Care UK Community Partnerships Ltd

Jubilee House

Inspection report

Pound Lane
Godalming
Surrey
GU7 1BX

Tel: 01483420400
Website: www.jubileehousegodalming.co.uk

Date of inspection visit:
04 April 2016

Date of publication:
17 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This unannounced inspection was carried out on 4 April 2016. Jubilee House provides nursing care for people who are living with dementia and some who have a mental health diagnosis. It is registered to accommodate up to 48 people. On the day of our inspection 37 people lived at the service. The accommodation is arranged over two floors. The upstairs floor accommodates people who are living with more advanced dementia. People downstairs have more physical needs.

There was a registered manager in place who was present on the day of the inspection. 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.

There were not always enough staff deployed around the service to consistently meet people's needs. People sometimes waited long periods of time before they received support from staff particularly around meal times.

There were areas around the service that required cleaning including one of the medicine rooms and one of the sluice rooms. Other areas of the service were clean and well maintained.

There were not always effective systems in place to assess and monitor the quality of the service. Audits had not always identified areas that required improvements. However other audits and surveys had been undertaken with people, relatives and staff but had been used to improve the quality of care for people. Records were not always stored appropriately or easy to access.

People's medicines were administered and stored safely. Risks had been assessed and managed appropriately to keep people safe which included the environment. The risk assessments for people were detailed and informative and included measures that had been introduced to reduce the risk of harm. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and make them safe.

Accidents and incidents with people were recorded electronically with a written copy kept in a file. Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff had undergone recruitment checks before they started work. People said that they felt safe.

People's rights were protected under the Mental Capacity Act 2005 (MCA), and the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people by ensuring that people were consenting to their care. This also ensured that where restrictions to people's freedom and liberty had been undertaken, these had been authorised by the local authority.

People were not always cared for by staff who had received appropriate training and knowledge specific to the needs of people who lived at the service. However all staff were kept up to date with the mandatory training including moving and handling and health and safety. Staff did provide good care to people on the day of the inspection.

Staff were supported in their work and said that they had regular supervision with their manager. There were opportunities for staff and their manager to discuss their performance.

The building met the needs of the people that were living there in particularly those who were living with dementia. There were destination points and signage to help orientate people around the service and assist with their independence.

Nutritional assessments were carried out when people moved into the home which identified if people had specialist dietary needs. People had access to a range of health care professionals, such as the GP, dietician and podiatrist.

Staff at the service were caring and supportive and staff treated people with dignity and respect. People told us they were involved in planning their care. Care plans had detail around people's backgrounds and personal history and included people's views on what they wanted. Staff knew and understood what was important to the person.

People were supported by staff that were given appropriate information to enable them to respond to people effectively. Where it had been identified that a person's needs had changed staff were providing the most up to date care.

People were able to take part in activities which they enjoyed. People and relatives told us that they knew what to do if they were unhappy about something. There was a complaints procedure in place for people and relatives to access if they needed to.

Staff said that they felt supported, valued and listened to. Systems were in place to monitor the quality of the service that people received. This included audits, surveys and meetings with people and staff.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had informed the CQC of significant events in a timely way.

We have made some recommendations in the full version of the report.

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.

Staff were not deployed around the service appropriately to meet people's needs.

Risks were assessed and managed well, with care plans and risk assessments providing clear information and guidance to staff. However improvements were needed around the cleanliness of some areas.

People received their medicines on time and as prescribed. Medicines were stored appropriately.

People told us they felt safe and staff understood what abuse was and knew how to report it appropriately if they needed to.

Safe recruitment practice was followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always have a good understanding of the specific conditions of people who lived at the service. However staff were up to date with the service mandatory training.

Staff said they felt supported in for the work that they undertook and had regular supervisions with their manager.

People's human rights were protected because the provider had followed the requirements of the Mental Capacity Act 2005. Appropriate applications had been submitted to the local authority if people were being deprived of the liberty.

Adaptations to the environment were effective at meeting the needs of people living with dementia.

People were provided with nutritious food and drink. People said the food was good. Peoples' weight and nutrition were monitored and all of the people had access to healthcare services to maintain good health.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and their dignity was respected.

Where people had expressed preferences around their care, these were supported by staff.

Is the service responsive?

Good

The service was responsive.

Staff we spoke with knew the needs of people they were supporting. We saw there were activities and events which people took part in that people enjoyed.

There was a complaints policy and people understood what they needed to do if they were not happy about something.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There were not always effective procedures in place to monitor the quality of the service. Not all areas of improvement had been identified. However in other areas where issues were identified action plans were in place these had been addressed.

People, relatives and staff said they liked the way the service was managed.

Staff said that they felt supported, valued and listened to in the service.

Notifications of significant events in the service had been made appropriately to CQC.

Jubilee House

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.

Prior to the inspection we reviewed all the information we had about the service. This included information sent to us by the provider about the staff and the people who used the service. We reviewed their 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 improvements they plan to make. We looked through notifications that had been sent to us by the registered manager. A notification is information about important events which the provider is required to tell us about by law.

This was an unannounced inspection which took place on the 4 April 2016. The inspection team consisted of two inspectors, a specialist nursing advisor and an expert by experience. The nursing advisor specialised in care for people living with challenging behaviours. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

During our inspection we spoke with the registered manager, six people, five relatives, 10 members of staff and two health care professionals. We looked at seven care plans, recruitment files and supervision records for staff, medicine administration records and mental capacity assessments for people who used the service. We looked at records that related to the management of the service. This included minutes of staff meetings and audits of the service. We observed care being provided throughout the day including during a meal time.

The last inspection of this home was on the 18 and 20 March 2015 where we found breaches of Regulation around safeguarding, complaints, good governance and staffing. We have followed up on those breaches as part of this inspection.

Requires Improvement

Is the service safe?

Our findings

On our previous inspection in March 2015 we found that there were not always enough nursing staff on duty. We found on this inspection that there had been some improvements and there were always the correct numbers of nurses on each shift. There was always one nurse on each floor plus a clinical lead. We confirmed from the rotas that there was always the correct numbers of nurses on duty. However more work was needed to ensure that staff were deployed around the service appropriately to meet the needs of people.

During lunch people who needed support to eat their meals did not always have help from staff when they needed it. For example, on both floors lunch started to be served at 13.00 however there were four people who needed support to eat and they did not get this until 14.00 due to staff assisting other people. One member of staff told us that this was a particular problem that day and that the meal time was slower on the day of the inspection than on other days. Another member of staff said, "During lunchtime a lot of people need assistance" Although staff responded to people who asked for care from them staff were not able to spend time with people who were not asking for their care. This left people who were in their rooms on their own for long periods of time. One member of staff told us, "We struggle to find time to sit and chat to people." whilst another told us, "When there are only three members of time we don't have a lot of time to spend with people."

The registered manager told us they used a dependency tool to assess how many staff were needed to support people. They told us three care staff were needed on each of the two floors each day and two on each floor at night. They said that although the tool showed that only three staff were needed on the ground floor they usually provided four to ensure that people were having their needs met. We reviewed the staff rotas for a period of four weeks and we found that on four occasions there were six carers on duty and on nine occasions there were only six carers for part of the afternoon shift. On the day of the inspection there were six members of care staff and we saw there were periods of time throughout the day where staff were not always visible because they were busy providing support to people. This left some people unsupported at meal times.

We recommend the provider reviews how staff are deployed across the service to ensure that people's needs are being met and that people are not left on their own for long periods of time.

Some parts of the premises were not clean. The medicine room on the ground floor was untidy and in need of cleaning. There were brown stains on the walls and around the sink. We also found that the downstairs sluice room was also not clean and smelled strongly of urine.

We recommend that steps are taken to ensure that the cleanliness of the environment is maintained to an appropriate standard.

People's medicines were administered and stored safely. There was a pre-printed medicine chart for each person with a photo of the person. Each medicine pack was pre-filled with the required medicine and

included a month's supply. There were four medicine rounds at the service. To avoid the risk of the person getting the wrong medicine at the wrong time each medicine pack was colour coded for each time of day. There was an up to date medicines policy and staff's medicine competencies were regularly reviewed.

Where people were being administered medicines covertly (administered without the person's knowledge), best interest meetings had taken place with the person's family and their GP. Guidance was provided from the pharmacist about how the covert medicine should be
administered and this was followed. Medication training was provided to nurses and senior staff and people's medicines were reviewed regularly. We saw people being given their medicines in a safe way and with an explanation from staff.

People told us that they felt safe living at the service. Relatives told us that they felt their family members were safe living there. One told us, "I feel that (the family member) is treated well and is safe." Another relative told us, "I trust them (staff) with (the family member's) care." Whilst another told us, "I never worry about (the family member) being safe.

Staff had knowledge of safeguarding adult's procedures and what to do if they suspected any type of abuse. Staff said that they would refer their concerns to the registered manager and if necessary to someone more senior. There was a safeguarding adults policy and staff had received training regarding this. There were flowcharts in the offices to guide staff and people about what they needed to do if they suspected abuse.

Risks to people were identified and appropriately managed. Risks were identified within care plans and guidance was given to staff to reduce the risks. For example, in one care we saw that one person got anxious during personal care tasks. Guidance was provided to staff on how to support them by communicating well, changing staff to see if this reduced the anxiety to the person and to be prepared so that care could be undertaken quickly to reduce the risk of anxiety. Another person was at risk of swollen legs. The care plan stated that the person should be encouraged to sit down regularly and elevate their feet. We saw this was being done. Staff had a good understanding of people's risks. One member of staff told us, "We read people's risk assessments and sign to say that we have read them." We confirmed this when we reviewed people's care plans. Another member of staff said, "We use crash mats for people who are at risk of falling out of bed and we make sure that we use safety equipment such as body hoists, standing hoists and walking frames." We saw that these were being used on the day of the inspection.

Other risks had also been assessed and managed appropriately to keep people safe. This included the management of manual handling where people had mobility problems, nutrition, skin care and personal care. Risk assessments were also in place for identified risks such as malnutrition and choking with clear guidelines on the action that should be followed by staff. One person was at risk choking, they were provided with thickened fluids to minimise the risk of this occurring and were also given a soft food diet. There was clear guidance to staff on these risks and what they needed to do to support this person safely. Accidents and incidents were recorded and staff knew how to respond. One member of staff said, "I would call the nurse immediately."

People would be safe in the event of an emergency because appropriate plans were in place. In the event of an emergency, such as the building being flooded or a fire, there was a service contingency plan which detailed what staff needed to do to protect people and made them safe. There were personal evacuation plans for each person that were updated regularly and a copy was kept in the reception area so that it was easily accessible.

People were protected from being cared for by unsuitable staff because there were robust recruitment

processes in place. All applicants completed an application with their full employment history. The provider ensured that the relevant checks were carried out that ensured staff were suitable to work at the service and included criminal records checks and references. Staff files included a recent photograph and a Disclosure and Barring System (DBS) check. DBS checks identify if prospective staff had a criminal record or are barred from working with adults at risk. Staff confirmed that they were unable to start work at the service until these checks had been undertaken. We found that the registered manager had ensured all of the nurse's registrations had been kept up to date and a copy was kept on their file.

Requires Improvement

Is the service effective?

Our findings

On our inspection in March 2015 we found that the nursing staff did not have any supervision around their competencies and were not up to date with the required clinical training. On this inspection we found that this had improved. The provider had recruited a clinical lead to undertake supervisions of the nursing team and to provide them with support when needed. We saw that all the nurses were up to date with their clinical supervision. Nurses were mostly up to date with the clinical training and where gaps had been identified we saw that the training had been booked. However, although training had improved there were still gaps in the nurse's competencies that needed to be addressed.

People at the service had complex needs and nursing staff were not always able to explain in detail people's diagnosis or conditions. One nurse told us that they had not had detailed specific training around people who lived with dementia or any training specific to people who had challenging behaviours. They told us that they relied heavily upon the care plan guidance but had not considered what other action could be taken to assist people who lived there. In one person's care plan it stated that they had periods where they were, 'catatonic' (abnormality of movement and behaviour arising from a disturbed mental state). One nurse was unable to explain what the term 'catatonic' meant and described it as having anxiety. They were not clear on how this should be treated and relied upon what had already been established in the care plan. Although we did not see any examples of poor care there was no system in place for nurses to be more pro-active around the care they provided.

A relative told us that they had approached a nurse when their family member was unwell and was told by the nurse that this could be down to the Alzheimer's they had. The relative told us that their family member did not have Alzheimer's but had another type of dementia. They told us they were disappointed that the nurse did not understand the different types of dementia. We spoke to the registered manager about this who told us they were looking to introduce reflective practice sessions around the care nurses provided and their understanding. At the time of the inspection this had not been started. The registered manager told us that they would look to getting this training arranged.

Most of the people at the service were living with dementia. Although dementia training had been provided to all staff some of the staff we spoke with told us that they wanted more detailed training around dementia and challenging behaviour. One member of staff said, "It would help me understand dementia more, the training here is quite basic." However another member of staff told us that, "The training is of good quality here and is good in giving staff the skills we need to complete our role." All care staff were up to date with the service mandatory training that included fire safety, food safety, health and safety, infection control, moving and handling and safeguarding.

We recommend that additional training is provided to staff around the specific needs of people who used the service.

Staff had received appropriate one to one support that promoted their professional development. Staff told us they had regular meetings with their line manager to discuss their work and performance. One member

of staff said, "I have grown and learned such a lot since I started working here." Whilst another told us, "I have regular one to ones and I find the feedback useful." Staff told us that they were supported by management to undertake additional qualifications. All of the staff we spoke with said that they felt supported.

Staff received annual appraisals to discuss their performance over the year and any further training or development needs. Staff who had been at the service for more than a year had received an appraisal with their line manager.

On our inspection in March 2015 we found there was a lack of capacity assessments completed to determine whether people were able to consent to their care and Deprivation of Liberty Safeguards (DoLS) applications to the local authority had not always been submitted.

On this inspection people's human rights were protected because the requirements of the Mental Capacity Act 2005 (MCA) and DoLS were followed. The Care Quality Commission (CQC) monitors the operation of DoLS which applies to care homes. These safeguards protect the rights of people by ensuring if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm.

Staff had an understanding of their responsibilities under the MCA and DoLS. One member of staff said, "We look at trying to make decisions for people that are in their best interest (when talking about people who were unable to consent to care)." Appropriate assessments of people's mental capacity had been completed. There was evidence of mental capacity assessments specific to particular decisions that needed to be made. Where a best interest decision had been recorded there was an assessment in relation to this decision. There was detail about why it was in someone's best interest to restrict them of their liberty. For example, some people were unable to leave the floor that they were living on. There was clear information around why it was in their best interest for the door to be locked.

Staff gave examples of where they would ask people for consent and we saw evidence of this during the inspection. For example, one member of staff asked someone if they could take them to the bathroom to assist them with their personal care and they waited for the response. Nursing staff told us that they would also ask the person if they agreed to the clinical care beforehand. One person told us, "Staff always check me with me first before they do anything to make sure its okay with me."

The environment was organised in a way that met the needs of people who lived there. The design of the environment helped people with dementia to be as independent as possible. For example, there was space to walk around independently inside the service and we saw people doing this throughout the inspection. There were age-appropriate points of interest, including large pieces of artwork with sounds. We saw people used these throughout the day. There was clear signage for people and each bedroom had a memory box outside to help orientate people to their own rooms. Chairs were arranged in social areas in small clusters that encouraged conversations as well as other quiet areas where people could sit if they wanted to.

We asked people for feedback on the food at the service. One person said, "The food is reasonable, you get a choice and they (staff) come up with an alternative if you want." Another person said, "I have two meals a day, the food is okay, I always find things I like to eat." One relative told us, "The food is perfect; I'm very pleased with it." Another relative said, "They (staff) are aware that (their family member) is on a special diet and they (the family member) have never lost weight here."

People at risk of dehydration or malnutrition were supported by staff as where people needed to have their

food and fluid recorded this was being done. Intake and output of food and fluid was recorded on forms that were kept in people's rooms so that staff could easily keep a record of what people had eaten and what they had had to drink. We checked that staff completed records accurately to reflected what people had actually eaten. We saw that drinks were within reach for people that were in being cared for in bed. People were weighed regularly; in most cases monthly. If there was a change in someone's weight then this would be changed to weekly. If staff had concerns they would raise this with the appropriate health care professional.

Nutritional assessments were carried out as part of the initial assessments when people moved into the home. These identified if people had any specialist dietary needs. However we did find that people who were on soft food or were vegetarian did not have a choice of meals. We also found that on the ground floor people who were not on a soft diet were offered a visual choice of meals however on the top floor this did not happen. We spoke to the registered manager about this, they told us that all staff should be offering visual choices and they would remind staff to do this. They also told us that they would speak to the chef about ensuring that all people were offered choices around meals.

The chef had records of people's individuals requirements in relation to their allergies, likes and dislikes and if people required softer food that was easier to swallow. For those people that needed it equipment was provided to help them eat and drink independently, such as plates specific to the needs of people who lived with dementia and adapted drinking cups.

People were supported to remain healthy. One relative told us, "I feel his health needs are met, they get dental care here and I know the GP comes regularly." People had access to a range of health care professionals such as the GP, dietician, chiropodist and the local authority mental health team. The GP visited regularly and people were referred when there were concerns with their health. One health care professional told us, "The nursing team are good; they are very good at making sure systems are in place, I think generally 'call outs (when they are called by staff to see someone) are appropriate." On the day of the inspection the GP visited people to assess any health needs that they had.

Good

Is the service caring?

Our findings

People told us that staff were caring. One told us, "They (staff) listen and help you if you want it." Another person said, "Staff are very, very nice and work very hard." Whilst another person said, "On the whole staff are very, very good." Relatives were also complimentary of the staff. Comments included, "On the whole staff are good, caring and kind", "Interactions with (their family member by staff) are always gentle and kind" and "Staff are absolutely great, I trust them with (their family member's) care."

We observed staff to be kind, caring and patient during the day. We heard one person calling out from their room on several occasions. Each time a member of staff reassured them, asked them if they were okay and if there was anything they needed. They made sure the person was calm before leaving their room. On another occasion one person called out, "Please help me" very quietly. A member of staff went to them and asked if they were uncomfortable in their chair. The member of staff asked another member of staff for assistance and took the person somewhere private to reposition them to make them more comfortable. During lunch staff sat at tables with people and encouraged conversations. One member of staff said, "I care for people here, I love these people."

Staff treated people with dignity and respect. During meal times staff asked people first before they placed clothing protectors on them and waited for a response. Although most of the doors to people's bedrooms were open staff were seen to always knock on the doors before entering. One person told us that their door was always shut when staff were giving personal care. One relative told us, "They treat (their family member) as an important person." People were called by their preferred names by staff which was clearly recorded in their care plan. Staff gave us examples of how they treated people with dignity and respect. One told us, "You treat people as human beings, I make sure that the curtains and doors are shut (when giving personal care)." Another member of staff said, "I talk to people while I'm providing care and tell them what I'm doing, I will cover people up with a towel if they are having a wash, I also ask people what they preferred to be called."

People's decisions around their care were supported by staff and people and relatives were involved in care planning. There was information in the care plans around people's choices, likes and dislikes. People told us that they were asked what was important to them. One person said, "I was involved in my care planning; I have a copy of my care plan in my room." Not all care plans had detail around people's backgrounds and personal history. The registered manager told us that they relied heavily upon relatives providing them with information around people's personal history and said that this wasn't always forthcoming. They told us that they were introducing new records to identify the backgrounds of people. Staff were able to explain the needs of people they supported. They understood people's life history and family. One member of staff said, "I know each and every one; their likes and dislikes." This member of staff told us how one person liked a particular way of dressing and how important this was to the person.

Staff communicated with people in an individualised way and according to their needs. Some people were unable to verbally communicate with staff but we saw staff understood people's gestures and sounds. One person had a specific way of communicating and staff understood this and acted on this. There was

guidance in the care plans for staff on how best to communicate with people.

People's bedrooms were personalised with photos of family and decorated with personal items important to the individual. Staff knew and understood what was important to the person and supported them to maintain their relationships with their families and friends. We saw that relatives and friends were welcomed. One relative told us, "The atmosphere here is very friendly, it's like a second home to me. I feel that the staff know me and always make me feel included." Another relative said, "(Their family member) is much happier here than the previous home, there is much more of a personal connection, they know their likes and dislikes."

People's independence was promoted and supported. Staff assisted people with cutting their food and would gently encourage them to feed themselves if they could. One person who used a wheelchair had the space they needed to move themselves around when they wanted to. One relative said, "They (staff) do well to promote independence here."

Good

Is the service responsive?

Our findings

People were supported by staff who were given appropriate information to enable them to respond to people effectively. Pre-admission assessments were completed before people moved in to ensure that staff were able to support their needs. Care plans were detailed and covered 'activities of daily living' and had relevant information with personal preferences noted. Care plans also contained information on people's medical history, mobility, communication, and essential care needs including: sleep routines, continence, care in the mornings, care at night, diet and nutrition and mobility. These plans provided staff with information so they could respond positively and provide the person with the support they needed in the way they preferred. On one care plan there was detail around the best way to support the person whose behaviour may be challenging.

There was a 'resident of the day' when the person was visited by the chef, the activities coordinator and the nurse to review their care needs. Care plans were reviewed regularly to help ensure they were kept up to date and reflected each individual's current needs. Where a change to someone's needs had been identified this was updated in the care plan as soon as possible and staff were informed of the changes. For example, one person had a change in their mobility and we saw that this information had been shared with staff. One member of staff said, "We have a handover to discuss changes to people, it's so important that you get to know about any changes." Relatives said that they were kept up to date of any changes in their family member's care. One relative said "(Staff) are always quick to get in touch with me if something changes (with their family member)."

Where clinical needs had been identified there was guidance for nurses on how to best care for this need. For example, for people with diabetes it was noted the signs to look for should the person become unwell. Care plans for management of skin integrity were evident clearly stating what the concern was and how the care should be administered.

Staff had a handover between shifts with the team leaders. They discussed any particular concerns about people to ensure that staff coming on duty had the most current information.
Daily records were written by staff each shift which included detail about the support people received throughout the day.

People told us that there were activities on offer. One person told us, "There are things to do here, there are choices and you are not made to join in." Whilst another person said, "I don't get bored." There were activity coordinators who took undertook a range of activities. These included gardening, baking, games, movies, listening to music, pampering and arts and crafts. On the day of the inspection there was a group activity where people were being supported to cut up and taste fresh fruit whilst taking part in a quiz. The activities coordinator told us that they planned activities around the needs of people. These included sensory sessions for those people who were living with dementia. Activities were also arranged around important days such as St Georges Day and Valentine's Day.

People who were able to could go out to the high street to the café. The activities coordinator told us that a

lot of work was also being undertaken to focus on people who did not leave their room. We saw them chatting to people in their rooms on the day of the inspection. Other events that took place included birthday parties, entertainers and visits from the local church and schools. We saw on the top floor people could access an outside garden area.

When asked people who were able to told us that they would have no concerns making a complaint if they needed to. One told us, "I only make (the odd) complaint but I feel staff listen to my concerns." One relative told us that they made a complaint around their family members care. They felt the (registered) manager responded well to this and they were satisfied with the response. There was a complaints procedure in place for people to access if they needed to. We saw that complaints were recorded with a record of how the complaint had been dealt with. In all of the cases the person was written to by the registered manager and a full investigation undertaken. Staff said that if people had concerns or a complaint they would support them to speak to the (registered) manager.

Requires Improvement

Is the service well-led?

Our findings

The registered manager was present on day of the inspection. People and relatives felt the service was managed well. One relative said, "There is nothing about the processes I would change here." Another relative told us that they knew the (registered) manager well and felt that they could go and see them whenever they needed to. One health care professional told us, "The registered manager and the clinical lead are very good at making sure systems are in place."

We did find that improvements were needed in how some of the records were maintained. For example, some records around people's care were not always easy to follow. Some of the documents were found on the electronic care system and some were found in the nurses stations in paper format. This made it difficult to establish where the most up to date information was kept. Some records kept in the nurses station needed updating as they included policies and procedures that were out of date and no longer used.

Systems were in place to monitor the quality of the service that people received however these were not always effective. The audits of the service had not identified the gaps in the clinical knowledge with staff, the cleanliness of the medicine and sluice room or the way that staff were deployed around the service.

We recommend that appropriate systems are in place to assess, monitor and improve the quality of the service including staff competencies and the cleanliness of the service and to ensure that records are maintained appropriately.

In other areas the systems in place to monitor to the quality of the service were effective. The regional manager visited the service to complete audits every other month. These audits covered various aspects of the service including the environment, care plans, policies, paperwork, equipment and staffing. Where a action had been identified there were measures in place to set out who was responsible to address them and when this needed to be done. For example, it had been identified that improvements were required around the heat of the food trolley and we saw that this had been addressed. In addition to this staff undertook internal audits which included health and safety, medicines and documentation.

There was a provider plan in place where improvements to the service were being reviewed. It had been identified that aspects of improvement to the environment needed to be undertaken. The registered manager and staff told us that the service was due for a refurbishment that was due to take place this year.

People and relatives were asked for their views in a number of ways. These included surveys, phone calls and regular meetings. One relative told us "I have been asked for feedback by phone and I'm happy to provide this." There were monthly resident meetings and a copy of the discussions were made available for people. Discussions included what changes people wanted to the environment, food, wellbeing and other matters. At the meeting in February 2016 one person asked if their room could be cleaned when they were awake (and not when they were sleeping during the day) and we saw that this was communicated to the housekeeping staff. Monthly relative's meetings also took place and we read discussions took place around the survey results, and new projects that were going to take place with activities> Relative's contributions to

this were asked for. One relative asked if they could be provided with a chair for them and their relative to sit on together and we saw that this request had been passed to the management team to consider.

Staff said that they were supported by the registered manager and understood the values of the service. One told us, "I feel valued here; I get thanked so much by (the registered manager) it makes me feel wanted and appreciated." Another member of staff said, "I feel valued, I'm always told that I'm doing good things." Whilst another member of staff said that the (registered) manager was approachable and would help out when needed. They told us the registered manager encouraged staff to improve and led by example.

Staff meetings took place regularly and there were discussions around training, infection control, health and safety, complaints and how they were responded to, survey results and policies. Staff were encouraged to contribute to the meetings and to be involved in the running of the service. For example, a meeting took place with staff around how best to report maintenance concerns. We saw that a system had been implemented. Contributions from staff were fedback to the 'Head of Department' meetings on what steps could be taken to address health and safety concerns and clinical concerns.

Staff at Jubilee House produced a quarterly newsletter to inform people, relatives and staff of events, changes to staff, awards to staff and 'thank yous' to volunteers for their time.

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. We saw that the registered manager had informed us of events in good time.