Dovehaven Residential Care Home Limited

Dovehaven Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Dovehaven Residential Care Home provides personal care and support for up to 40 people. It was supporting 30 people at the time of the inspection, including people living with dementia. Accommodation is over three floors.

People's experience of using this service and what we found
Although people and their relatives told us that they were satisfied with the care and support provided by staff, the service did not always appropriately manage risk to people. People were exposed to a risk of harm.

Safety and quality checks of the environment had not identified some of the concerns found at our inspection.

There were not enough staff to meet people's care and support needs in a timely or person-centred way.

The service was not always well managed. Assurance and auditing processes did not adequately mitigate risk to the health and welfare of people living at the service. Leadership did not promote a positive culture to ensure people received care in line with their preference and choice.

The registered provider began to address our findings following the inspection, showing they were responsive to making the required improvements, and that the safety and quality of the service was a priority.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
This service was registered with us on 24/03/2020 and this is the first inspection. The last rating for the service under the provider's previous legal entity was Good (published on 03 October 2018).

Why we inspected
We received concerns in relation to staffing numbers, delays in care, fluid and food intake and risk of falls. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We have made a recommendation about some aspects of infection prevention and control measures.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Dovehaven Residential Care Home on our website at www.cqc.org.uk.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Dovehaven Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Dovehaven Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last registration. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to

complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with six people who used the service about their experience of the care provided. We spoke with three members of staff including the Head of Compliance, a regional manager and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were also reviewed.

After the inspection
Due to the risks of coronavirus, we reviewed paperwork remotely where possible. We spoke with four members of care staff by telephone. We also spoke with four relatives to obtain feedback about the care and support received by their family member. We continued to seek clarification from the provider to validate evidence found. We spoke with the local authority and fire service to keep them informed of our inspection findings.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• Although people told us they felt safe living at Dovehaven residential home, individual and environmental risk was not always effectively managed. Although risks to people had been identified in people's care records, there was no evidence that risks had been mitigated appropriately. For example, some people had been identified as being at risk of malnutrition and dehydration, but records were not maintained to document their daily food and fluid intake.
• During our inspection we observed significant concerns within the environment. Risk had not been consistently identified and addressed to prevent people from being exposed to risk of burns. The surface temperatures of some radiators in people's rooms were excessively hot and did not have radiator covers. We also observed exposed pipes in a communal bathroom which were hot to the touch. This meant that people were at risk of harm from scalding. We immediately highlighted this with the registered manager who addressed our concerns on the day of the inspection.
• We were not fully assured that processes had been established to ensure people could be safely evacuated from the home in the event of fire. No consideration had been taken to review the environment, the means of evacuation for people with limited mobility and the number of staff required to safely carry out an evacuation. Night care staff spoken with were unable to explain how they would safely evacuate people from the building in the event of an emergency or fire. We notified the fire service of our concerns so they could review and assess fire safety processes within the home.
• Information was not always used effectively to reduce risk. A system was in place to record any incidents or accidents. Although the recording and oversight of the information was effective at identifying any trends, practices to help prevent any future risk and reoccurrence had not always been implemented. This meant lessons were not always learned and the necessary improvements made when things had gone wrong.

We found no evidence that people had been harmed, however, systems were either not in place or robust enough to ensure risks to people were appropriately managed and mitigated. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We highlighted our concerns to the registered provider so immediate action could be taken to keep people safe.

Following the inspection, we gained assurances from the registered provider that environmental concerns had been addressed and actioned.

Staffing and recruitment
• Staff were not always appropriately deployed to ensure people's care and support needs were safely met in a timely way.
• We observed people waiting for prolonged periods of time before they received the assistance they needed from staff. People echoed our concerns, comments included, "It takes them [Staff] a while to come. Some are quicker than others" and "They could do with more [Staff]."
• We also observed some people still in their nightwear, despite it being almost lunchtime. One person waited almost three hours for assistance to move from their bed into their chair. Another person did not get washed until mid-afternoon. This meant people's care was not being delivered in a person-centred and dignified way.
• Feedback from staff included, "In the morning and evening we don't stop. We are exhausted" and "You're literally running from one person to another."
• On completing a Short Observational Framework for Inspection (SOFI) in the main communal lounge, we observed people sat for prolonged periods of time with no meaningful engagement or stimulation and minimal or little observation and contact with staff.
• A falls audit carried out in August 2020 had identified that an additional member of staff was required to increase oversight of people at risk of falls. We reviewed information recorded in the staffing rota and noted that a third member of staff was not always deployed to meet peoples needs.

There was evidence that people had been harmed and were at risk of harm as there was not enough staff to meet the needs of the people using the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Although the service regularly used agency staff to cover absences, care was taken to use the same agency staff, to ensure that wherever possible, people were cared for by staff who were familiar with their care and support needs.

• Suitable recruitment processes were in place to provide assurances that staff employed had the skills and characteristics to work with vulnerable people.

Preventing and controlling infection
• Systems and processes to reduce the risk of infection were not sufficiently robust.
• We recommend the provider takes action to improve their infection control practice accordingly.
• We carried out a visual inspection of areas of the home and found the home had a malodour on some floors.
• We also noted concerns with décor and furnishings in some people's bedrooms. For example, warped sink cabinets which not only looked unsightly but also posed an infection risk. We highlighted this to the compliance manager.
• Although we observed staff using personal protective equipment (PPE) effectively and safely, we did not see a sufficient number of designated PPE stations. We spoke to the registered manager about this who told us PPE was stored in bathrooms and the staffroom. We spoke about the need to implement more visible PPE stations.
• The service did not have any cases of COVID-19 at the time of the inspection. We were assured that the provider was preventing visitors from catching and spreading infections, meeting shielding and social distancing rules and admitting people safely to the service.

Systems and processes to safeguard people from the risk of abuse
• Staff spoken with told us how they were able to recognise and report on safeguarding matters.
• There was a policy on safeguarding in place which provided staff with up to date information.

Using medicines safely

• Medicines were managed in a safe way. For people who were prescribed PRN (as and when required) medicines, PRN protocols were in place to provide staff with guidance on how and when to give this type of medicine.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated as requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
• Systems and processes did not operate effectively to prevent the risk of harm to people and audits had not identified some of the concerns found at our inspection.
• For example, audit processes had not highlighted the concerns we found with the physical environment and the delays experienced when people received care and support.
• Although audits had consistently highlighted a high number of falls, insufficient action had been taken to help address and reduce the risk of repeated falls. For example, for some people, there had been prolonged delays in installing falls prevention equipment.
• Records were not consistently maintained to provide us with assurances that people received safe care and treatment. Fluid charts had not been completed for people who required their fluid intake monitoring. Positioning charts had not been implemented for people who required repositioning to prevent their skin from breaking down.
• Care plans were not always reflective of people's current care needs. One person had been referred to a dietician, the advice from the dietician had not been incorporated into the person's care plan. Additionally, when people were at risk of skin breakdown, records did not contain guidance as to how to effectively manage any risks to prevent this.
• Although auditing processes and systems had identified risks to people from falls, dehydration, malnutrition and skin integrity, there was a failure and/or delay in managing and mitigating risks to help prevent reoccurrence. This meant people were exposed to a prolonged and repeated risk of harm.

The provider failed to effectively assess, monitor and mitigate risks to the health and safety of people. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered provider responded to our concerns and provided assurances that auditing and governance processes would be re-assessed to help better identify and respond to risk.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The service did not always promote a positive culture that was person-centred and which achieved good outcomes for people. Insufficient numbers of staff meant people were left waiting for assistance from staff

for excessive periods of time. This sometimes compromised people's dignity.
• People were not always empowered to make their own choices and preferences with regards to their care and support. Minutes of staff meetings recorded that due to staff shortages, people were not always receiving a bath or shower as frequently as they should or as often as they preferred. A compliance audit undertaken by the service identified that a month could elapse before people were provided with a bath or shower.
• Staff spoken with confirmed our concerns (staffing, falls risk, fire safety etc). Staff told us, "We're run off our feet. We would love to have the extra half an hour to sit with the residents" and "It's heart-wrenching not to be able to sit with people for even ten minutes a day."

The service had failed to ensure that people received appropriate person-centred care based on an assessment of their needs and preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Although we identified significant failings, people and their relatives told us they were happy with the care and support provided. People told us, "The staff are good here'' and "I have what I need." Comments from relatives included, "Since the new management team came on board, the home has really improved," "I have total peace of mind that [Name] is safe and well cared for" and "[Name] is happy and settled, staff are brilliant, there's nothing I would change."

Working in partnership with others;
• The service worked with others such as commissioners, safeguarding teams and health and other social care professionals, to ensure people received the care they needed from external agencies.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The service notified CQC of notifiable events in line with their regulatory requirements. We were assured that the provider had acted on their duty of candour and shared information appropriately with us.

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 9 HSCA RA Regulations 2014 Person-centred care The registered provider failed to ensure that people received appropriate person-centred care and treatment based on an assessment of their support needs and preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure that care and treatment was provided in a safe way. Risks to the health and safety of people had not been appropriately assessed and had not been adequately mitigated. People living at the service had not been kept safe from avoidable harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider failed to operate effective systems and processes to assess, monitor and drive improvement in the quality and the safety of the services provided. Accurate and complete records in respect of people's care had not always been appropriately implemented and maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care	The registered provider failed to deploy sufficient numbers of staff to ensure that people's care and support needs were met in a safe and timely way.