Rushcliffe Care Limited

Jasmine Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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 comprehensive inspection that took place on 27 October 2016. At the last inspection completed on 18 February 2016, we found the provider had not met the regulations for; ensuring that staffing levels were sufficient to meet people's needs and ensuring that staff received appropriate supervision and appraisal as necessary to enable them to carry out their duties. At this inspection we found the provider had made the required improvements and the regulations were being met.

The service provided nursing care for up to 66 older people living with dementia and similar health conditions. At the time of our inspection there were 52 people using the service. Most of the people that used the service had advanced levels of dementia.

The service had a registered manager. 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 felt safe living at Jasmine Court. The provider had systems in place for reporting and investigating accidents and incidents. Staff understood what may constitute abuse or avoidable harm to people. They were aware of and practiced the provider's protocols of reporting incidents of concern.

Risks assessments were in place to manage risks associated with people's care and support. We saw that these were regularly reviewed and control measures put in place to protect people's health and welfare.

There were enough staff to meet people's needs; however, staff were not effectively deployed at meal times. People that used the service, their relatives and the staff that supported them told us that there were enough staff but expressed concerns that the staffing levels about their availability at meal times.

People were supported to have their medicines. Trained nurses supported them with this task. Guidance was not always available or followed to support people who received their medicines covertly or on an 'as required' basis.

The provider had an infection control policy. Staff did not always follow this policy.

Staff had access to an effective training and mentoring programme to support them to gain the skills they required to fulfil their role. They received regular guidance from senior staff. They told us that they felt adequately supported in their role.

People's liberty was not deprived unlawfully. This was because the provider had made applications to the local authority for DoLS authorisation for people that required this. The staff we spoke with demonstrated a good understanding of Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS).

People received the support that they required to eat and drink. People received the support that they required to meet their health needs. They had prompt access to healthcare services when they needed them.

A public address system was used to pass information to staff. We found this to be loud and startling and did not meet the needs of people living with dementia or similar conditions. The registered manager who told us that they would take action for staff to minimize the use of the system and would look into alternative ways they could disseminate information to staff.

Staff were kind and compassionate to people. Staff that we spoke with demonstrated an interest in the people that used the service and this showed that people mattered to them. People were treated with dignity and respect. Staff provided the support that people needed to be involved in decisions about their care by giving them choices.

People's care plans were comprehensive. Their relatives were involved in planning their care and support.

We received mixed responses about the support people received to engage in meaningful activities. People had access to activities and sensory equipment. The registered manager sent us their action plan which identified that they will develop a wider range of activities to encourage more engagement and stimulation. They said they would do this by December 2016.

People had opportunities to provide feedback about the service they received. They told us that registered manager and staff dealt with any concerns promptly.

The service was led by a registered manager who understood their responsibilities under the Care Quality Commission (Registration) Regulations 2009. People and their relative felt that the home was well-managed. Staff felt supported by the registered manager to meet the standard expected of them. The registered manager and deputy manager were approachable and accessible to staff and people.

The provider had systems in place to monitor the quality of the service and drive continuous improvement.

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 consistently safe.

There were sufficient numbers of staff on duty to meet people's needs, however they were not always effectively deployed.

The provider had an infection control policy. Staff did not always follow this policy.

People felt safe when they received care from staff. Accidents and incidents were reported and investigated.

People received the support they required to take their medicines.

Is the service effective?

Good

The service was effective.

Staff had access to an effective training and mentoring programme. They received regular guidance and support from their line manager.

Staff understood their responsibilities under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They supported people to have prompt access to healthcare services.

People were effectively supported with their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

Staff demonstrated an interest in the wellbeing of the people they support and made them feel like they mattered. They involved people in decisions about their care and support.

Staff respected and promoted people's dignity and human rights.

Is the service responsive?

Good

The service responsive.

People were not socially isolated. They had access to sensory equipment and activities. The registered manager had commenced work to develop a wider range of activities to encourage more engagement and stimulation.

People knew how to raise any concerns or complaints they may have. They told us that staff dealt with their concerns satisfactorily.

People's care plans were comprehensive and reflected their current needs.

Is the service well-led?

Good

The service was well-led.

The registered manager understood their responsibilities under the Care Quality Commission (Registration) Regulations 2009.

The registered manager and deputy manager were accessible to staff, relatives and people using the service. Staff had a clear understanding of the standards expected of them. They were supported by the registered manager to meet those standards.

The provider had procedures for monitoring and assessing the quality of the service.

Jasmine Court 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 checked 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.

We carried out our inspection visit on 27 October 2016. The inspection was unannounced. The inspection team consisted of an inspector, a nurse specialist advisor and an expert by experience (ExE). An ExE is a person who has personal experience of using this type of service or caring for someone who uses this type of service.

Before our inspection visit we reviewed information we held about the service. This included previous inspection reports, and notifications sent to us by the provider. Notifications tell us about important events which the service is required to tell us by law. We also reviewed the Provider Information Return (PIR). This is a form completed by the provider, where the provider gives key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority we were responsible for the funding of some people that used the service.

We spoke with four people who used the service, relatives of three people who used the service, two care workers, two nurses, the cook and the deputy manager, area manager and following our visit we have telephone contact with the registered manager. We looked at the care records of six people who used the service, medication records of 22 people, staff training records, three staff recruitment and supervision records and the provider's quality assurance documentation and policies. We observed staff and people's interactions, and how staff supported people. From our observations we could determine how staff interacted with people who use the service, and how people responded to the interactions. This was so that we could understand people's experiences.

Requires Improvement

Is the service safe?

Our findings

At our last inspection carried out on 18 February 2016 we found that the provider did not ensure that staffing levels were sufficient to meet people's needs. These matters were a breach of Regulation 18 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements. There were enough staff to provide the support that people required although we found that staff were not effectively deployed at mealtimes. People's relatives told us that there were enough staff to meet the support needs of their loved ones. One relative told us, "There appears to be enough staff. There are always staff around when I visit." Other relatives' comments included, "There are enough staff to do the caring. There are not enough staff available to sit and talk to them though." and "The staff situation was quite bad when mum first came here. It's improved a lot. It's improved much more since the new manager came."

When we observed the support that people received at meal time in the dining rooms. Most of the people who used the service needed varying degrees of support to eat their meals. We saw that some people had long waits before staff was available to serve or support them with their meal. For example, one person waited for 50 minutes after they were seated to receive their meal. This increased people's confusion in some people. One person appeared affected by this was shouted loudly for their meal causing another person to shout back. A relative told us, "I am concerned that there aren't enough staff at meal times. Mum can feed herself but she needs to be reminded to keep on eating and to eat her food. Other comments from relatives included, "I have been here and there was only one member of staff in the dining room." and "There doesn't appear to be enough staff at lunchtime." We brought this to the attention of the quality managers who told us that they would look into the arrangements over lunch time to ensure that they made best use of available staff.

Staff told us that the staffing levels had improved and were sufficient to meet people's needs. They told us that the provider had implemented a new shift pattern which they found effective. A care worker told us, "It's improved, it's much better. More staff have been recruited." A nurse told us that staffing levels were mainly sufficient but could be challenging during periods of staff absences. They said this was managed internally by staff to minimize the impact on the care people received. They said, "It can be an issue with staff ringing in sick, but we [nurses] go on the floor to help if required."

People and their relatives told us that they felt safe at Jasmine Court. One person told us, "I am safe here." Another person said, "I feel safe in my bedroom." Relatives also agreed that people were safe when they received services at Jasmine Court. A relative said, "[Person] had to move here from a previous care home. They [previous place] couldn't manage him. He's better off here. He's safe here." Another relative said, "Mum is safe here. She's been here about two and half years."

Staff knew their responsibilities to keep people safe from abuse and avoidable harm. They applied the provider's policies to report any concerns they may have about people's welfare. They told us that they would report any concerns to the nurse or other senior members of staff. A care worker told us, "I will report any concerns instantly to the nurse who would relay to the manager. Any incident, we will alert the nurse or manager via buzzer."

The provider had systems in place for reporting and investigating accidents and incidents. Records showed that when accidents or incidents occurred, that staff took appropriate actions to develop people's support in a way that minimised the risks of a reoccurrence of the accident or incident. The registered manager or registered nurses investigated incidents and they notified the Care Quality Commission of relevant incidents.

Staff assessed risks associated with people's care and well-being. These included risks assessment for people's mobility needs, falls management and nutrition. They used the risk assessments as a guide to provide care and support in a way that minimised the risks to people whilst allowing them to be as independent as possible. For example, people had aids and staff to enable them mobile from one area of the home to another. We saw that risk assessments were reviewed to ensure they reflected people's current needs.

We saw that the home managed small amounts of money for six people. These funds were stored securely. The provider had a system for managing people's monies. However, this this was not audited regularly. The records did not include guidance for staff on the appropriate handling on receipt of money or who can authorise transactions. This is required so that the risk of financial abuse is minimised.

The premises were well maintained. The building was designed to meet the needs of people that used the service. We saw that a fire door had been propped open with a heavy door stop. This was not in keeping with fire regulations. We brought this to the attention of the deputy manager who removed the door stop. Staff did not always check equipment people required as directed in the provider's protocols. Records stated that "equipment is to be checked weekly" However, we saw that equipment people required such as blood sugar monitoring and suction equipment had not been checked for over a two week period.

The provider had safe recruitment practices. They completed relevant pre-employment checks before staff commenced their employment. These included obtaining references that asked for feedback about prospective staff and a Disclosure and Barring Service (DBS) check. DBS checks were completed before staff commenced their employment and again every three years. This assured them that staff remained suitable to work with people who used care services. Where staff had been employed through the overseas nursing programme, we saw that the provider also completed relevant police checks from the home country.

People's medicines were stored safely following current guidelines. People medicines were administered by nursing staff who had received relevant training to manage people's medicines safely and in compliance with legislation and current guidance. A nurse told us, "When I started, I had training and my manager went round doing the meds with me. She told me some of the things that I needed to be aware of with respect to the residents. For example, some residents hiding the meds in their mouth also about people requiring their meds covertly." Nurses were clear regarding what action to take in the event of an administration error to ensure the safety of the resident in the first instance and then how this is reported as an incident. We saw that they had use of the BNF. The BNF is a reference book for nurses on all prescribed medicines, their use, dosage and side effects. It is updated every six months and should be no more than 12 months old. We found the BNF in use to be out of date since March 2015. The NMC (Nursing and Midwifery Council) standards for administration of medicines states that nurses should not administer any medication unless they know what the medicine is and used for, what the normal dose range is, side effects and any contra-indications.

Where medicines were prescribed on an 'as required' [PRN] basis there was not always a clear protocol for when it should be used and the frequency of use. Where people received their medicine covertly, there was

no evidence that staff reviewed this regularly and that they followed recent guidance to manage this. People receive medicines covertly where their needs require that their medicines are disguised before they receive them. The home audited all aspects of medicines on a weekly basis; audits over the previous two months had not identified any issues with systems and processes.

One person had a highly communicable infection. We saw that the infection was isolated to this person. Their care records evidenced that full infection control measures had been implemented according to the provider's infection control policy. However, we saw that their records did not show that their doctor had reviewed their medicines. This is of particular importance as some medicines may have some adverse effects for this type of infection.

We observed that most staff wore protective equipment. However, we observed where a domestic staff and a care staff did not adhere to the provider's guidance when they provided support. Their actions presented poor infection control practice.

Good

Is the service effective?

Our findings

At our last inspection carried out on 18 February 2016 we found that the provider did not ensure that that staff received appropriate supervision and appraisal as necessary to enable them to carry out their duties. These matters were a breach of Regulation 18 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had made the required improvements. Staff received regular guidance and supervision from their line managers. This included support from senior care workers, nurses or the registered manager. They told us that they found their supervision meetings helpful as managers also used this to motivate and encourage staff. A senior care worker told us, "Supervision is not only when you have done bad. Supervision is also when you have done good. I had one recently with [staff name]." Records showed that most staff had received regular supervision since our last inspection.
People received support from staff who had the skills and experience to meet their needs. Relatives we spoke with felt confident that staff had the skills to carry out their role effectively. One relative told us, "There is a regular programme of training for the staff. I see them when they come in to do some training. They tell me what they are doing." Another relative said, "They [staff] are all well trained and do a good job." A care worker told us, "We have lots and lots of training. Every year we have training." A senior care worker told us, "The training is good. We get training for everything – safeguarding, moving and handling, nutrition and others. Training is not just training, it's how you put it into practice." They told us that the provider operated a mentoring system to support staff development and practice. They said, "All new staff are allocated a mentor." They told us that they supported other staff through the mentoring programme. They told us how they supported staff to improve areas where issues may have been identified in their practice. They said, "I talk to them…if they keep repeating same issues, I will speak to the training centre and tell them that this person needs retraining."

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

People can only be deprived of their liberty so that they can 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.

Due to the level of needs of the people that used the service, most people required a DoLS. We saw that the provider had made applications to the local authority for DoLS authorisation for people that required this. This meant that people's liberty was not deprived unlawfully. Staff we spoke with demonstrated a good understanding of MCA and DoLS. People's care records showed that staff considered their capacity to make

their own decisions and areas of their decision making where they may require support and the level of support they may require where necessary. We observed that staff sought people's consent before they provided their care and support and took time to interact and explain the support that they provided them.

People told us that they liked their meals and the variety of meals on offer. One person said, "The food is lovely. If there's something I don't like I can have sandwiches." Another person said, "I have enough to eat and drink." Other comments included, "The food's ok – it's not like my own cooking though." One relative told us, "The food is varied. [Person] has soup every day. They have four or five different varieties. On the whole the food is good and varied. They will always offer something else if he doesn't eat it." Another relative told us, "She gets enough to eat and drink throughout the day. There are drinks on the side in her room." Another relative commented, "The food here is good for mum she eats it all." We saw that staff offered people alternative meal choice when they expressed reluctant to eat their meals.

At our inspection on 18 February 2016, staff and relatives were not confident that people who required a vegetarian or pureed diet received nutritionally balanced meals. At this inspection we found that the provider had made the required improvements. The needs of people who required special diets or had specific preferences were met. Catering staff attended training provided by health professionals to meet people's nutritional needs. Staff were aware of people's needs and provided meals that met their needs. We observed that staff served a person a gluten free diet. A care worker told us, "They tend to give us more things which are gluten free. We give [person] in the same way [as others] so theirs doesn't look different. I allocate someone who's experienced, they serve [person] first so they don't go picking other people's food. The kitchen supervisor ensures things are well labelled."

Staff completed records to monitor people's fluid or food. We saw that these were completed regularly and descriptively to support staff monitor when people required additional support to stay hydrated or meet their nutritional needs. Fluid intake charts did not identify the target amount of fluids people required. The target intake is good practice and important to guide the care staff were additional fluids are required or a trigger for them as to when to alert other professionals when the target has not been met. We did not see that people had not been adversely impacted due to this.

People received the support that they required to meet their health needs. Their care records showed that staff promptly responded to changes in people's health needs. They promptly referred people to health care professionals when needed. Staff followed advice and guidance recommended by professionals. For example, one person received their medicines and nutrition via a PEG tube. The feeding regime was clear regularly reviewed by a dietician. There was clear guidance for staff on the safe positioning of the person whilst administrating their medicines and feeds.

On the day of our visit we saw that staff used a public address system to alert staff to incoming telephone calls that required their attention. We found this to be loud and startling. This could cause dis-orientation to people living with dementia and similar conditions. A relative told us, "There is a tannoy which does seem loud but mum's hearing isn't good enough for her to hear it." We brought this to the attention of the registered manager who told us that they would take action for staff to minimize the use of the system and would look into alternative ways they could disseminate information to staff.

Good

Is the service caring?

Our findings

People and their relatives told us that staff treated people with kindness. One person told us, "The staff are lovely people. If I need anything the staff always will help me." Another person said, "The staff are kind to me. They will bring me a cup of tea." A relative commented, "The staff are kind and caring – some more so than others." Other relatives' responses included, "The care is exemplary." and "All of the nurses are friendly and approachable."

Staff that we spoke with demonstrated an interest in the people that used the service and that people mattered to them. A nurse told us, "Despite the challenges our aim is to give people dignified care and keep them pain free. It is a rewarding job not monetarily but satisfying to give people the care they need. It's lovely when they give you their thanks in return." A care worked told us, "I am here for them [people] emotionally and physically. We are not here for the money."
A relative told us," The staff are lovely. They are very good and they all work very hard." Staff showed a good knowledge of the people that they support. They told us how they used their knowledge of people's likes, preferences and history to provide support in a way that met their needs. We saw that staff used their knowledge of a person's previous work history to engage in meaningful conversation with them.

We spent time observing the care that staff provided to people in communal areas. We saw that they interacted with people in a warm and compassionate manner and supported people at a pace that suited each individual. They were available to people when they requested their support, and communicated with them effectively by using different styles of communication. This included enhancing verbal communication with touch, ensuring that they were at eye level with people who were seated and altering the tone of their voice appropriately.

Where possible, staff encouraged and supported people to be involved in making decisions about their daily care and support. Staff supported them to make simpler decision by giving them choices. A care worker told us, "We have to give them choices. For example, ask them what they want to eat, wear and so on."

Staff supported people to be as independent as they could. For example, one person's care records showed that they were able to feed themselves with their left hand. We observed that during lunch time that staff prompted them to eat using their left hand and were available to support them to maintain their dignity whilst they did so.

Staff treated people with dignity and respect. A relative told us, " [Person] is always treated with dignity and respect." We observed several instances of staff promoting people's dignity whilst they supported them. This included talking to people respectfully and being discreet when they supported people with their personal hygiene. There were signs on people's bedrooms doors to prompt staff to provide care that prompted people's dignity.

People's records and information were managed in a confidential manner. This maintained people's right to privacy. We saw that people's care records were stored in a locked office and were completed and

accessible only to authorised staff. Charts for monitoring people's food and fluid intake, repositioning, personal care and topical creams were stored in a file located in people's bedrooms. When staff had telephone and face to face discussions with health professionals regarding people's needs this was also done in a confidential manner.

There was no restriction to when people's friends or family could visit them. Relatives told us that they visited people freely and were made to feel welcome at their visit. A relative told us, "I am always welcomed when I visit." Another relative said, "They always welcome me when I visit."

Good

Is the service responsive?

Our findings

People's care records focused on their individual needs. They were comprehensive and included information to guide staff to provide the support that people required. This included information such as their history and preferences. We saw in one person's record that they had a 'life story – forget me not' which guided staff to their previous experiences. This supported staff to provide care that it is tailored to people's individual needs.

Due to the complexity of needs of most people that used the service, they had limited involvement in their care planning. Their relatives told us that staff involved them when they planned people's care and support. One relative told us, "I am involved with mum's care. I know what medication she is on and visit the doctor with her. I also help to make her food choices." Another relative told us, "I don't live locally. They always ring me to keep me informed of what has happened to mum." We saw that people's care plans were reviewed monthly or sooner if there were changes in people's needs. Staff told us the care plans were mainly completed by the nurses. A nurse said, "Registered nurses do the care plans. Care assistants are our eyes on the floor. We rely on them for updates on the residents."

People and their relatives told us that the support they received met their individual needs. One person told us, "I'm looked after." A relative commented, "When [person] first came I used to bring a razor with me to give him a shave. The personal care here is very good and so I don't need to shave him when I come. I don't bring a razor anymore." Another person said, "Mum is always clean. Her skin, hair nails and clothes are clean."

People's bedrooms were personalised to reflect their preference. People were able to bring their personal belongings and furniture when they came to live at Jasmine Court. A relative told us, "We've been able to bring some of mum's furniture here." Another relative told us, "We like to decorate her room with photographs." We observed that some people had sensory equipment and music in their bedroom.

We received mixed responses about the support people received to engage in meaningful activities. One person told us, "I don't do much all day – I don't watch TV because what they put on there is childish and I don't like it. It's children's stuff. If anyone wants any help they will do it for you." Another person said, "The doctor said that they need to get something to occupy me. They haven't got me anything to do. I join in with whatever they are doing. I watch TV. I can't walk." Relatives we spoke with told us that staff provided activities which were tailored to meet each person's needs. A relative told us, "The activities staff are good. [Person] doesn't do much though, he doesn't watch TV. He has a radio in his room which was provided by the home and not by me." Another relative said, "Mum doesn't join in any of the activities. She has some sensory things in her room and these do seem to have settled her a lot."

The deputy manager told us that the home employed a team of activity coordinators who organised activities and provided suitable sensory equipment for people who were unable to join in group activities as this met some people's mental health needs. The home also had a sensory room which had a range of equipment and activities. Following our inspection, the registered manager sent us their action plan which

identified that they will develop a wider range of activities to encourage more engagement and stimulation. They said they would do this by December 2016. A care worker told us, "We have three activities coordinators. The activity is tailored to the person. We take them [people] to the sensory room." They went to tell us how they tailored an activity to a person. They said that they had provided a board for a person who was asking to go to a neighbouring town "to aid communication ." They said this person wrote things down on their board and this provided the stimulation they needed as this was related to their past work history.

People knew how to raise a complaint about the service they received if required. One person told us, "If I wasn't happy about something I would tell the staff. I don't know whether they would do anything though." Another person said, "I don't think that there are any improvements needed here." People's relatives also knew how to raise any concerns or complaints they may have. They told us that the registered manager provided opportunities for them to do so. They were confident that staff would action any concern they raised. One person told us, "If I had a compliant I would tell the manager. I came on one occasion and there was a coffee morning. We're made to feel very welcome. I am comfortable raising my concerns." Another relative said, "I would be comfortable to complain. I did make a complaint when she first came here. I can't remember what it was about now. But it was all dealt with." Another commented, "There were one or two issues when mum first came. Everything was sorted out."

Good

Is the service well-led?

Our findings

The service had an experienced registered manager. It is condition of registration that the service has a registered manager in order to provide regulated activities to people. The registered manager understood their responsibilities to report events such as accidents and incidents to the Care Quality Commission. They promptly sent notifications to the Care Quality Commission when required. They carried out thorough investigations of incidents that staff reported, and worked with the local authority where required to investigate such incidents.

The registered manager was supported in their role by a clinical advisor, deputy manager and a team of registered nurses. The provider had a clear management structure. Staff had management support at various tiers of the service. Care workers received support and guidance from registered nurses. The deputy manager and registered manager were available to support the registered nurses and wider staff team. During our visit, we saw that the nurses were responsive to the care staff when they had questions or they required support and advice to provide support to people.

Staff felt supported by the registered manager and deputy manager to meet the standard expected of them. A nurse told us, "I have had the support I require to overcome challenges within the role." They told us that they received support through supervision meetings and staff meetings with the registered manager. They told us that they discussed their support needs and received guidance in meetings. We saw that this was reflected in the meeting records we reviewed. Records showed that most staff had received regular supervision since our last inspection. A care worker told us, "I have had about two or three [supervision meetings]. I find them useful."

Staff complimented the registered manager. They told us that the registered manager was approachable and promoted an open culture. A nurse told us, "[Registered manager is approachable, you can meet her anytime as long as she is not busy. We also have several meetings with her where we can raise any concerns. [Deputy manager] is our initial contact." A care worker told us, "[Registered manager] is a good manager, she listens." Another care worker told us, "[Registered manager] and [deputy manager] are approachable irrespective of how busy they are." The cook told us that the registered manager and deputy manager were very approachable and were very supportive of the ideas they had for developing the new menus.

People's relatives we spoke with were satisfied with the care and support their loved one received at Jasmine Court. A relative told us, " I feel very happy about mum and how she's looked after They try very hard." The registered manager provided opportunities for people and their relatives to give their feedback about the service they received. One of the ways they did this was through surveys and questionnaires to relatives. The deputy manager told us that the responses to their recent survey had been received at their head office and would be sent to Jasmine court when analysed. Following our visit, the registered manager sent us details of the survey responses. We saw that majority of respondents were happy with the service at Jasmine Court. We saw that the registered manager had developed an action plan to address the issues people raised in through the survey. This also identified which member of staff was responsible for carrying out the action plan. This showed an inclusive approach of both support staff and managers when learning

from incidents and making necessary improvements. Relatives also had opportunities to provide face to face feedback through meetings with staff.

The provider had systems and procedures in place for assessing and monitoring that the quality of care they provided. These included quality assurance audits of people's care and support and the general maintenance of the building and equipment. We saw that staff discussed results of these audits with the registered manager. They developed an action where improvement requirements were identified. This showed that they used their systems to drive continuous improvement in the quality of service people received.