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Dovehaven Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 3rd & 4th May 2017 and was unannounced.

Dovehaven is a Care Home with nursing and provides accommodation for up to 40 elderly people. The home is situated in a residential area of Southport, close to the town centre and local amenities. The home has equipment and aids to assist people and different areas of the home are accessible for people who use a wheelchair or have limited mobility. At the time of the inspection there were 37 people living at the home.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The home had a consistent staff team and there appeared to be sufficient staff on duty. However a number of people told us they felt more staff were needed as calls for assistance were not always responded promptly by the staff. The registered manager said they would look into this with immediate effect and this would include a review of the current staffing levels.

We have made a recommendation about reviewing staff response time to calls for assistance.

Social activities were organised in the home though the registered manager appreciated these needed to be developed further with the provision for more formal activities programme and 'one to one' time for people who were at risk of social isolation. The need for this was raised by people during the inspection.

Our observations showed care and support was carried out in a caring, kind, respectful and unhurried manner. People we spoke with and their relatives told us they had confidence in the staff's ability to care for them.

External contracts were in place and internal health and safety checks and audits were completed to help maintain the safety of the building and its equipment.

Risks to the people living at the home were appropriately assessed and recorded in care records.

Staff were recruited safely subject to the completion of appropriate checks to ensure they could work with vulnerable people. We saw the required checks had been made.

Medicines were administered safely to people and the registered manager completed medicine audits to ensure the safe management of medicines.

The staff we spoke with described how they would recognise abuse and the action they would take to report

any actual or potential harm. Training records confirmed staff had undertaken safeguarding training.

People had a plan of care which set out their health and social care needs. Plans of care contained person centred information, which showed that people had been consulted regarding their care. Care reviews took place and people were supported to maintain their health and well-being by accessing a range of external health professionals.

Staff received training and support and had a good understanding of their roles within the service and what was expected of them.

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.

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 registered manager of the home.

We saw people's dietary needs were met with reference to individual preferences and choice. People said they liked the meals served.

A complaints' procedure was in place and people and their relatives felt confident in raising concerns with the registered manager.

The registered manager was able to evidence a range of quality assurance processes and systems to monitor standards within the home and to drive forward improvements. This included a number of audits (checks) for various aspects of the service.

Staff and people said the home was well managed and the registered manager approachable and supportive.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

The registered manager had a good understanding of their role and responsibilities in relation to what was expected from them as a registered manager with us, Care Quality Commission (CQC). The registered manager had notified us 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?

Good

The service was safe.

People told us that they felt safe living at the home.

Suitable systems and processes were in place to ensure the premises and equipment were maintained and safe to use.

People were protected against the risks associated with medicines because arrangements to manage medicines were consistently followed.

People's care needs had been risk assessed to ensure their well-being and safety.

Staff had been checked when they were recruited to make 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.

Consent was gained from people in accordance with the Mental Capacity Act (2005).

Applications to deprive people of their liberty had been made appropriately.

Staff received a programme of induction and training. Staff received supervision and appraisal to support them in their role.

People were supported by care staff and external health care professionals to help maintain their health and wellbeing.

Staff we spoke with were aware of people's dietary needs and preferences. People spoke positively regarding the meals served.

Is the service caring?

Requires Improvement

The service was not always caring.

People told us the response time by staff when they needed assistance was a concern to them. We made a recommendation for the provider to review this.

People told us staff were kind and respectful when assisting them.

We observed people's dignity and privacy being respected by staff during the inspection and interactions were warm and genuine.

People had choice regarding the care and support they received and staff encouraged them to be independent. 0

Is the service responsive?

Good

The service was responsive.

Feedback received regarding activities was mixed with people asking for the provision of more 'one to one' time and a more formal activities programme

People knew how to raise any concerns. Complaints were recorded and acted on in accordance with the home's complaints' procedure.

Care plans were person centred, reviewed regularly and reflected people's preferences.

Systems were in place to gather people's views regarding the service.

Is the service well-led?

Good

The service was well-led.

The service had a manager who was registered with the (CQC) Care Quality Commission.

The registered manager was long standing and provided efficient and effective leadership of the home. Staff said they felt supported by the registered manager who they described as 'approachable'.

People and relatives reported positively regarding the overall management of the home.

The registered manager had systems and process in place to monitor the standard of the service and to drive forward improvements. This included audits (checks) on how it was operating.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

Dovehaven Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 3rd & 4th May 2017 and was unannounced. The inspection team included 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.

Before our inspection we reviewed the information we held about the service. This included the statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We also contacted the commissioners of the service.

The provider had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make.

We used all of this information to plan how the inspection should be conducted.

During the inspection we spoke with the regional manager, registered manager, three nurses, one of the providers for the home, the chef, housekeeper, a domestic member of staff, maintenance person, seven members of the care team, 13 people living in the home and three visitors/relatives.

We looked at the care files of six people receiving support from the service, two staff recruitment files, medicine administration charts and other records relevant to the quality monitoring of the service. We also observed the delivery of care at various points during the inspection.

Good

Is the service safe?

Our findings

People told us they felt safe. In response to asking people what made them feel safe, people said, "The staff", "All the nurses look after me", "For what they've done for me, I know I'm well looked after here", "You've got people around you" and "The doors (referring to the security of the building) and the girls (staff)."

The care files we viewed showed that 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. These assessments had been reviewed regularly to ensure any change in people's needs was identified to help staff support people safely. People also had access to a call bell to summon assistance if needed.

The lounge/dining areas were spacious for people to use though the majority of people were nursed in bed due to their frailty and medical conditions. Throughout the inspection we saw staff offering support in a safe manner. For example, with lunch, ensuring the right consistency of the meal if a person had difficulty swallowing and the use of moving and handling equipment to transfer people safely and in comfort.

We looked at the arrangements in place for making sure the environment was safe. A fire risk assessment of the building was in place and people who lived at the home had a PEEP (personal emergency evacuation plan) to ensure their safe evacuation in the event of a fire.

External contracts were in place to ensure services such as, gas, electric, water and lifting equipment were safely maintained. We viewed the certificates for these checks and they were in date. A variety of internal checks were also completed, such as the integrity of mattresses, portable appliance testing, hot water temperatures and day to day maintenance jobs. These were completed in a timely manner.

We looked at how staff were recruited and the processes followed to ensure staff were suitable to work with vulnerable people. We looked the recruitment records for three newly recruited staff and asked the registered manager for evidence of application forms, appropriate references and Disclosure and Barring Service (DBS) checks. DBS checks consist of a check on people's criminal record and an additional check to see if they have been placed on a list for people who are barred from working with vulnerable adults. This assists employers to make safer decisions about the recruitment of staff. We saw appropriate checks had been. It is important that robust recruitment checks are made to help ensure staff employed are 'fit' to work with vulnerable people.

We looked at how the home was staffed. During the inspection the registered manager was on duty with two nurses, six carers, a chef, kitchen assistant, laundry assistant, two domestic staff and maintenance person. The registered manager had supernumerary hours for management of the service but also worked 'on the floor' as a registered nurse. Staff rotas we viewed showed that these levels were consistent though the number of carers on occasions dropped to five at 6pm.

We asked people living in the home if they got their medicines when they needed them. People told us they received their medicines on time and could have painkillers if they needed them. One person told us they were able to administer their own medicine. Another person said, "They (staff) stay with me whilst I take them (tablets)." We observed part of a medicine round and people received their medicines safely.

We reviewed the storage and handling of medicines as well as a sample of Medication Administration Records (MARs), stock checks and other records for people living in the home. The PIR informed us that staff received medicine training and their competencies were in date. This was confirmed on inspection. The training given helped to ensure staff had the skills and knowledge to administer medicines safely.

Medicines were stored in two locked trolleys which were kept in a locked clinical room. The temperature of the room and the medicine fridge were monitored and recorded daily and we saw that these were within safe ranges. If medicines are not stored at the correct temperature, it can affect how they work. Controlled medicines were stored in a separate locked cupboard in line with legislation. Controlled drugs are prescription medicines that have controls in place under the Misuse of Drugs Act and associated legislation.

MAR charts we viewed contained photographs of people to assist with accurate identification, as well as information regarding any allergies that people had and the charts had been completed fully. Staff had signed the MAR charts to say they had administered the medicines. This helped to ensure medicines were given safely as prescribed.

Quantities of medicines received into the home must be checked to provide an accurate stock check. We found quantities of medicines received had been checked and recorded. We checked the stock balance of a number of medicines (including a controlled medicine) and they were accurate.

We saw evidence of PRN (as required) protocols and records in place. PRN medicines are those which are only administered when needed for example for pain relief. Guidance regarding administration of people's medicines recorded within people's care plans; this included the administration of PRN medicines.

Nutritional supplements were given as prescribed for people who had a poor intake and the application of topical preparations (creams) were recorded on the MAR charts and cream charts.

Some of the people living at the home where prescribed 'thickening' powder to thicken their drinks. This is to aid people who may have swallowing difficulties to accept fluids and reduce the risk of choking. We saw thickening powders were stored safely when not in use. The number of scoops of thickening powder required to ensure the correct consistency of fluid for each person was recorded on people's care fluid chart. This instruction was in accordance with people's nutritional assessment and advice from the speech and language therapy team (SALT). Talking with staff confirmed their knowledge around the use of thickening powders and application of creams for people.

For people who required 'covert' administration for medicines (medicines given without the person's consent or knowledge in their 'best interest') there were clear instructions for staff regarding the medicines to be administered covertly and agreement sought from the relevant parties.

We spoke with staff about adult safeguarding and how to report concerns. All staff we spoke with were aware how to raise concerns and were familiar with the safeguarding process in relation to their role. A staff member when talking about how they would deal with an alleged incident, said, "Would report straight away. The manager is very approachable; we have a whistle blowing line we can also ring. There's a poster (for safeguarding) near the nurses station."

A policy was in place to guide staff on the appropriate actions to take in the event of any safeguarding concerns being raised and details of the local safeguarding team and other information in relation to protecting people and their rights was displayed on the staff noticeboard. This enabled referrals to be made to the relevant organisations. Incidents that had been deemed as safeguarding were recorded along with any actions taken to improve practice.

We found that accidents were recorded and appropriate actions were taken to ensure people's health and safety. The registered manager was aware of the need to analysis incidents and accidents so that any emerging themes were identified and acted on.

The cleanliness of the home was good. Staff had access to personal protective equipment (PPE), such as aprons and gloves and we saw they used this when providing care. Bathrooms contained liquid soap and paper towels in line with infection control guidance. The cleanliness of the home was checked by the registered manager and people said their rooms were cleaned thoroughly.

Good

Is the service effective?

Our findings

We asked people what they thought about the food. People said, "Alright, I get enough, I ask if I want more and they give it to me", "It's very good, we get a choice", "Second to none", "It's better than hospital food, but it gets monotonous", "It's excellent", "The cook is very good", "I enjoy the food too much", "It's very good, there's not a great choice but it's usually good. I had Lancashire hotpot today and it was very good." A person told us their special diet was catered for.

We spoke with the chef who was knowledgeable regarding people's dietary needs and requirements, special diets and known food allergies. The menu was on a four week rota and this provided a selection of well-balanced meals. There was no menu displayed however people told us the staff asked them what they would like for lunch, at coffee time and what they wanted for tea during the afternoon. People told us the chef talked to them about their likes and dislikes and sought their views about the menus., Meat, fish, fruit, vegetables and dairy products were sourced locally and people were served full fat milk to enhance their diet. We saw that the main meal was served at lunch time and a lighter meal at tea time.

During the inspection staff supported people with their meals and drinks. Due to people's frailty and medical conditions the majority of people were served lunch on a tray in their room. We noted that desserts were served at the same time as the main meal. People we spoke with did not raise this as an issue however we brought this to the registered manager's attention. People might be over faced with the main meal and dessert served together and the temperature of a warm dessert would be affected if served at the same time.

Staff support was available for them in accordance with individual need and this assistance was carried out in a sensitive and patient manner. People who were nursed in bed or had chosen to stay in their room had jugs of water and cordial available. We saw people were given drinks throughout the day; cups with lids were available to support people, as necessary, to drink independently. A drinks machine was available in the dining room and for a person sitting in the lounge staff ensured their drinks were replenished and their lunch served there.

During our inspection we reviewed the care of six people living at the home. We found staff liaised effectively to ensure that people living at the home accessed health care when needed. When we looked at people's care notes we saw references to referrals and support for people from a range of health care professionals Care staff told us they understood the importance of reporting any changes with people's health to the nursing staff who would ensure any necessary referrals were made. Staff had a good knowledge of people's care and support. A staff member said, "Love it here. Care is good. Everybody is comfortable and well supported." Another staff member reported, "We give a very good standard of care, (manager) makes sure everything is done correctly."

One person we reviewed had experienced changing care needs because of on-going health issues. We saw they had been referred to a variety of health care professionals including the person's GP, SALT and an optician. We spoke with the person who told us they were being supported well. People told us they received medical attention if they were ill and they spoke positively regarding how staff arranged

appointments. One person told us, "They (staff) are very good and get the doctor if needed." A person had recently been seen by the GP because of a skin complaint and had been prescribed a cream that staff were applying daily. We saw there were good records and a supporting care plan to help ensure good monitoring.

People told us the staff were knowledgeable about their care. Their comments included, "I think they're getting to know me", "I have help getting washed and dressed and they're very good with me, very gentle", "Very much so, they've promoted my independence", and "They (staff) do, I had a full assessment when I first came in." People in bed appeared comfortable and settled.

Medical conditions that required clinical intervention were recorded and treatment plans were followed by the staff to monitor people's health. An example of this was for a person who had a pressure ulcer and for another person a tube for enteral feeding. Both people had a plan of care for staff to follow. Enteral feeding refers to the delivery of a nutritionally balanced feed via a percutaneous endoscopic gastrostomy tube (PEG). The PEG is passed into a patient's stomach to provide a means of feeding when their oral intake is not adequate. Staff were providing care of the PEG site in accordance with the plan of care though this care had not been recorded on the person's care chart on the day of the inspection. This was brought to the registered manager's attention and rectified. In respect of the pressure ulcer the person had a wound assessment and supporting documentation to evidence the current treatment plan.

All of the people and visitors we spoke with felt that staff were competent and had the skills to carry out care. We were told the provider had set up an academy with training managers to oversee the training requirements for staff employed at the Dovehaven homes. The Dovehaven academy set out short term and long term objectives for the staff in respect of assessing staff's training needs for subjects they consider mandatory and staff were enrolled on formal qualifications in care. The academy supporting Dovehaven Nursing Home consisted of a manager with three assessors for QCF (Qualifications and Credit Framework) and eight hours of administration support. The academy linked in with an external training company to complete overall management of training needs for the provider.

We looked at the induction process for new staff employed at the home. The registered manager explained the induction process which included a standard checklist of information carried out over the first few days of employment, a handbook for new staff, some shadowing of experienced staff and attendance at mandatory training such as moving and handling, safeguarding of vulnerable adults, fire safety and general health and safety. Staff we spoke with confirmed these arrangements for induction.

We asked about how the induction met the standards of the Care Certificate. This is an identified set of standards that health and social care workers adhere to in their daily working life. The standards cover areas such as, infection prevention and control, safeguarding adults, working in a person centred way and duty of care. The Care Certificate requires staff to complete a programme of training, be observed by a senior colleague and be assessed as competent within 12 weeks of starting employment.

At this inspection we met with an administrator for the academy who was able to tell us about how the Care Certificate had been introduced and which staff were currently completing this at the home. Work had recently been completed to commence a three day classroom based induction which covered (mapped over to) the standards in the Care Certificate. We were shown a programme for this and how it would be completed. Any standards not covered in the three day programme would be covered outside of this with workbooks and further training over 12-15 weeks, including the Dovehaven group existing standard induction.

We spoke with a new staff member who was undergoing the new induction. We also saw records of other staff who were currently completing induction. A staff member told us, "I've had some good training already including safeguarding and moving and handling. I'm on the three day induction next week and I'm also being signed up for further training."

The PIR provided information regarding the home's commitment to formal qualifications in care. We discussed with the registered manager the formal qualifications in care which staff had achieved or were enrolled on. We saw that staff were undertaking accredited qualification made up of units such as, NVQ (National Vocational Qualification) or Diploma under the QCF [Qualifications and Credit Framework). With regards to formal qualifications in care the registered manager told us eight out of 21 care staff had obtained a NVQ in care. This was confirmed by records we saw.

The registered manager informed us that training was provided 'face to face' and also via DVDs and questionnaires. The training matrix sent to us following the inspection evidenced a series of on-going updates and training to support staff. Staff supervision and appraisals were undertaken with the staff. A staff member referred to the supervision as "Very useful – nice to be told you are doing a good job."

The registered manager told us they were keen to develop areas of good practice. For example, the registered manager attended recent updates in male catheterisation and medication management as well as previous updates and training in infection control, mental capacity and student (nurse) mentoring. Other nurses had completed training in advanced care planning for end of life care, syringe driver training and all nurses had updated on care planning. A senior care staff had completed recent training to be a fire marshal. The PIR informed us that 74% staff had completed equality and diversity training to promote a deeper understanding of how to respect and promote people's rights; 91% of staff had completed person centred care training; 94% staff had completed safeguarding of vulnerable adults (SOVA) training. Further training was being arranged for staff where needed.

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

Staff had applied for a number of people to be supported on a DoLS authorisation. The applications were being monitored by the registered manager of the home. We saw that if people were on a DoLS authorisation there was a supporting care plan to reference this.

The staff and registered manager were able to discuss examples where people had been supported and included to make key decisions regarding their care. In one example a person had bed rails in place to help ensure their safety but who lacked capacity to consent to these. We saw there had been an assessment made of the person's mental capacity regarding this decision and care had been taken to include any relatives in the decision making process. The staff had made a 'best interest' decision following this process for the bedrails to be placed. We also saw that a risk assessment had been completed to help ensure any further risks had been assessed.

Other examples included care files showing were people had consented to their plan of care. 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 the decision had been made in the person's best interest after consultation with advocates (family members). 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 form on file. We noted the care record did not include whether the LPA was for health, finance or both; the registered manager said they would update the information accordingly.

Staff showed they understood the main principles of the MCA and how to apply them. We saw people's mental capacity was assessed using a standard assessment when needed. We noted that two people on 'covert' administration for medicines (medicines given without the person's consent or knowledge in their 'best interest') did not have a mental capacity assessment on file; the registered manager completed a mental capacity assessment for the individuals at the time of the inspection.

Dovehaven Nursing Home is a converted older building. We saw there had been adaptations made as much as possible to accommodate people with on-going nursing needs. For example, the use of chair lifts on stairs to assist with mobility. Bathrooms we saw included easily accessible shower facilities and there was equipment such as bath chairs available. There was a high provision of nursing equipment such as mobile hoists, specialised mattresses (to reduce the risk of people developing pressure ulcers) and mobility aids.

Requires Improvement

Is the service caring?

Our findings

We asked people to tell us how staff responded to their requests for help. In respect of staff responding to a call bell (which people activated when they needed assistance) we received mixed comments. People said, "I don't have to wait normally", "The staff come as quickly as they can, they are very good", "I don't have to wait", "I don't think they have (enough staff), I have to wait a long time for them to answer the bell, it varies quite a lot. It's at any time, I don't seem to get the attention I need when I ring the bell, they might be upstairs", "There are times when they'll be a bit short (staffing numbers affecting the time to respond to a call for assistance)."

People appreciated that staff were very busy and that staff did not always have time to sit and chat. Their comments included, "The staff do come back if they say they will", "Sometimes they do when they're not too busy" and "They're (staff) always having to move on to the next one."

Staff told us they answered calls bells as soon as they could though at different times of the day the response time could be longer. For example, serving and supporting people with their meals or providing personal care for someone else. A staff member said, "It's difficult when you are in the middle of a job when the bells are going. Not a big issue but sometimes it can be 15 minutes plus before we can answer." Another staff member reported that people did not have to wait too long, only up to five minutes and this would be because they were helping other people.

During the inspection we observed staff supporting people in accordance with their requests and needs. It was however difficult to monitor the length of time calls were answered as these calls were activated using individual pagers which were carried by the staff. We observed several staff members sitting with people at different times of the day or popping into rooms to check if people were comfortable and needed a drink.

We spoke with the registered manager and provider regarding the feedback from people and it was agreed that an audit would be carried out look at staff response time to calls for assistance and part of this audit would include a review of the current staffing levels.

We recommend the provider reviews how staff respond to people's needs to ensure people's taking into account people's dependencies and the current staffing levels.

Following the inspection the area manager informed us an audit of response time to calls for assistance by people at different times of the day was in the process of being completed. An extra carer has since been appointed to work 30 hours a week to provide more support on 'the floor' and a further 30 hours for a carer who will shortly be returning to work. The provider responded promptly to address the concern and has provided assurance that this will be monitored further to ensure the increase in staff hours is effective.

There was a relaxed and quiet atmosphere in the home; people appeared comfortable and content in the presence of the staff. There was only one person using the lounge during the inspection as the majority of people were being nursed in bed or wished to stay in their room.

We asked people if they could talk to the staff and tell them how they feel, also whether the staff treated them with kindness. People we spoke with told us the staff were polite and respectful in their approach. Their comments included, "Very kind, lovely", "They're (staff) approachable, they wouldn't be here if they weren't", "I can speak to the matron", "I get on very well with them. We have a laugh and a joke, it's a lovely place to be", "With dignity and respect so far", "They're (staff) respectful and kind", "Definitely with respect, they get me a little something at Christmas and Easter, and we get a birthday cake", "Very nicely, kind and polite". A relative said they felt able to talk with the staff. Likewise another relative when talking about the staff said, "The ones (staff) I've seen are very nice, and they seem to care for (family member). In respect of staff offering support people said, "They (staff) let me do things at my pace" and "I am so much better now, the staff have helped me on my feet."

We observed people's dignity and privacy being respected by staff during the inspection, such as staff knocking on people's door before entering their rooms and waiting for a reply before they entered. People's preferred term of address was also respected. Staff's approach to people was genuine, caring and considerate.

We saw that care files containing people's private information were stored securely in order to maintain people's confidentiality.

Care plans were written in such a way as to promote people's independence. For example, they clearly reflected what people were able to do for themselves and what they required staff to assist them with. We saw this in respect of moving people safely with the use of equipment.

We saw that people had access to advocacy support if needed. One person was engaged with the local advocacy support service and this was recorded in their care file. The local advocacy service was advertised in the home for people to refer to.

Staff we spoke to knew the people they were caring for well and told us they were kept up to date about any change in people's needs through daily handovers and reading people's care plans. Relatives also told us they were kept well informed and we saw that staff had open and respectful relationships with relatives who visited. A relative told us how the registered manager had gone through the plan of care with them; they went on to say their family member received support when they needed it and the staff were kind, caring and very professional in manner.

We observed relatives/visitors visiting throughout both days of the inspection. The staff told us there were no restrictions in visiting, encouraging relationships to be maintained.

The PIR informed us that the staff had established close links with a local hospice and that the staff were 'in the process of including paperwork used in the community to document any end of life directions/wishes and arrangements.' We saw that a new proforma was in place in people's care files to record end of life care, bereavement and future planning. Staff were aware of how to respect and follow people's choices and wishes for end of life care and when to implement and recorded advance care plans for anticipated care needs and wishes. The PIR also provided information about the provision of end of life training for staff; the registered manager informed us that the staff would be undertaking a recognised comprehensive end of life care training programme to support the provision of compassionate end of life care. The registered manager agreed to inform us when staff commenced this course.

Good

Is the service responsive?

Our findings

People and relatives we spoke with told us they knew how to raise any concerns and felt confident that the registered manager would address any issues they had. A complaints policy was available and this was displayed for people to refer to along with a copy of this document in the home's brochure in people's rooms. In respect of complaints a person said they had complained, "A few times, but it's been sorted." A relative told us they had no concerns and would feel confident in raising any issue with the registered manager and that their concern would be dealt with promptly.

There was a complaints' log available to evidence how complaints had been investigated and whether they had been resolved. We reviewed a complaint which had been logged and investigated. Actions were recorded and the complaint resolved to the satisfaction of all involved.

Talking with staff confirmed their knowledge around people's routines, choices, likes and dislikes. For example, time of retiring at night or getting up in the morning, preferred foods, method of communication and how people wished to spend their day. When talking about the routine in the home staff said where possible they always tried to accommodate people's wishes around their preferred routine. People told us, "Some (staff) appreciate your routine and follow it", "I can choose when to get up and have my breakfast, no worries on that", "I can get up late if I want, "They (staff) come and get you up otherwise you could be in bed all day, unless you're ill and "I don't have any problems with routine."

We asked people if they should choose who they would like to help them with their care. People's comments included, "No, but I get the same one (staff) and I'm happy", "I can't choose my carer" and "I like the staff who help me and could speak up if I wanted to about this." Other people said they were not aware they could choose a carer to help them but they did not raise any concerns about this.

The dependencies of people in the home was high and therefore the majority of people were not able to join in with social activities which could be arranged for them. People told us they would appreciate more 'one to one' time with the staff. A person said, "It is lovely just to have some company and to have a chat." We asked people how they spent their time. People's comments included, "I go out with my daughter for lunch and get about quite a bit". "I play the guitar, read the paper and do the crossword. I go out into town to meet my friends, and watch TV in an evening", "I read magazines, I don't feel lonely or bored", "I stay in my room, I get lonely, but I have visitors every day" and "I read the paper, watch television, and read magazines. The time goes so quickly". A visitor to the home commented that there was no stimulation for people.

We discussed with the registered manager the current social arrangements and 'what was going on in the home' for people to join in with. This included members of the clergy; links with local churches were encouraged so people could continue with their chosen faith.

There was no formal social programme apart from a social activities organiser employed by the provider who visited the home once a week for one afternoon session; they brought along a dog to the home which people enjoyed and also helped arrange some trips out in a minibus. Two members of the public had also

up until recently provided other social visits however these were now more infrequent. The risk of isolation was great in the home due to the fact the majority of people spent the day in their room (due to their dependencies or albeit their own choice). The registered manager appreciated that more time was needed to be allocated for social activities with emphasis on the provision of more 'one to one' time which people told us they would like. The provider agreed to review how best to implement more meaningful social input would be carried out in conjunction with the staff audit around response times to calls for assistance. Following the inspection the registered manager informed us of that the number of hours allocated for social engagement had been increased by 30 hours a week. They also told us about a trip out in a minibus which had since taken place.

We saw that care files contained a pre admission assessment completed prior to people moving into the home; this ensured the service was aware of people's needs and that they could be met effectively from the day they moved in.

We looked at how people were involved with their care planning. We saw evidence that people's plan of care and key decisions had been discussed with them and/or their relative and this was recorded in the care files we looked at.

People had a plan of care and these were specific to the individual person. A care plan provides direction on the type of care an individual may need following their needs assessment. The care plans we saw recorded information which included areas such as, personal care and physical wellbeing, medication usage, communication, sight, hearing, mental health needs, skin integrity, nutrition, mobility, sleeping and social care. Care plans were detailed and were written in a way that painted a good portrait of the person's care needs and individual preferences. For example, we saw information about people's preferred foods, sleep patterns, ways in which people communicated their needs (including non-verbal signs), whether people had glasses or a hearing aid and how they liked their personal care to be given by the staff. People's religious beliefs and wishes were also documented. The PIR informed us that care plans were reviewed monthly and we saw all care documents were subject to regular review to ensure they provided up to date information about the people they supported.

Care monitoring records were completed, for example people's food and fluid intake, their output and positional change in when being nursed in bed. These along with people's plan of care and the staff's daily written evaluation/notes meant care files contained important information about the person as an individual and their particular health and care needs. Staff were aware of the importance of these records for monitoring people's health and welfare. Records seen were current and a senior member of staff checked their completion each day to ensure they were kept up to date to monitor people's health.

Staff we spoke with told us they were informed of any changes in people's care needs through daily verbal and written handovers between staff and people's care files. Staff we spoke with demonstrated a good knowledge of people's individual care, their needs, choices and preferences. For example, staff told us how they monitored people's health and dietary needs. Any concerns around a person's intake for example, staff told us they would report this to the nurse in charge so that the person could be monitored closely.

We looked at processes in place to gather feedback from people and listen to their views. This included the completion of satisfaction surveys and resident/relative meetings. The registered manager told us that resident/relative meetings were poorly attended however they told us that they met with people and their relatives most days. We saw the registered manager had a visible presence during our time in the home. A relative said they could always speak to (manager) and they made themselves available any time.

We saw satisfaction surveys were sent out in January 2017 to people and their relatives, also health professionals who had contact with the home. The comments received were positive about the staff and the standard of service provided. Comments included, "All staff are very good indeed" and "Treated with respect and dignity at all times." We did see a comment about the need to increase social activities which the registered manager was aware of though this did not appear to have been acted on at that time.

Good

Is the service well-led?

Our findings

The home had a registered manager in post. People and relatives spoke positively regarding the overall management of the home. People said they saw the manager 'around' the home and staff told us the registered manager worked alongside the staff team and met with people and relatives each day. This we observed during the inspection.

Staff described the registered manager as 'supportive', 'approachable', knowledgeable' and they confirmed the registered manager ran the home very well. A staff member said, "You can go to (manager) any time, just brilliant."

We saw there was a clear management structure in place. The registered manager was supported by a regional manager, compliance manager and the provider; the registered manager informed us they received good support from the senior management team. In respect of reviewing staff responding to people's needs quickly enough the provider took swift action to assess this and implement changes which has included the provision of more care and social activity hours. We have asked for this to be subject to further monitoring including further dialogue with people living at the home regarding staff response to calls for assistance; we have received assurance from the registered manager that this will be undertaken.

A training officer for the provider was supporting the registered manager in respect of staff training and development. During the inspection the registered manager was supported by a regional manager and one of the providers' representatives who attended the inspection feedback. We saw that the providers visited the home regularly and that they were very much involved in the running and development of home. The providers and senior management team were integral to the monitoring and oversight of the service provision which was found to be effective.

The registered manager said there was a robust governance system to help monitor and develop standards in the home and we reviewed how this was implemented. We saw that quality assurance systems were in place to monitor performance and to drive continuous improvement.

An audit calendar was in place which identified areas of the service to be audited on a monthly or six monthly basis and the registered manager and members of the senior management team responsible for their completion. Audits included medicines, infection control, health and safety, maintenance, accidents/incidents, registered manager's 'walk around', staff supervision and appraisal and dependencies of people living in the home. The medicine audit had been amended to include a check on the administration of creams as it was appreciated that the provision of topical preparations had not been audited previously. This demonstrated a commitment to improving the existing audits. Other audits included meal times and provision of clinical care, for example the use of thickening powder in drinks and catheter care. We reviewed a number of these audits and found these provided a detailed over view of how the service was operating; any actions identified had been completed or were in the process of completion with prompt timescales. The findings from the audits were shared with the staff by the registered manager and senior management team.

We were provided with a copy of the organisation's 'SCREW' audit for Dovehaven Nursing Home (so called in respect of the five questions we ask; is the service 'safe', 'caring', 'responsive', 'effective 'and 'well led'?). The audit was completed in January 2017 by the compliance manager and the scores overview recorded 78% compliance. The audit included management, dignity and respect, person centred care, safe care, safeguarding, nutrition and hydration, premises and equipment, complaints, governance, duty of candour and staffing. Actions from the report were acted on. The next 'SCREW' audit will be completed in July 2017.

Staff told us staff meetings were held within the home and minutes were available; separate meetings were held for the day and night staff to ensure everyone could attend. Meetings were held at senior management level and with the providers. It was evident good communication existed around the service and its future development.

Staff were aware of the home's whistle blowing policy and told us they would not hesitate to raise any issue they had.

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 Nursing Home.

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 Dovehaven Nursing Home was displayed for people to see.