people received support in a timely way and that there were staff close by should anyone require assistance.

The registered manager told us the existing staff team covered any shortfalls in staff cover due to sickness, leave or vacancies. The exception to this was one nursing shift each week, which was being covered by the same regular member of agency staff. We reviewed staff rotas and saw the number of nurses on duty on the day shift varied between one and two nurses. The registered manager explained that when there was one nurse on duty, an additional experienced member of care staff who had received training to carry out delegated nursing tasks was also put on duty. The nurse and senior care staff we spoke with confirmed this and told us they found this arrangement worked well. Care staff we spoke with felt there were adequate numbers of staff on duty to allow them to meet people's needs.

Staff were aware of their responsibilities in relation to safeguarding. They were able describe the signs they would look for that might indicate a person was being abused or neglected, and were aware of how to report such concerns accordingly. During the inspection, the registered manager informed us about a safeguarding alert they were going to raise in relation to concerns they had about the care a person living at the home had received from another service. This showed the service were proactive in identifying potential safeguarding concerns and reporting them appropriately to help ensure people were protected from harm. Staff were confident that any concerns they reported would be acted upon appropriately.

The registered manager kept a record of any safeguarding issues they raised or were made aware of. We saw the service had investigated safeguarding concerns when requested to do so by the local authority, which included reviewing documents and taking statements from staff members. Where required, we could see the service had made changes to practices and procedures to help ensure people were kept safe.

Staff were recruited following robust procedures to help ensure they were of suitable character to work with vulnerable people. We saw staff had completed an application form that required their full employment history and contained a health declaration. Staff attended an interview and the service had also obtained references, identification and a disclosure and barring service (DBS) check prior to making a decision to

recruit the applicant. DBS checks provide information on any convictions a person has, and helps employers make safer decisions when recruiting staff.

The environment was visibly clean and tidy. We saw personal protective equipment (PPE) was available for staff to use and was located around the home, as were dispensers containing anti-bacterial foam. We saw signs around the home encouraging staff and visitors to wash their hands or use the anti-bacterial foam from the dispensers. During the inspection we visited the laundry and saw procedures were in place to keep clean and dirty laundry separated. All such measures would help to reduce risks from the spread of infection.

Good

Is the service effective?

Our findings

The environment at the home was clean, light and spacious. The home was set in large, well-maintained gardens that were accessible to people living at the home. We saw equipment such as tracking hoists (hoists attached to tracks on the ceiling) was available in some areas of the home, which one staff member described as being 'ideal'. The home had a room containing sensory equipment on the first floor as well as an interactive games system. We saw one person using the games system during our inspection, and staff told us the sensory room was regularly used by people who were visited by an aromatherapist.

People told us they liked the food provided, and they told us they were offered a choice of meal. Comments included, "They do cook good food. There is choice", "The food is alright. Staff ask you what you want to eat", "I like it [the food] because it is homemade" and "It is brilliant. I like salad and cheese. They give you anything you want."

The chef was proactive in adapting the menus and meeting people's preferences in relation to the food served. We saw they asked for people's meal preference in the meal in the morning and provided other options if people did not want what was on the menu. During the inspection we saw several different meals being served. The chef told us, "There is nothing I would not do for the residents. We chop and change the menu to meet peoples' individual likes and dislikes on a regular basis. It is interesting how culturally different our residents are, and I cater for their need irrespective of where they come from. For example, we have a lady from Poland and I make her favourite Polish meal. I also prepare a jerk chicken for some residents in the home."

We saw the chef had information on people's specific dietary requirements. From discussion with them, we found they also had a detailed knowledge of people's preferences. For example, they talked about one person who liked to have their breakfast slightly later in the morning and another person who liked the milk for their cereal warmed. We saw that meal times were a social occasion, and people received effective support from staff to eat and drink when they required such support. For example, we saw staff supported one person to eat a fork mashable texture meal. They spoke with the person about the meal and supported them at a pace they were comfortable with. Outside of meal times we saw there were regular drinks rounds and snacks on offer. People could also help themselves to drinks from drinks dispensers located around the home.

Some people living at the home received their nutrition via a percutaneous endoscopic gastrostomy (PEG). A PEG is a tube that is inserted into the stomach, often to provide food, fluids or medicines to people who are not able to take them orally. We found staff had the required information from a dietician as to what support people required with their PEG, and the amounts and types of feed that should be given. Staff kept records of the care they provided in relation to people's PEGs. However, there was no record in relation to rotation of the PEG and checking the cleanliness and condition of the site where the PEG was inserted. It is important such care is provided to prevent potential complications with the PEG arising. Nursing staff confirmed they routinely carried out this care but had not recorded it on the forms. We have discussed record keeping in further detail in the well led section of this report.

Records showed a range of health professionals including GPs, speech and language therapists (SALTs) and dieticians had been involved in people's care. Whilst we found staff were aware of and following advice from other professionals, this information was not consistently recorded in the same place in people's care files and was in some cases hard to find. This would increase the risk that staff and other professionals reviewing the person's care would not have the most up to date information about the person's current needs.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw applications had been made to the supervisory body (the local authority) where the service had identified people lacked capacity and were subject to potentially restrictive practices. The staff we spoke with were aware of people who had an authorised DoLS in place and any conditions attached to the authorisation.

During the inspection we observed that staff asked for people's consent before providing care or support. People told us they were involved in decisions about their care as far as was possible. Most people's care files did not contain capacity assessments or forms to indicate they had provided their consent where able to the planned care. However, we saw that where more significant decisions needed to be made, such as in relation to the use of potentially restrictive practices such as using bedrails, the home had followed correct procedures in assessing people's capacity to make that specific decision. Where people were found to lack capacity, the home had followed a best interests decision making process to determine what care to provide.

We saw some people's care files contained forms that nominated others to make best interests decisions on their behalf in the case that they became unable to make decisions about their care themselves. Some of these forms were also signed just by people's relatives who did not have legal authority to make decisions on behalf of their family member. Decisions about another person's care can only be made by a person such as a relative where they have valid legal authority, such as a lasting power of attorney for care and welfare. We discussed this with the registered manager who told us the forms indicated who the person wanted to be involved and consulted about decisions relating to their care, and not who the ultimate decision maker would be.

We recommend the provider reviews guidance in relation to the MCA and DoLS and processes around decision making where people lack capacity.

Staff told us they received regular supervision and appraisal, and told us they felt well supported by the management team. The home employed a clinical lead who nursing staff told us they were able to go to for advice, and who supported clinical supervision. Records of supervisions confirmed that staff received regular one to one sessions with their manager or supervisor. The home used a set format for supervisions, which included feedback to the staff member on their performance and discussions about topics including the home's philosophy of care, safeguarding and a review of training. We also saw that in some instances people living at the home had been asked to provide anonymous feedback on individual staff members'

performance, which was incorporated into supervision discussions. Covering this set agenda helped the registered manager effectively monitor staff performance, as well as helping to ensure staff received the support and encouragement they needed to improve their performance.

Staff had completed training in a range of topics that were relevant to their job roles. This included moving and handling, fire safety, the MCA, infection control, health and safety, dysphagia (swallowing difficulties) and safeguarding. We saw some staff had also completed additional training to allow them to support people who had particular care needs. For example, nursing staff and some care staff had completed training in areas such as tracheostomy, PEG care, epilepsy, venepuncture (taking blood samples), syringe drivers and wound management. Staff told us they felt they received sufficient training to enable them to meet people's needs effectively. People we spoke with living at the home also felt staff were competent and well trained.

We spoke with one member of staff who had recently started work at the home. They told us they had received a good quality induction, which had included time for them to shadow more experienced staff and get to know people living at the home. We saw the provider had materials in place to support staff who were new to care to undertake the care certificate. The care certificate is a set of minimum standards that should be covered for new care workers. Following the standards helps ensure any new care staff are competent to provide safe and effective care.

Good

Is the service caring?

Our findings

People reported they had positive relationships with the staff team, who they told us were kind and caring. Comments we received about staff included, "Everyone is nice. They care", "The place is nice; the staff are very friendly", "The staff are lovely; they look after me even after I have been mean to them" and "Staff are brilliant. I get grumpy at times and staff take it."

During the inspection we observed that whilst busy, staff took time to interact and talk with people. People were comfortable asking staff for assistance if they needed it. We could tell people knew the staff working with them as they used their first names when talking to them. Staff, including the registered manager knew people living at the home well, and were able to tell us about people's social histories and preferences.

We saw staff supported people in a respectful manner that supported their dignity. For example, when supporting people to eat meals, staff talked with the person, sat at their side and did not rush them. Staff members' conversations with people involved offering them choices, listening to their responses and providing reassurance when needed. Staff regularly checked people were comfortable and asked them if there was anything they wanted. People appeared clean and well-presented and we saw staff helped people to clean their face and hands after their meals if needed to help maintain their dignity.

During the inspection we observed positive examples of staff supporting people's independence and encouraging people to make decisions themselves. At one point in the inspection we heard a staff member ask a person if they wanted a dessert. Another person living at the home answered on this person's behalf. However, the staff member took time and encouraged the person to communicate their wishes themselves. We observed another staff member supporting people over the meal time. They told the person they were there if they wanted help with anything, but assured the person they were not watching them eat. This showed the staff member had considered how to support this person's independence and uphold their dignity whilst being on hand to provide assistance if needed.

People told us staff respected their privacy. We saw staff knocked on people's doors before entering. Staff told us they felt comfortable challenging other members of the staff team if they saw any poor practice in relation to respecting people's privacy. One staff member told us, "We are always looking out for each other and looking to improve. A colleague might say that they didn't see me knock on a door before I entered. It's a reminder to protect people's privacy and dignity." We saw care records were kept securely in an area they could only be accessed by staff or other authorised persons.

There was a display board in the home giving information on the Gold Standards Framework (GSF) for end of life care. The GSF is an accredited approach to delivering good quality end of life care to people using services. The registered manager told us the home had previously held GSF accreditation and was in the process of applying for re-accreditation. We saw some people's care files contained details about their end of life care wishes. Care files also contained check-lists to help guide staff about the care and care planning that was required at different stages of the person's life.

Requires Improvement

Is the service responsive?

Our findings

People had personalised care plans in place that provided staff with information on people's health and social care needs and how to meet them. We saw care plans contained information on people's preferences in relation to how they received their care. For example, one person's care plan informed staff that they usually preferred their hair to be short and their nails to be cut short. Information on people's social histories, interests and others involved in their care was also recorded in people's care records. This information would help staff get to know people and provide person-centred care.

Although staff had reviewed care plans on a regular monthly basis, we found some care plans had not been rewritten in over one year. Staff we spoke with were aware of people's current care needs and how to meet them. However, this was not always reflected in people's care plans. For example, one person's care plan indicated they should use palm protectors to prevent injury to their hands and staff were not currently supporting the person to wear these. Another care plan directed staff to monitor a person's oxygen saturation levels and this was not done routinely. We discussed this with staff and were satisfied these people were receiving safe and appropriate care, despite it not following their documented plans.

We also found examples of where risk assessments and care plans directed staff to monitor people's weights weekly. However, we found weights for these people were only being recorded on a monthly basis. One person's care plan stated they should also be supported to take nutritional supplements and we found this was no longer the case. We discussed these findings with one of the nurses and were satisfied these people were not at risk of malnutrition and that there was a good rationale for the care currently being provided. However, as this was not reflected in the care plans, this would increase the risk that inconsistent care could be provided.

We received mixed responses when asking people about the activities provided. Some people listed a range of activities such as bingo, arm chair exercises and shopping that they enjoyed, whilst other people told us there was little of interest on offer to them. One person told us, "I go to the lounge, talk to people, play tombola, bingo, hang man and ten pin bowling. [Activities co-ordinator] organises all that. They are fantastic." A second person told us, "There's not much for me I am afraid. I would like to go to the park."

We saw there was an activities schedule that showed a wide range of activities were planned and that consideration had been given to the interests of people living at the home. The schedule included activities such as gardening, films, mocktail/cocktail making, 'your own hobby', 'minibus adventure' and 'pub experience'. We saw there had also been a recent fair and barbeque fundraiser at the home, and during the inspection we saw a seated exercise session taking place. However, at the time of our inspection the activities co-ordinator was working as a member of care staff due to vacancies within the staff team and staff annual leave. This had had an impact on the provision of activities. The registered manager told us they would resume their role supporting activities once they had recruited new care staff.

The home had a complaints policy in place. The policy stated that complaints would be acknowledged within three days, and provided people with contact details for external agencies, such as the local authority

and local government ombudsman, who they could escalate their complaint to if they were not satisfied with the home's handling of their concerns. People told us they would feel confident to raise any concerns or complaints they had with the registered manager or another member of staff. Most people told us they had not found any need to complain, and found any feedback they provided, such as at residents meetings, was listened to and acted upon. One person told us they had recently raised a complaint with the registered manager. We saw this had been recorded in the home's complaints log and that the registered manager was in the process of investigating the concern. We saw examples of older complaints where the registered manager had completed investigations and taken appropriate actions to make improvements or resolve the complaints within reasonable periods.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post who was also a director of the company. The registered manager was supported by a part-time clinical lead, an operational lead and a senior nurse. Staff were clear about their roles and responsibilities. They told us the registered manager was approachable and supportive. One staff member told us, "I've worked for [registered manager] for a long time. She is very good and very fair." Another staff member said, "[Registered manager] is a good leader. Firm but fair. Approachable and her door is always open."

Staff told us they enjoyed working at the home and felt valued for the work they did. We saw there were regular staff meetings that covered topics such as dignity, mental capacity, safeguarding and professional boundaries. This helped to ensure there was good communication amongst the staff team and that they were aware of their role and responsibilities. We saw there were print outs of a pair of eyes that were stuck to various doors and walls around the home. Staff told us this was a reminder from the registered manager that if they could see something that was not right or could be done better, the staff should be able to see this too. Staff we spoke with told us this was effective and did make them think.

We found the service had carried out a recent survey in August 2017 of people living at the home to get their opinions on what it did well, and what it could improve on. Shortly after our inspection, the registered manager sent us the analysis they had carried out of the results. The findings of the service showed people had a positive experience of the home. The service also carried out 'dignity audits'. These had been carried out in January, February, March and May 2017 and involved asking individuals for more detailed feedback about the home's performance and their experiences. We saw the registered manager had produced action plans following the audits that had been followed up. Actions included issuing a memo to staff about mobile phone use and arranging for decoration of a person's bedroom for example. This showed the home listened to and acted upon people's feedback to improve the quality of the service.

Audits and checks were carried out in relation to care plans, infection control, the environment and medicines. The care plan audit consisted of a check list of contents contained in the front of people's care files, along with a monthly care plan review form. However, we found these measures had not identified, nor ensured that people's care plans were always up to date and reflective of their current care needs. Medicines audits had not been completed consistently, this increased the risk that unsafe practices or management of medicines would not be identified. We saw the medicines audit had been completed in February, March and May 2017. There had been no audit from May 2017 to the time of our inspection at the end of September 2017.

We also identified shortfalls in relation to keeping accurate and complete records of care provided that had not been recognised by the audit and quality assurance systems in place. For example, we found staff did not keep a record of position changes for people who required this care to help reduce the risk of pressure sores. Records in relation to PEG care did not evidence that regular rotation or cleaning had taken place when this was required, and stocks of medicines carried forward from previous cycles were not always recorded on medication records. Some people's care files contained forms that were unclear and risked

being interpreted as providing other people with authority to take decisions on their behalf when they did not have legal authority to do this. We also found records of visits from health professionals were not always clearly recorded in a separate record, and were instead recorded in people's daily notes, which made it difficult to locate this information. It is important that clear and accurate records of care are maintained so that staff and other professionals can work out what care people have received and require.

These shortfalls in the provider's systems to monitor and improve the quality and safety of the service and to maintain complete, accurate records of care, were a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services that have received a performance rating from CQC, such as Doves Nest Nursing Home are required to display their rating at the home, and on any website maintained by or on behalf of the home. We found the home's rating from our inspection in March 2016 was displayed at the entrance to the home. However, it was not being displayed on the provider's website for the home. This was a breach of Regulation 20A(2)(7) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not carried out adequate assessment of risks in relation to individuals' care and support. Regulation 12(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not maintained accurate and complete records of care provided. Systems and processes to monitor and improve the quality and safety of the service were not operated effectively. Regulation 17(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider was not displaying their performance rating on their website. A fine of £100 has been paid by the provider as an alternative to prosecution. Regulation 20A(2)(7)

The enforcement action we took:

We issued a fixed penalty notice for £100