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Dovehaven

Inspection report

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Date of inspection visit:
17 July 2017
18 July 2017

Date of publication:
01 September 2017

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

Dovehaven is a care home providing accommodation and personal care for up to 40 older people. Due to its location there is good access to public transport and many local facilities are a short journey away in Southport town centre. There were 37 people accommodated at the time.
This was an unannounced inspection and it took place on 17 and 18 July 2017.

At the last comprehensive inspection in July 2016 we found breaches of regulations with in respect to, receiving and acting on complaints and good governance; we rated the home as 'requires improvement'. We completed a 'focused' follow up inspection in December 2016 and we found the breaches had been met. The home retained an overall rating of 'requires improvement' as we needed to ensure the service would show a record of consistency with meeting regulations.

At this inspection there was a manager in post who had applied to the Commission for registration. 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.
We found on this inspection that there were breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

There were systems in place to monitor the environment to help ensure it was safe and well maintained. However, these were not robust and we found that fire safety standards had not been monitored effectively which exposed people to potential risk of harm.

Staffing numbers had been increased since our last inspection and were, mostly, satisfactorily during the day. We found, however, the service had not been adequately staffed at night time for a short period which had left people exposed to potential risk of harm in case of an emergency.

We found the services governance [management] arrangements did not ensure effective monitoring of safe standards of care at all times. Some of the local audits and checks had failed to identify the issues we found on the inspection.

Care plans were completed and reviewed so that people's care needs could be monitored. We found that some of the care plans and charts used for evaluating care could be more detailed and consistent for staff to follow. We made a recommendation regarding this.

Medicines were administered safely. However, supporting protocols and records had not been completed .These were brought up to date at the time of the inspection.

We found the home supported people to provide effective outcomes for their health and wellbeing. We saw people were referred appropriately to health care services and there was liaison with health care professionals when needed in order to support people.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We saw required checks had been made to help ensure staff employed were 'fit' to work with vulnerable people.

Care and treatment was organised so any risks were assessed and plans put in place to maximise people's independence whilst help ensure people's safety.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report any concerns they had. .

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made. 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.

When necessary, referrals had been made to support people on a Deprivation of Liberty [DoLS] authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the manager of the home.

We saw people's dietary needs were managed with reference to individual preferences and choice.

People we spoke with said they were happy living at Dovehaven. Staff interacted well with people living at the home and they showed a caring nature with appropriate interventions to support people.

People we spoke with and their relatives felt staff had the skills and approach needed to ensure people were receiving the right care. There was good support in place for staff to receive training and on-going support

People generally felt involved in their care and there was evidence in the care files to show how people had been included.

Social activities were organised in the home. People told us they could take part in a variety of social events which were held; these continued to be developed.

We saw a complaints procedure was in place and people, including relatives, we spoke with were aware of how they could complain. We saw there were good records of complaints made and the manager had provided a response to these.

The registered manager was aware of their responsibility to notify us [The CQC] of any notifiable incidents in the home.

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 safe.

Although there were systems in place to monitor the environment to help ensure it was safe and well maintained we found that fire safety had not been monitored effectively which exposed people to potential risk of harm.

Staffing numbers in the home were mostly satisfactorily maintained; we found the home had not been adequately staffed for the night time shift for a short period which left people exposed to potential risk of harm in case of an emergency.

Medicines were administered safely. Some supporting protocols and records were not completed but these were completed and brought up to date on the inspection.

Staff had been appropriately checked when they were recruited to ensure they were suitable to work with vulnerable adults.

We found there were protocols in place to protect people from abuse or mistreatment and staff were aware of these.

Is the service effective?

Good

The service was effective.

Staff said they were supported through induction, appraisal and the home's training programme.

We found the service supported people to provide effective outcomes for their health and wellbeing.

Staff sought consent from people before providing support. When people were unable to consent, the principles of the Mental Capacity Act 2005 were followed in that an assessment of the person's mental capacity was made.
We saw people's dietary needs were managed with reference to individual preferences and choice.

Is the service caring?

Good

The service was caring.

When interacting with people staff showed a caring nature with appropriate interventions to support people. Staff told us they had time to spend with people and engage with them.

People told us their privacy was respected and staff were careful to ensure people's dignity was maintained.

People told us they felt involved in their care and could have some input into the running of the home.

Is the service responsive?

Requires Improvement

The service was not fully responsive.

Care plans were completed and were being reviewed so peoples care could be monitored. We found some care plans and charts used for evaluations of care could be more detailed and consistent for staff to follow. We made a recommendation regarding this.

There were some social activities planned and agreed for people living in the home.

A process for managing complaints was in place and people we spoke with and relatives knew how to complain. Complaints made had been addressed.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager. There was an acting manager in post who was applying to the Commission for registration.

There were a series of on-going audits and checks to ensure standards were being monitored effectively; some of the audits had not identified issues we found on the inspection.

We found the management structure had clear lines of accountability and responsibility which helped promote good service development.
The Care Quality Commission had been notified of reportable incidents in the home.

There was a system in place to get feedback from people so that

the service could be developed with respect to their needs and wishes. These included meetings and other formal processes.

Dovehaven

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 was 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 was an unannounced inspection which took place on 17 and 18 July 2017. The inspection team consisted of two adult social care inspectors, a pharmacy inspector and an 'expert by experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience with the care of older people.

Prior to the inspection we collated information we had about the service and contacted the social service contracting team to get their opinions. We also reviewed other information we held about the service.

During the visit we were able to meet and speak with 15 of the people who were staying at the home. We spoke with two visiting family members and one visiting professional.

We spoke with eleven of the staff working at Dovehaven including the manager and deputy, care/support staff, domestic staff and senior managers. We also spoke with one of the providers [owners] of the home.

We looked at the care records for four of the people staying at the home. We also looked at ten medication records, two staff recruitment files and other records relevant to the quality monitoring of the service. These included safety audits and quality audits including feedback from people living at the home and relatives. We undertook general observations and looked round the home, including people's bedrooms, bathrooms and the dining/lounge areas.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home. One person commented, "I'm quite sure I'll come to no physical harm" and another person said, "I feel safe because of the care, they're all very, very good."

There were arrangements in place to check the environment and to ensure it was safe but these were not robust.

During the inspection we checked the home to see if arrangements for fire safety were being maintained; we found concerns that exposed people to potential risk in case of an emergency.

We toured the home and found two fire exit doors were blocked. The acting manager showed us a daily 'walk around' audit which covered aspects of fire safety and was completed up to date; the audit had not identified the two fire exits which had been blocked; in one room the furniture blocking the fire exit route had been in place for some time. We reported our observations to the acting manager who made arrangements to ensure both exits were free.

We were made aware that the home had had difficulty in covering the night shifts for the previous three nights. The duty rota indicated two staff on the night shift from 14 to16 July 2017 for the 37 people accommodated. The acting manager reported it had not been possible to get an extra staff member [service normally had three staff on night duty]. We saw that there were also a number of agency staff who had limited knowledge of the service; this increased the risk in the event of an emergency fire evacuation. The acting manager explained that, as part of the emergency procedure, a 'grab file' was available and this contained information regarding the fire procedure. We found the file incomplete. Key information including Personal Emergency Evacuation Plans (PEEP's) had not been maintained and were not up to date or missing. For example, a person had been admitted to the home on 3 July 2017 but was not included on the PEEP's record in the 'grab file'. The acting manager updated the file before we completed our inspection.

We were concerned that reduced staffing numbers, some of whom had only a limited knowledge of the home together with a lack of robust fire safety arrangements had left people exposed to potential risk over the period 14-16 July 2017.

These findings were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

Health and safety audits were completed on a regular basis where obvious hazards were identified. Any repairs that were discovered were reported for maintenance and the area needing repair made as safe as possible. We spot checked safety certificates for electrical safety, gas safety and fire safety equipment and these were up to date.

Most people we spoke with told us there was enough staff to support them. Comments included; "They could do with a few more, everybody's busy [but I don't have to wait long for attention]", "I think they've

enough in principle", "I think so, I don't need looking after", "Occasionally they could do with extra, but they're so good those girls, they work really hard", "They seem to have", and "There's a shortage if somebody doesn't come in and it makes a big difference to the girls." A visitor told us, "There was a problem with staffing but it's been sorted since the new manager arrived. The care is very good now." During the inspection, we checked to see if there were sufficient staff to support people in a timely and effective manner. During the visit we made observations in the day area/lounge and spoke with people who used the service. We saw that people received care on time and were not left waiting for long periods

The manager told us there had been an increase in the staffing numbers since our last inspection. The morning shift day been increased by one carer so there were now four care staff in the mornings as well as the manager who also came in the home early [from 7am]. The night time shift had also been rationalise to make sure there were three waking night staff; this for 37 people resident at the time of the inspection.

When we spoke with care staff we were told that they enjoyed working in the home and felt there was a good atmosphere and good team work. Staff we spoke with confirmed that staffing in the home was relatively stable. One care staff commented, "The additional carer of a morning has made a big difference – we can spend more time and are not as rushed."

Our observations confirmed that people were mostly attended to in good time. However, there were some negative observations. For example there was very little staff around between 11:40 to midday and no staff at this time available in the TV room/conservatory. There was no call bell in the main lounge and residents relied on other residents to use the call bell in the conservatory, as nobody could reach it from where they were sitting.

We were concerned by the fact that for three consecutive night shifts prior to the commencement of our inspection there had only been two care staff on duty in the home. This included agency care staff. The manager explained the extenuating circumstances around this and the arrangement made to cover the home.

Prior to our inspection we received information of concern regarding the way medicines were being managed. A CQC medicines inspector looked at how medicines were handled in the home. We looked at records about medicines and arrangements for ordering and storing medicines. The last comprehensive inspection in July 2016 stated that medicines were being handled safely and we found the same at this inspection.

We watched some people being given their early morning and lunchtime medicines. Staff gave medicines in a kind and patient way and signed the records after the person had taken their medicine. Medicines that should be given at specific times to be effective were given at the right times.

We looked at people's medicine administration records (MARs) and examined six of the 31 residents' records in detail. Four residents did not have a photograph in their MAR record, which makes it more difficult to identify individuals when giving medicine, however, this was rectified on the day of the inspection. Records clearly stated if someone had an allergy, which reduced the risk of them receiving something they were allergic to. We didn't see any 'gaps' in administration records and any handwritten entries were signed by two people, which helped to prevent mistakes.

Some people were prescribed one or more medicines to be taken only 'when required'. Extra guidelines (protocols) explaining why the medicine had been prescribed and how it should be given was available for some residents but not all and was not routinely kept with their medication record. After discussing with the

manager, the protocols were updated and moved to the medicine record folder.

Some people were prescribed topical medicines to be applied to the skin, for example creams and ointments and one person required a patch applied to the skin. We did not see any current records for the application of these medicines or body maps to show staff where they should be applied. There was some information in one person's care record but care staff did not always record when they had applied these medicines. Following the inspection, senior staff implemented the correct recording documentation and informed us that regular audits will take place to ensure they are completed correctly.

A number of residents were prescribed a powder to thicken their drinks because they had difficulty swallowing. We observed a carer making a thickened drink in the kitchen, to help one resident to take their medicine. Instructions were followed properly. A record was made each time the powder was used and protocols were in place for each person stating the required consistency for liquids, minimising the risk of choking.

Some residents were responsible for managing their own medicines and assessments had been made to make sure these people were safe. We spoke with residents about their medicines and they were confident and had no issues.

Recent staff changes meant that there had been difficulty in ensuring staff in medicine administration were available at all times. Additional competency training had been arranged and staff had assisted by rearranging shifts in order to manage in the interim. Regular medicine audits (checks) had been undertaken and had highlighted actions that should be taken. The manager told us that each issue had been addressed but had not been signed as completed at the inspection. This was rectified.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked at two staff files of staff recently employed and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw appropriate checks had been made and staff records were clear and it was easy to access information. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported to senior managers. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw that the local contact numbers for the local authority safeguarding team were available.

The care files we looked at showed staff had completed risk assessments to assess and monitor people's health and safety. We saw risk assessments in areas such as falls, nutrition, mobility, pressure relief and the use of bed rails. This meant that people's safety was monitored.

When we looked round the home we found it to be clean. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. This meant that appropriate action was taken to ensure the home was clean and the risk of infections or contamination limited. We spoke with two members of the domestic team who told us there was always a good supply of cleaning equipment and the cleaning schedule / rota ensured all areas were maintained in clean and hygienic state.

Good

Is the service effective?

Our findings

People told us they felt confident in the staff, they were competent and had the skills and approach needed to ensure people were receiving the right care with respect to maintaining their health. This was mainly due to a consistent care staff base in the home who knew people well.

One person said, "They all work very well and are good at their jobs." Another person commented, "They seem to know what they are doing." A visitor said, "Staff are really very good, I'm fully confident they look after everybody well."

We looked at the training and support in place for staff. The manager supplied a copy of a staff training matrix and records for training undertaken and planned. This was up to date and reflected a series of 'mandatory' training sessions for staff. We saw training had been carried out in subjects such as health and safety, medication, safeguarding, infection control and fire awareness, dementia and the Mental Capacity Act 2005 (MCA).

The registered manager told us that some staff had a qualification in care, for example, QCF (Qualifications and Certificates Framework) and this was confirmed by records we saw. We saw the percentage of staff with these qualifications was 60% on this inspection.

The registered provider had an internal training body for all of the Dovehaven care services, 'The Training Academy' which planned, monitored and provided training for staff. We saw records for one new staff member who had undergone a standard induction programme which lasted three days in total over a few weeks. The programme was cross referenced to the 'Care Certificate' which is a nationally agreed blue print for induction for all care workers.

Staff we spoke with said they felt supported by the acting manager and the training provided. Staff told us they had been offered a variety of training and enjoyed going on the training days.

Staff told us that they had appraisals and there were support systems in place such as one to one supervision sessions. The manager showed us a 'supervision calendar' when individual sessions were planned for staff. We saw that formal staff appraisals were behind schedule but the acting manager informed us these would be recommenced.

Staff gained further support from input into staff meetings. We saw the notes from a meeting held on 5 July 2017 where issues such as respecting people's individual bed times and completing observation charts had been discussed. Staff reported they were asked their opinions and felt the manager supported them with any opinions or feedback they gave.

People we spoke with told us the GP was called promptly if required. One person said, "I had an accident and the paramedics were called out straight away." We found staff had liaised effectively to ensure that people living at the home accessed health care when needed. We spoke with a visiting health care

professional who told us that staff referred people appropriately and always acted on any instructions or advice given to support people's health care.

Records contained a review of people's medical history, to highlight any health concerns that may need support. Formal literature about people's medical conditions was available for staff to refer to help them support people. For example one person had been referred to the dietician due to weight loss and the necessary supporting assessments were in place each month. Another person had a urinary catheter and the district nurse team were having regular input to monitor this every six to eight weeks.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. 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.

The manager was able to discuss examples where people had been supported and included to make key decisions regarding their care.

For example, we saw examples of DNACPR [do not attempt cardio pulmonary resuscitation] decisions which had been made. We could see the person involved had been consulted and agreed the decision or had been assessed by the GP if they lacked capacity to be involved in this decision. There were other examples where a person's mental capacity to make 'key' decisions regarding care and treatment had been assessed using the standard 'two stage' mental capacity assessment tool. For instance, assessments for the decision to live in the home or for on-going placement. One person's assessment stated, 'The assessment determined that (person) had capacity and could retain the information which had been provided'. Another assessment was in place for administration of medication; the assessment determined the person did not have the capacity to understand why they needed to be administered the medication for his own safety. We reviewed one person whose ability to make clear decisions fluctuated and this was reflected in their assessments for individual decisions.

One person was unable to consent to their care and had a relative who had been appointed as Lasting Power of Attorney (LPA) to act in their best interest; this was clearly documented with evidence of the LPA forms on file. For another person we saw their mental capacity had been assessed by staff using an appropriate assessment tool as they were acting to support the person by the use of bedrails to help ensure they were safe when in bed. A 'best interest' decision had been taken by staff to place the bedrails following the assessment.

This showed staff understood the key principals involved in supporting people to make their own decisions regarding their care.

The manager felt confident that staffs understanding regarding the application of the principals of the MCA had improved and stated they had had good support from the training academy and senior managers' also providing support.

Staff had applied for a number of people to be supported on a Deprivation of Liberty (DoLS) authorisation. DoLS is part of the Mental Capacity Act (2005) and aims to ensure people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom unless it is in their best interests. The applications were being monitored by the manager of the home.

People reported they generally liked the food in the home. Comments included, "There's some things you like and some you don't, but you can have a sandwich if we don't like it", "I think it's a good choice at lunchtime. I get enough, and if I'm downstairs I get enough drinks", "It's good, I was complimenting the chef yesterday, we get a choice, it's lovely, I most certainly get enough", "It's very good and we get plenty", "I suggested that we have more salads, I like salads and when we ask we are listened to" and "I feel it's alright, I enjoyed my lunch."

Throughout our inspection we saw meals and drinks being provided for people on a regular basis.

We observed lunch and a person informed us they had a meeting a few weeks ago and the menus had been 'revamped' since. The dining room was well appointed. Tables were laid with cutlery and were nicely presented. One person was supported by the provision of special cutlery to aid their independence.

We spoke with the chef who was very knowledgeable about the different dietary needs which needed to be catered and accommodated for. For example soft diets, diets for medical conditions, those on thickened fluids. There was a four weekly rolling menu and people were consulted about the menu and choices. The chef attended all team meetings so they could be updated on any of the changing needs of the people in the home and get people's opinions.

Food and drink was available throughout the night as staff had access to the kitchen and store room if the people requested.

Good

Is the service caring?

Our findings

Comments about the staff were generally very positive and included ; "Kind", "Most of them are pretty good", "They're very, very good, very kind they are so understanding. I've no complaints whatsoever, and they're friendly", "Quite good, I get on well with them, they're kind" and "very good, very kind." One person told us, "It's great here, The staff are really good. The routine is very relaxed and we can wake up when we want and go to bed when we want." Other people concurred with this and said they could choose when they wanted to go to bed and get up in the mornings.

We observed staff providing care and support; this was carried out in a dignified and unhurried manner. Staff were on hand to help where needed; examples of this were to support people with their meals and to assist people mobilising and aspects of personal care. We saw some people being assisted to eat in their bedrooms; staff were unhurried and communicated well as they were supporting people. We observed that staff used people's preferred term of address

We saw that staff knocked on people's doors and waited to be given permission to enter.

Throughout the day we witnessed positive communication between the staff and people they supported. It was evident that the people staff supported were known to them; staff had a good understanding of people's individual needs, preferences and how they wished their support to be given.

People said they felt involved in their care. One person said, "We have resident meetings so staff can discuss with us any issues. We can take any issues to staff and they listen."

Visitors were welcomed by staff we saw visitors freely conversing with staff members. A family member told us they were very pleased with the care at the home and that their relative was very settled. There were no restrictions in visiting, encouraging relationships to be maintained. People we spoke with told us their relatives could visit at any time.

Some people we spoke with new what 'advocacy' meant but none we spoke with felt they needed access to this kind of support. Staff showed us leaflets by the main entrance that advertised Sefton advocacy services and a leaflet up on the notice board. The manager told us about one person who was currently in receipt of support form an advocate to help sort their finances. The manager said, "If we feel someone would benefit from an advocate we would always give them a leaflet and talk them through it. If permission is given we would call on their behalf if needed."

Requires Improvement

Is the service responsive?

Our findings

People told us they were able to make choices. One person told us, "It's very comfortable here; I'm free to spend my day as I please." Other comments were, "I'm quite happy, I always sit here, I've no complaints at all" and "I always do what I want."

Prior to our inspection we received concerning information that people were not being given a choice regarding what time they wished to get up in the morning and were being woke to start their day against their wishes. We started our inspection by arriving unannounced at 6am on the first day of the inspection; we did not find any issues of concern. People were able to choose when they got up in the morning. People said they could choose how and where they wished to spend their day, what meals they would like served and what time to get up and retire at night. A number of people chose to spend time in the lounge whilst others preferred to spend time in their own room.

We asked people about their involvement in planning their care. Some said they had seen their care plan but this had been 'early on' [after admission]. One person said, "I haven't seen the last one [review], I did ask to see it a while ago. They don't review it with me." Another person commented "Yes, but it's not reviewed regularly."

The manager said that everybody had been shown their care plan and had it been discussed but would endeavour to ensure that they were also included, periodically, when care plans were reviewed. We saw in two of the care files people and their relatives had been invited to a 'care review' and the care plan had been fully discussed and reviewed. A senior manager said this had been introduced and would be a standard to maintain for everybody.

We looked at four care files and found that people had a plan of care. A care plan provides direction on the type of care an individual may need following their needs assessment .Care records held an assessment of people's needs; this ensured the service was aware of people's needs and that they could be met effectively from admission. There were also specific assessments of areas such as, nutrition, health and mobility.

We discussed how some of the care plans could be improved by including more detail. This would help ensure staff had access to clear instructions for care and may encourage a more personalised approach. For example one person with a catheter had a care plan but it lacked detail to clarify how staff should monitor this and any observations they should record in liaison with the district nurses. Similarly a person who was on regular pressure relief to reduce the risk of skin damage did not have a recording chart in place so this aspect of care could be monitored and evaluated.

We recommend the provider completes a review of care plans to ensure that they provide sufficient detail to assist delivery of personalised care.

Care plans were specific to the individual and a life history and personal care booklet held information to help staff to get to know people's physical and social care needs. Personal information and background

history was captured from the outset which then enabled staff to provide person centred care. A Life story book was placed in each file which established information around childhood, employment, school, religious beliefs, and interests. Care plans were written in the first person, such as a plan for one person's personal care which said, 'Allow me choose the time I want to get ready and ensure that I have choices over clothing" and a social care plan which read, 'I like to read crosswords, sometimes watch TV (Coronation street being her favourite)'.

People told us they could take part in a variety of social events. Comments varied and some people felt the planning of activities could be further improved but we received many positive comments. These included, "Sometimes I read or play dominoes, we've played dominoes a lot this week. We go out on trips. A lady comes on Thursdays and takes us out, but we have to take it in turn, we can't go out every week", "Sometimes I sit here and read magazines or watch TV. I have a cigarette in the garden. I've been on a few trips some from the home, some with my family and I've played dominoes", "I just sit, but I don't get bored, I don't join in the activities sometimes", and "I've made some good friends and I join in the activities. On Tuesday we're going out."

We spoke with an activities organiser when was employed by the home. We were shown records of the activities people had joined in. The activities organiser also spent time on a one to one basis with some people who preferred to stay in their bedrooms. Another staff member, who carried out many of the activities for people, commented that there was more time now to interact socially with people as staffing had increased in the morning.

We saw 'residents' meetings had been held and some feedback was to develop more activities for people. The manager said this was an ongoing project. We saw activities were not readily displayed in the home.

People we spoke with told us they knew how to raise concerns and relatives agreed .People had access to a complaints procedure and this was available to people within the home. One relative told us they had raised a complaint a while ago and this had been dealt with. A system was in place to record and monitor complaints and those we viewed had been responded to appropriately in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

People we spoke with and staff felt involved in the running of the home. One person said, "I've filled in a questionnaire, but I don't know if we've had feedback". Another person told us, "I've attended two residents meetings." A staff member said, "We get good support from (manager), things are getting better and improving."

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The manager and quality assurance manager for the Dovehaven group were able to evidence a series of quality assurance processes and audits carried out internally and externally. However, the audits in place had not identified all of the issues we found on the inspection. They had also failed to take effective action in regards to identified concerns.

Audits were carried out by the manager and senior managers. These processes have generated a series of developments over the recent year to improve the quality monitoring in the home and were being carried out on a regular basis. They included checks and audits regarding health and safety, equipment in use, infection control, and other environmental standards in particular.

As part of the feedback to the manager and senior managers we identified improvements were needed with respect the management of fire safety arrangements [including emergency staff cover], care planning and supporting documentation and medicine records.

A 'topical creams audit' carried out a month previous to our inspection which identified improvements were needed in recording by staff but we found this had not been actioned. The daily walk round audit carried out by the manager, or staff in charge, had failed to identify fire exits which had been blocked or restricted or the issues around updating the emergency 'grab' file. Audits carried out to monitor standards of care planning and evaluations had not been carried out since April 2017.

We discussed with the manager the need for governance systems to be further embedded in line with the providers own policies and procedures.

These findings were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

Statistics collected around untoward incidents were also very well monitored and there was good analysis to help ensure any risks could be reduced. An overarching quality audit was conducted six monthly by a senior manager which covered key areas based on current regulations.

There was no registered manager at the time of our inspection. The acting manager had been in post for six months and was in the process of applying the Care Quality Commission (CQC) for registration. The manager was supported by a deputy and senior managers including a regional manager and quality manager who were part of the overall governance. There was a clear management structure with all levels of

management supervising the home's quality assurance systems and processes.

The feedback we received about the manager was positive. People we spoke with identified the manager as a good lead for the home and was described as accessible and supportive by both staff and people living at Dovehaven. One person told us , "She's very, very good." Another Person commented, "She's very approachable, and very nice. You can always talk to her."

We saw the manager held a series of meetings with staff to provide a formal forum for discussion and feedback. We saw the notes from a staff meeting held on 5 July 2017. Issues arising were the need for care staff to ensure charts were completed and issues around people's routines around bedtimes.

We found the manager open and accessible to any feedback we gave. The manager had been open in tackling some recent cultural staffing and practice issues in the home and was also aware of the need to reflect on the way this had been managed.

There were forums for people living at the home and visitors to provide feedback. We were shown feedback surveys undertaken with people living in the home and relatives, staff and visiting stakeholders such as health care professionals. We noted that most of the comments were positive about the home and the service provided. Some changes had been made as a result of the feedback including dining arrangements and menu changes and the development of further activities. The manager had not yet collated the findings from these surveys and provided feedback for people living at Dovehaven.

The Care Quality Commission (CQC) had been notified of events and incidents that occurred in the home in accordance with our statutory notifications. This meant that CQC were able to monitor information and risks regarding Dovehaven.

From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate. The rating from the previous inspection for the home was displayed for people to see and was also displayed on the registered provider website.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Fire safety arrangements had not been monitored effectively which exposed people to potential risk of harm. This included the home not been adequately staffed for the night time shift for a short period which left people exposed to potential risk of harm in case of an emergency.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were a series of on-going audits and checks to ensure standards were being monitored effectively; some of the audits had not identified issues we found on the inspection.