Embrace (UK) Limited

Dovecote 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?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This was an unannounced inspection which we carried out on 30 November 2016. We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

We last inspected Dovecote Nursing Home in October 2015. At that inspection we found the service was in breach of its legal requirements.

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

A registered manager was in place. 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.

People said they were safe and staff were kind and caring. People were protected as staff had received training about safeguarding and knew how to respond to any allegation of abuse. Regular checks took place to ensure the building was safe and well-maintained. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

Risk assessments were in place and they accurately identified current risks to the person as well as ways for staff to minimise or appropriately manage those risks. Staff knew the needs of the people they supported to provide individual care. Care was provided with kindness and people's privacy and dignity were respected. Records were in place that reflected the care that staff provided.

Appropriate training was provided and staff were supervised and supported. Staff had a good understanding of the Mental Capacity Act 2005 and best interest decision making, when people were unable to make decisions themselves. People were able to make choices where they were able about aspects of their daily lives. People had access to health care professionals to make sure they received appropriate care and treatment. Staff followed advice given by professionals to make sure people received the care they needed. People received their medicines in a safe and timely way.

Changes had been made to the environment. It was brighter and many areas had been refurbished. It promoted the orientation and independence of people who lived with dementia. Activities and entertainment were available for people and people were consulted to increase the variety of activities and outings.

Menus were varied and a choice was offered at each mealtime. Staff supported people who required help to eat and drink and special diets were catered for. A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to.

Staff and people who used the service said the registered manager was supportive and approachable. They were pleased with the improvements that had been made to the service. People told us they felt confident to speak to staff about any concerns if they needed to. Communication was effective, ensuring people, their relatives and other relevant agencies were kept up to date about any changes in people's care and support needs and the running of the service.

People had the opportunity to give their views about the service. The registered manager acted on feedback in order to ensure improvements were made to the service when required. The provider undertook a range of audits to check on the quality of care provided.

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 were kept safe as systems were in place to ensure their safety and well-being. Staffing levels were sufficient to meet people's current needs safely. Appropriate checks were carried out before new staff began working with people.

Staff had received training with regard to safeguarding. People were protected from abuse and avoidable harm. Risk assessments were up to date and identified current risks to people's health and safety. People received their medicines in a safe way.

Regular checks were carried out to ensure the building was safe and fit for purpose.

Is the service effective?

Good

The service was effective.

Staff received the training they needed and regular supervision and appraisals. Effective communication ensured the necessary information was passed between staff to make sure people received appropriate care.

People's rights were protected. Best interest decisions were made on behalf of people, when they were unable to give consent to their care and treatment. Staff liaised with General Practitioners and other professionals to make sure people's care and treatment needs were met.

People received food and drink to meet their needs and support was provided for people with specialist nutritional needs. The environment was well-maintained and was designed for the orientation of people who lived with dementia.

Is the service caring?

Good

The service was caring.

Staff were caring and respectful. People and their relatives said the staff team were kind, happy and patient.

Staff spent time with people and interacted and engaged with them not just when they provided support. People were encouraged and supported to be involved in daily decision making.

Staff were aware of people's backgrounds and personalities. This helped staff provide individualised care to the person. Good relationships existed and staff were aware of people's needs and met these in a sensitive way that respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

Staff were knowledgeable about people's needs and wishes. There was a good standard of record keeping to help ensure people's needs were met.

There were more activities and entertainment to stimulate people and to help keep them engaged.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Good

The service was well-led.

A registered manager was in place. Staff and relatives told us the registered manager was readily available to give advice and support. They were very complimentary about the changes that had been made in the home.

Improvements had been made by the registered manager and provider and were being maintained by the registered manager and management team to promote the delivery of more person centred care for people.

The home had a more robust quality assurance programme to check on the quality of care provided.

Dovecote Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 30 November and was unannounced. The inspection team consisted of an adult social care inspector, an adult social care manager and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service for older people.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We contacted commissioners from the local authorities and health authorities who contracted people's care. We spoke with the local safeguarding teams. We also contacted health and social care professionals who worked with the service.

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

We undertook general observations in communal areas and during mealtimes.

During the inspection we spoke with 17 people who lived at Dovecote Nursing Home, six relatives, the registered manager, the area manager, three registered nurses, eight support workers including one senior support worker, the activities organiser, a visiting professional and two members of catering staff. We looked in the kitchen, bathrooms, lavatories and some bedrooms after obtaining people's permission. We reviewed a range of records about people's care and how the home was managed. We looked at care records for

seven people, recruitment, training and induction records for six staff, five people's medicines records, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Good

Is the service safe?

Our findings

At the last inspection we had concerns staffing levels were not sufficient to meet people's need safely and in a person-centred way. At this inspection we found improvements had been made and staffing levels were sufficient to meet the current occupancy levels and people's needs. People who could comment told us there were sufficient staff and they felt safe. Their comments included, "Yes, I am safe here", "I don't wait long when I buzz for help" and "I think there are enough staff."

The registered manager told us staffing levels were determined by a dependency tool. This was used monthly to check against each person's dependency profile to calculate if there were sufficient staff to meet people's needs safely. At the time of inspection there were 47 people who were living at the home supported by three nurses and eight support workers, including one senior support worker. We were told one nurse that was on duty was working supernumerary hours as there would usually be two registered nurses on duty each day. Staffing rosters and observations showed on the top floor 25 people were supported by one registered nurse and four support workers. On the ground floor 22 people were supported by one registered nurse, one senior support worker and three support workers. These numbers did not include the registered manager who was also on duty each day. Overnight staffing levels included from 8:00pm until 8:00am one nurse and six support workers.

The registered manager understood their role and responsibilities with regard to safeguarding and notifying the Care Quality Commission (CQC) of notifiable incidents. They had ensured that notifiable incidents were reported to the appropriate authorities and independent investigations were carried out if necessary. We viewed the safeguarding records and found concerns had been logged appropriately by the registered manager. Since October 2015 33 safeguarding alerts had been raised. They had been investigated by the provider where required and the necessary action had been taken by the provider to address the concerns. The information had been shared with other agencies for example, the local authority safeguarding team.

Staff had receiving training about safeguarding, they had an understanding of safeguarding and knew how to report any concerns. Staff were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse. One staff member told us, "I'd report any concerns straight away to the nurse on duty or the manager."

Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the department of psychiatry of old age and the community mental health team. Staff told us they followed the instructions and guidance of the community mental health team for example to complete behavioural charts if a person displayed distressed behaviour. This specialist advice, combined with the staff's knowledge of the person, helped reduce the anxiety and distress of the person because the cause of distress was then known. A visiting professional commented, "They (staff) actively seek support from the challenging behaviour team."

Records were in place to provide guidance to staff if a person became distressed. Care plans gave staff instructions with regard to supporting people if they became agitated or distressed. Guidance helped ensure

staff worked with the person, to help reduce the anxiety and distressed behaviour. Records were regularly updated to ensure they provided accurate information. The registered manager told us they planned to carry out some training with staff about distressed behaviour and care documentation to ensure the care provided was consistent.

Risk assessments and their evaluations were up to date to reflect current risks to people. They were regularly evaluated to ensure they remained relevant, reduced risk and kept people safe. They included risks specific to the person such as for choking, losing weight, falls and pressure area care.

Regular analysis of incidents and accidents took place. The registered manager said learning took place from this and when any trends and patterns were identified, action was taken to reduce the likelihood of them recurring. For example, with regard to falls. We were told the registered manager had been pro-active and agreed to participate in a pilot working group around managing falls in care homes. A care professional told us, "[Name] the home manager was an active part of the working group in developing the guidance and tools that are being used." A monthly falls meeting took place which looked at falls and the strategies to reduce the risk of further falls. They also commented, "This is an excellent way of reducing the overall number of falls."

A personal emergency evacuation plan (PEEP) was available for each person taking into account their mobility and moving and assisting needs. The plans were reviewed monthly to ensure they were up to date. These were used in the event of the building needing to be evacuated in an emergency.

People were supported with their medicines safely. We observed the staff member verified the person's photograph on the medicine chart, to ensure they administered the medicine to the correct person. A monitored dosage system was used to store and manage the majority of medicines. This is a storage device designed to simplify the administration of medicines by placing the medicines in separate compartments according to the time of day. We checked the procedures and records for the storage, receipt, administration and disposal of medicines. All records seen were complete and up to date, with no recording omissions. Our check of stocks corresponded accurately to the medicines records. Staff were trained in handling medicines and a process was in place to make sure each worker's competency was assessed. Staff told us they were provided with the necessary training and felt they were sufficiently skilled to help people safely with their medicines.

The medicines policy provided guidance for the use of 'when required' medicines which may be required when people were in pain, agitated or distressed. People had a medicines care plan, which detailed the differing level of support needed by each person. The information was detailed and provided staff with a consistent approach to the administration of this type of medicine and when it should be given.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were kept in a fridge within the locked treatment rooms. Records showed current temperatures relating to refrigeration were recorded daily and were within the required range for the storage of refrigerated medicines. Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse.

We spoke with members of staff and looked at personnel files to make sure staff had been appropriately recruited. We saw relevant references and a result from the Disclosure and Barring Service (DBS) which checks if people have any criminal convictions, had been obtained before applicants were offered their job. Records of other checks were available and up to date. Diversity monitoring took place as part of the recruitment process to ensure a mix of staff were employed to meet the different needs of people who used

the service. Application forms included full employment histories. Applicants had signed their application forms to confirm they did not have any previous convictions which would make them unsuitable to work with vulnerable people.

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

Good

Is the service effective?

Our findings

At the last inspection we had concerns not all areas of the home were well- maintained for the comfort of people who lived there. At this inspection we were told the home refurbishment was completed. Lounges, dining rooms, kitchen, bathrooms and shower rooms had been refurbished and some bedrooms had been decorated and carpets and furniture replaced. The registered manager told us five bedrooms were being refurbished each month until they were all re-decorated and with bedding and carpet replaced. The environment was designed to ensure it was stimulating and therapeutic for the benefit of people who lived there. We saw there was visual and sensory stimulation to help maintain the involvement and orientation of people with dementia. For example, on the top floor a sensory area had been created for relaxation it was designed as a garden area with a water feature. The communal areas and hallways had decorations and pictures of interest, there were displays and themed areas around the home, for example, musical instruments, movie stars and local places to help people recollect and remind people as they sat or walked around. There was appropriate signage around the building to help maintain people's orientation. Lavatories and bathrooms had pictures and signs for people to identify the room to help maintain their independence. Memory boxes had been completed for some people that contained items and information about people's previous interests and they were available outside people's rooms to help them identify their room. They also gave staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves. One relative said, "I'm really pleased with the refurbishment."

We checked to see how people's nutritional needs were met. We looked around the kitchen and saw it was well stocked with fresh, frozen and tinned produce. People were encouraged to make choices about their food. Menus in dining rooms advertised a choice of two hot meals at meal times. Food was well presented and looked appetising. People were positive about the food saying they had enough to eat and received nice food. Their comments included, "The food is okay", "There's enough to eat", "The food is good," and, "There's more than enough to eat."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. A dietician we contacted commented, "There has been a considerable improvement in the numbers of referrals of patients requiring dietetic intervention in the past six months. The appropriate nurse is available to give full information with regard to weight measurement and progress on advised diets and supplements." Records were up to date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Care plans were in place that recorded people's food likes and dislikes and any support required to help them to eat.

We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. They told us they received verbal information from nursing staff when people required a specialised diet. We saw

a board was available in the kitchen to show information and capture any changes that had been communicated about people's dietary requirements. The cook explained about how people who needed to increase weight and to be strengthened would be offered a fortified diet and they explained how they would be offered milkshakes, butter, cream and full fat milk as part of their diet. People received drinks in between meals and the afternoon tea trolley provided a variety of drinks including hot chocolate, milk shakes and biscuits. Snacks were also available in communal areas for people to help themselves. These included snacks such as confectionery, fruit and biscuits to help increase the nutrition of people who were at risk of poor nutrition and weight loss.

People were supported to maintain their healthcare needs. People's care records showed they had regular input from a range of health professionals. We were told a weekly clinic was held at the home that was run by the General Practitioner and specialist nurse for older people. People's relatives were also invited to attend people's appointments to keep them up to date with people's health and well-being. The clinic was held to review people's acute health needs to make sure they were treated promptly.

Staff received advice and guidance when needed from specialists such as, the community nurse, falls co-ordinator, psychiatrist and GPs. Records were kept of visits and any changes and advice was reflected in people's care plans. Comments from health care professionals we contacted before the inspection included, "Staff will now contact the department with any concerns in between appointments which has enhanced patient care", "They (staff) are good at keeping me in the loop to update me about [Name]'s progress" and "Where I have discussed recommendations for individual residents, this advice has been followed and implemented promptly.. I am always confident that they will take my advice on board."

Staff told us and their training records showed they had opportunities for training to understand people's care and support needs and they were supported in their role. Staff comments' included, "It's quite good for training", "We get lots of training and it's really good," "Opportunities for training" and "Good and thorough training, with opportunities to do more", "You can mention a training course to the nurse in charge and straight away it's sorted" and "I do e learning training and face to face training." The staff training records showed staff were kept up-to-date with safe working practices, the staff training matrix showed the staff team had achieved 93% compliance for this training. The registered manager told us there was an on-going training programme in place to make sure staff had the skills and knowledge to support people. Training courses included Parkinson's disease, positive behaviour support, dementia care, distressed behaviour, pressure area care, end of life care, diabetes awareness, nutrition and hydration, falls prevention, dignity awareness and equality and diversity. A health professional told us, "As part of the pilot with regard to reducing falls I have conducted training around managing falls, which achieved an extremely high attendance rate amongst staff and they were eager and willing to learn."

We spoke with members of staff who were able to describe their role and responsibilities clearly. Staff told us when they began work at the service they completed an induction programme and they had the opportunity to shadow a more experienced member of staff. They also started studying for the Care Certificate qualification as part of their induction. This ensured they had the basic knowledge needed to begin work. Staff were supported in their role. Support staff said they received regular supervision from one of the home's management team every two months and nurses received supervision from the registered manager. Staff comments included, "I have supervision every three months with the nurse in charge or the manager", "We're asked how we're doing and if there's any training we'd like to do," "I've just had supervision recently." Staff also received an annual appraisal to evaluate their work performance and to jointly identify any personal development and training needs.

Staff told us communication was effective to keep them up to date with people's changing needs. Their

comments included, "Communication is good", "We have a handover morning and night" , "The senior carer will tell us what's been happening when we've been on our two days off" and "The handover is the priority." A handover session took place, between senior staff, to discuss people's needs when staff changed duty, at the beginning and end of each shift. The senior support staff then cascaded the information to support workers. This was to ensure staff were made aware of the current state of health and wellbeing of each person. We saw handover records contained information about the care provision and the state of well-being for each person over the previous 12 hours. Staff told us the diary and communication book also provided them with information.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and be the least restrictive possible.

Staff had a good understanding of the MCA and best interest decision making, when people were unable to make decisions for themselves. Records contained information about people's mental health and the correct 'best interest' decision making process, as required by the MCA. Peoples' care records showed when 'best interest' decisions may need to be made. People were involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. For people who did not have the capacity to make these decisions, their family members and health and social care professionals involved in their care made decisions for them in their 'best interests'.

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Staff were aware of and had received training in the MCA and the related DoLS. The registered manager and staff were aware of the deprivation of liberty safeguards and they knew the processes to follow if they considered a person's normal freedoms and rights were being significantly restricted. The registered manager told us 41 applications had been authorised and three other applications were being processed by the local authority.

Good

Is the service caring?

Our findings

People who could comment told us they had good relationships with the staff and were happy with the support they provided. Their comments included, "There's a good atmosphere", "I like the changes", "The staff are good" and "The place is fine." Relative's comments included, "I'm more than happy with the care", "The staff are outstanding", "I'm confident [Name] is receiving good care", "People are looked after with kindness", "I'm really impressed with the care" and "[Name] is really well cared for." Visiting professionals comments included, "The care is excellent and they (staff) are really interested in meeting the needs of each resident as fully as possible", "From what I have observed the quality of care is excellent" and "Staff will go above and beyond to help support someone."

We observed the atmosphere was calm, relaxed and tranquil. It was noticeable since the last inspection that the top floor lounge was more tranquil and calm. Throughout the home staff interacted well with people. They were kind and caring and they spent more time engaging with people and not only supervising them. Some people had complex needs and we saw most staff interacted well with people who we saw were relaxed with them. On the ground floor we saw an incident took place between two people which was not dealt with so well by a member of staff as it left one of the people vulnerable. This was discussed with the manager at the inspection who told us it would be addressed with the staff member. We saw staff engaged with people in a quiet and compassionate way. Staff modified their tone and volume to meet the needs of individuals. When staff spoke with a person they lowered themselves to be at eye level and if necessary offered reassurance with a gentle touch on the arm. They asked the person's permission before they carried out any intervention. For example, "Can I help you with your apron?" and, "Can I put this around you to keep you clean?" Staff explained what they were doing as they assisted people and they met their needs in a sensitive and patient manner.

We observed the lunch time meals on both floors of the home. Improvements had been made to people's dining experience since the last inspection. The PIR stated, 'The focus of the mealtime experience has been to improve mealtimes and make them a social occasion for all residents. We have introduced a ten point meal time experience initiative to ensure people are served immediately.' We saw the meal time was relaxed and unhurried. Written and pictorial menus about food were available to help people make a choice of food. We saw at lunch time people were verbally offered a choice of meal, if a person was undecided they were shown two plates of the available meal to help them make the choice by smell and visually. People sat at tables that were well set with tablecloths, napkins and condiments and staff remained in the dining areas to provide help and support to people. Some people remained in their bedrooms to eat. Staff provided full assistance or prompts to people to encourage them to eat, and they did this in a quiet, gentle way and explained to people what they were getting to eat with each spoonful. Staff talked to people as they helped them and as lunch was served. For example, "Is that enough or do you want a bigger plate?" and "Shall I see what the pudding is?"

Care plans provided information about how people communicated. Examples in care plans recorded, '[Name] can verbalise their basic needs if asked a closed question', '[Name] can understand basic instructions', 'Can answer yes or no and ask for items' and '[Name] can verbally tell staff their needs. Staff to

take plenty of time to listen.' This information was available for staff to provide guidance about how a person should be supported.

Staff we spoke with understood their role in providing people with effective, caring and compassionate care and support. They were able to give us information about people's needs and preferences which showed they knew people well. Staff described how they supported people who did not express their views verbally. Staff observed facial expressions and looked for signs of discomfort when people were unable to say for example, if they were in pain. Staff member comments included, "You get to know by facial gestures" and "You can tell by someone's posture if they are in pain." Staff gave an example of supporting a person who usually objected and did not want to have some aspects of their personal care attended to. They described how they had reassured the person and had created a barber shop to help the person relax and engage to have a shave and haircut.

We saw people who lived with dementia were encouraged to make a choice and be involved in decision making. For example, with regard to meals, drinks and other activities of daily living. Staff gave examples of asking families for information and showing people options to help them make a choice such as showing two items of clothing. This encouraged the person to maintain some involvement and control in their care. People told us they were offered choices and involved in daily decision making about other aspects of their care. For example, activities and bathing. Care records provided information for staff that detailed people's level of comprehension and how they could be enabled to make a choice. Examples included, '[Name] is able to make a choice from two options' and '[Name] will let staff know their preferences.'

People's privacy and dignity were respected. People told us staff were respectful. We observed that people looked clean, tidy and well presented. Staff knocked on people's doors before entering their rooms, including those who had open doors. Most people sat in communal areas but some preferred to stay in their own room. Care plans provided information for staff to help support the person if they could no longer communicate their preferences. Examples included, '[Name] was previously a private person and this must be respected' and '[Name] enjoys chatting with staff and fellow residents. Enjoys sitting in the lounge during the day.' Staff received training to remind them about aspects of dignity in care and a dignity champion was also appointed from the staff team to promote dignity within the home.

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us seven people had the involvement of an advocate, as there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people. We were told the service used advocates, such as an Independent Mental Health (IMHA) advocate as required in the process where people did not have a relative. This meant up to date healthcare information was available to inform staff of the person's wishes at this important time to ensure their final wishes could be met.

Good

Is the service responsive?

Our findings

At the last inspection we had concerns people who lived with more severe dementia or a dementia related condition were not encouraged to remain engaged or be stimulated. Staff did not have time to carry out activities with people when the activities person was not available. At this inspection we saw that improvements had been made.

An activities coordinator was employed and when they were not on duty staff carried out activities with people. The activities person told us, "Staff all do activities so it's not just up to me to do things. I get phone calls at weekends asking where different equipment is because they want to do activities with people." They also told us they were doing some training to help support them provide activities for people who lived with more severe dementia. They told us a virtual reality headset had been purchased for use as an activity to help engage and stimulate people who lived with dementia. During the inspection we did note the increased concentration and interest by some people as they viewed the marine creatures and sharks on the headset. The activities person said, "I have been planning some dementia work with the local authority, lots of local activity co-ordinators have been engaging with it."

A programme of activities advertised activities that were available and this included, board games, music quizzes, skittles, bean bags, pamper sessions, 'pat a dog', reminiscence, singing, newspapers, music therapy, movie afternoons, armchair exercises, baking and crafts. As part of the refurbishment plan we saw people were involved in helping select the pictures and themed areas for the home. For downstairs we saw the activities coordinator engaged people by asking them to think about their favourite place and their descriptions and memories would be displayed on the walls if people agreed. Discussions were minuted and we saw they included memories of Chopwell Woods, Whitley Bay, Holy Island, Whitby and local places of interest. There was a large garden and people had the opportunity to sit out when the weather was fine. Entertainment and concerts also took place. We saw a variety of seasonal entertainment was arranged for over the Christmas period including a Christmas party, local school choir and entertainers. The hairdresser visited weekly and a local member of the clergy visited regularly. Transport was available and people had the opportunity to go out on trips and these included seasonal activities such as visiting a Christmas tree festival and Christmas shopping at the Metro Centre. Other trips that had taken place included pub outings, Beamish open air museum and for fish and chips.

Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives. Care plans were developed from these assessments that outlined how these needs were to be met. For example, with regard to nutrition, personal care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations were detailed and included information about peoples' progress and well-being. Reviews of peoples' care and support needs took place with relevant people. A relative commented, "My sister attends [Name]'s reviews."

Care plans provided information for staff about how people liked to be supported. For example, some care

plans for personal hygiene stated, '[Name] prefers roll-on deodorant as spray makes them cough' and '[Name] needs prompting to clean their own teeth daily' and 'support from one to two staff with their personal care.' Care plans were broken down to provide details for staff about how the person's care needs were to be met. They gave instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted.

Other information was available in people's care records to help staff provide care and support. For example, '[Name] needs to sit up in in bed for 20 minutes after eating,' and' [Name] requires a soft diet.' Staff completed a daily diary for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support plans which were up-dated monthly. Charts were also completed to record any staff intervention with a person. For example, for recording the food and fluid intake of some people and when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs and preferences.

People's care records and personal profiles were up to date and personal to the individual. They contained information about people's history, likes, dislikes and preferred routines. Examples included, '[Name] enjoys pop classics such as the Beatles and Abba' , '[Name] likes to lie in bed and listen to the radio' and 'Prefers a quieter environment.'

Staff at the service responded to people's changing needs and arranged care in line with their current needs and choices. The service consulted with healthcare professionals about any changes in peoples' needs. For example, referrals were made to the dietician and speech and language therapist if a person was losing weight or there were concerns about a person's ability to swallow. A tissue viability nurse was consulted where more specialist advice was required about pressure area care.

Monthly meetings were held with people who used the service and their relatives. The registered manager told us meetings provided feedback from people about the running of the home. A relative told us, "Relatives meetings take place." Meeting minutes showed items discussed included, 'menus, changes to the environment, activities and outings, dignity in care and complaints.' A separate monthly meeting also took place with people who used the service and we saw menus and activities and outings were discussed.

People said they knew how to complain. People we spoke with said they had no complaints. A relative told us, "I know who to speak to if I had any complaints." The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and we saw eight complaints had been received since the last inspection and they had been appropriately investigated and resolved. We saw several compliments had been received from relatives of people who used the service thanking staff for the care provided.

Good

Is the service well-led?

Our findings

The home had a registered manager who was experienced and qualified in managing care services for older people. They had become registered as manager for Dovecote Nursing Home in May 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

The registered manager had been appointed at the beginning of the year. They were enthusiastic and had introduced many ideas to promote the well-being of people who used the service. Staff we spoke with were positive about their management and had respect for them. Staff commented, "The manager is approachable", "The new manager is very approachable", "[Name], the manager will come on the floor to help, they don't just stay in the office" and "The manager gets the job done."

The atmosphere in the home was lively and friendly. People told us the atmosphere was warm and relatives and visiting professionals said they were always made welcome. Staff, people and relatives said they felt well-supported. Their comments included, "The atmosphere is lighter and more positive", "The changes are great", "The residents are happier" and "It's a different place, the atmosphere is different." Staff comments included, "We're a good team, we work together and we have the equipment we need to do the job" and "We work as a team."

The registered manager promoted an ethos of involvement and empowerment to keep people who used the service involved in their daily lives and daily decision making. Staff and relatives were also involved and encouraged to give ideas about the running of the home. For example with regard to choice of décor, service improvements and employment of staff. We saw scores for the external audit of resident and relative involvement and inclusion between June and September 2016 ranged between 95 and 100%. A variety of information with regard to the running of the service was displayed on noticeboards in the home to keep people informed and aware and this included staff roles, the complaints procedure, safeguarding, falls information, advocacy and forthcoming events.

The registered manager assisted us with the inspection, together with the area manager. Records we requested were produced promptly and we were able to access the care records we required. The registered manager and provider's representative were able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

The registered manager said they were well supported in their role by the provider and area managers. They told us they subscribed to a range of care industry and related publications and kept up to date with best practice and initiatives. These included links with the Alzheimer's Society and the Tyne and Wear Care Alliance, an employer-led body that supports workforce development in the independent care sector.

Staff told us monthly staff meetings took place and minutes of meetings were available for staff who were unable to attend. Staff meeting minutes from November 2016 showed topics discussed included training, care planning, staff performance, complaints and incident reporting. Staff meetings kept staff updated with

any changes in the service and to discuss any issues.

Auditing and governance processes were robust within the service to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. All audits showed the action that had been taken as a result of previous audits. A monthly risk monitoring report that included areas of care such as safeguarding, complaints, pressure area care and serious changes in a person's health status was completed by the registered manager and submitted to head office for analysis.

The registered manager had introduced a range of audits and initiatives within the service to improve on the quality of care provided. For example, with regard to the reduction of falls the registered manager agreed to participate in a pilot around managing falls in care homes. The home was also taking part in another Vanguard model of care initiative as promoted by the government this was apparent with the weekly clinic that took place in the home. This was helping reduce the number of hospital admissions. In order to improve people's dining experience a regular 10 point audit had been introduced by the registered manager. To capture people's views about food they received a daily meal satisfaction survey that had been introduced and results were available for June 2016.

Records showed audits were carried out regularly and updated as required in order to monitor the service provided by the home. The registered manager completed some daily audits such as a daily walk around the building to check the environment and check morale of staff and people who used the service. Some records were also monitored daily by the registered manager for example, the food and fluid charts to ensure they were completed correctly. The daily handover sheets that recorded the handover that took place between staff were also passed to the registered manager for their information. Monthly audits included checks on people's dining experience, medicines management, care documentation, training, mattress audits, kitchen audits, accidents and incidents, involvement and inclusion and nutrition. Three monthly audits were carried out for infection control, falls and health and safety. A financial audit was carried out by a representative from head office annually. We were told monthly visits were carried out by a representative from head office who would speak to people and the staff regarding the standards in the home. They also audited and monitored the results of the audits carried out by the registered manager to ensure they had acted upon the results of their audits. All audits were available and we saw the information was filtered to ensure any identified deficits were actioned.

The registered manager told us the registered provider monitored the quality of service provision through information collected from comments, compliments, complaints and survey questionnaires that were sent out annually to people who used the service and staff. An annual external Ipsos Mori survey 'Your Care' rating was carried out for the provider for 2015 and the results were available on behalf of 17 people who had responded. An action plan was available to show identified areas for improvement as a result of the feedback. A relative survey was carried out by the provider in March 2016. We saw the results had been analysed and feedback was available showing what action was to be taken as a result of the survey. For example, more social stimulation required, improved décor, increase staffing levels, improved hydration, person-centred care, minutes of resident/relative meetings not available. We noted some of the issues raised in the relative's survey in March 2016 had been identified at inspection in October 2015 therefore had not been actioned in a timely way. The action plan as a result of the survey showed the action that had been taken and the improvements were evident at this inspection since the current registered manager came into post. Under the management and leadership of the home manager the improvements should be maintained.