Sage Care Homes (Jasmin Court) Ltd

Jasmin Court 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 inspection took place on 19 and 20 April 2016 and was unannounced on the first day.

We last inspected the service in October 2015 when we found three breaches in legal requirements and the service was rated as 'requires improvement.' The breaches were in respect of care and treatment not always being provided in a safe way, including the management of infection control, the premises not always being suitable for the purpose intended, and a lack of a robust system to monitor how the home was operating.

The provider sent us an action plan detailing what improvements they intended to make and by when. You can read the report from our last inspections, by selecting the 'all reports' link for 'Jasmin Court' on our website at www.cqc.org.uk'

Jasmin Court is in north Sheffield and is registered to provide accommodation for 50 older people who require nursing and/or personal care. Accommodation is provided on the first and second floors, accessed by a lift. Communal areas such as dining rooms and lounges are situated on the ground floor of the home. At the time of the inspection 41 people were living at the home.

The service did not have a registered manager in post. However, there was a new manager who had been in post for around five months. They told us they had applied to become registered as manager with the Care Quality Commission. 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.

During this inspection we looked to see if improvements had been made since our last inspection in October 2015. We found that substantial improvements had been made.

The home had a welcoming, friendly atmosphere, which people said they liked. Throughout our inspection we saw staff supporting people in an inclusive, caring and responsive manner. They encouraged people to be as independent as possible, while taking into consideration their abilities and preferences. The people we spoke with told us they felt the home was a safe place to live and they were happy with the care and support they received. They made positive comments about how staff delivered care and said the available facilities met their needs.

We saw there were systems and processes in place to protect people from the risk of harm. The management team were knowledgeable about safeguarding people from abuse and all staff had received training in this subject. Assessments identified any potential risks to people and care files contained information about how to reduce these risks.

Medicines were stored safely and procedures were in place to ensure they were administered correctly. We

saw people received their medications from staff who had been trained to carry out this role.

There was enough skilled and experienced staff on duty to meet the needs of the people living at the home and suitable pre-employment checks were undertaken before employing new staff.

Staff had received a structured induction on how the home operated and their job role at the beginning of their employment. They had access to a varied training programme and support to help them meet the needs of the people who used the service.

The requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were in place to protect people who may not have the capacity to make decisions for themselves. The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected.

Records demonstrated the correct processes were being followed to protect people's rights, including when Deprivation of Liberty Safeguards were considered.

People were provided with a choice of healthy food and drink ensuring their nutritional needs were met. We saw specialist diets were provided if needed and the people we spoke with said they were happy with the meals available.

Overall, care files reflected people's needs and preferences in satisfactory detail and people had been involved in planning their care. However, records for people new to the service, or only staying for a short time, were not as detailed.

The home had an activity co-ordinator who facilitated a structured programme of activities which people said they enjoyed.

The provider's complaints policy was available to people using and visiting the service. We saw that when concerns had been raised they had been investigated and resolved promptly. The people we spoke with raised no concerns.

There was an improved system in place to enable people to share their opinion of the service provided and the general facilities available. We also saw a structured audit system had been used to check if policies had been followed and the premises were safe and well maintained. Where improvements were needed action plans had been put in place to address shortfalls.

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.

Staff were knowledgeable about how to recognise signs of potential abuse and aware of the reporting procedures.

Assessments identified risks to people, and plans were in place to reduce any potential risks.

Recruitment processes for new staff were thorough, so helped the provider make safer recruitment decisions when employing new staff.

We found there was enough staff on duty to meet the needs of people living at the home.

Suitable systems were in place to make sure people received their medicines safely. This included key staff receiving medication training.

Is the service effective?

Good

The service was effective.

Staff had completed training in the Mental Capacity Act to help them understand how to support people whilst considering their best interest. Records demonstrated the correct processes were being followed to protect people's rights. However, decisions made in people's best interest were not always recorded in sufficient detail.

Training was provided to make sure staff could meet the needs of the people they supported.

People received a well-balanced diet that offered variety and met their individual needs. Our observations, and people's comments, indicated they were happy with the meals provided.

Relevant healthcare professionals were involved in people's care when required.

Is the service caring?

Good

The service was caring.

We found staff were kind and respectful to people who used the service. They respected people's preferences and ensured their privacy and dignity was maintained.

We saw staff took account of people's individual choices while supporting them to be as independent as they were able to be, and encouraged them to voice their opinions.

Is the service responsive?

Good

The service was responsive.

People had been encouraged to be involved in planning their care. On the whole care plans reflected people's needs and had been reviewed and updated in a timely manner. There was room for some plans to be more person centred and the manager had started the process of addressing this.

Dedicated activity staff provided a programme of social stimulation which people said they enjoyed.

There was a system in place to tell people how to make a complaint and how it would be managed. People told us they would feel comfortable raising any concerns with staff.

Is the service well-led?

Good

The service was well led.

People we spoke with told us the manager was approachable, always around, and ready to listen to them.

There were systems in place to assess if the home was operating correctly and if people were satisfied with the service provided. This included service audits and meetings. We found action plans were used to address any areas that needed improving.

Staff were clear about their roles and responsibilities and had regular staff meetings, and access to policies and procedures to inform and guide them.

Jasmin 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 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 19 and 20 April 2016 and was unannounced. Which meant that the home's management, staff and people using the service did not know the inspection was going to take place. The inspection team consisted of two adult social care inspectors. At the time of the inspection there were 41 people using the service.

To help us to plan and identify areas to focus on in the inspection we considered all the information we held about the service, such as notifications from the home. We also used information received from professionals who had visited or worked with the home, such as service commissioners and visiting healthcare and social care professionals, including information about the outcomes of the most recent commissioner's contract monitoring visit.

We spoke with 12 people who used the service and four visitors. On the first day we looked around the home to assess if the shortfalls found at the last inspection regarding the premises and equipment had been addressed. We also spent time generally observing care throughout our visits, and at lunchtime on both days.

During our inspection we spoke with nine members of care staff, the manager, deputy manager, two nurses, a cook, a laundry assistant and an activity co-ordinator. We also obtained the views of an external social care professional who was visiting the home. We looked at records relating to people who used the service and staff, as well as the management of the service. This included reviewing seven people's care records, medicines management documentation, four staff personnel files; including records of their recruitment, training and support, minutes of staff and residents' meetings, complaints records, infection control and maintenance records, and how the home monitored the quality of service provided.

Good

Is the service safe?

Our findings

At our previous inspection in October 2015 the service was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). This was because the prevention, detection and control of the spread of infection had not been fully assessed, and sluice and cleaning rooms did not have appropriate floor coverings. Risks such as uneven floors, which had been previously identified, had not been addressed, and staff did not use appropriate slings when supporting people who required moving with a hoist.

Since the last inspection the uneven floor in the corridor leading from the dining room had been rectified. People we observed who required the use of a hoist to move them had slings suitable for the transfers. Staff had received training updates on moving and handling people, which included the appropriate use of hoists and slings. This meant that staff were better equipped to meet people's needs in a safe manner.

The moving and handling risk assessments and care plans we saw reflected people's needs and the equipment used, and they had been reviewed regularly. The room used to store moving and handling equipment was clean and freshly painted, with a range of slings available for use.

We found considerable improvements had been made in the way the cleanliness and prevention and control of the spread of infection was managed. All areas identified at the last inspection had been addressed. For example, the patch of damp, flaking plaster on the wall in the laundry had been repaired and repainted. Impervious floor covering had been provided in the various store rooms and cleaning rooms, and boxes provided to hold equipment, rather that it being stored on the floor. Appropriate floor covering and a wash hand basin had been provided in one identified sluice room, and the necessary shelves and racking had also been provided to supply suitable storage for equipment in all of the cleaning rooms. The corners of the shelving had also been modified, so there were no sharp corners.

Everywhere we visited in the home was clean, smelled nice, and was well decorated, maintained and presented. The deputy manager was the lead for infection control in the home and showed us the records they kept to make sure the home was kept clean. They were very enthusiastic and committed to ensuring that good practice was followed in the prevention and control of infection, and very well organised. We saw that cleaning and infection control tasks had been broken down into clear schedules, with clear timescales, such as daily tasks. These were signed by staff when completed and there was evidence that the standard of work was checked by the management team. For instance, we saw separate cleaning schedules, for ordinary beds and mattresses and for air flow bed and mattresses, which staff had signed and dated when they completed the tasks. These also included checks, to make sure each person's bed, pillows and mattress were in good condition, along with any bedrails and bumpers used. There was a space for staff to report any faults with the equipment, and for follow up actions to be noted. This was in addition to other, more specific and detailed mattress and bedrail audits.

A colourful and informative notice board in the reception area highlighted the importance of infection control, including topics such as the correct way to wash your hands. Information about the colour coding

for mops, buckets and cloths was also included on the board, along with the Department of Health prevention of infection in care homes guidance. Hand washing posters and hand gel dispensers were also visible throughout the home.

The people we spoke with felt the home was a safe place to live. A visitor said they liked the fact that the front door was kept locked and people had to sign in and out of the home. They also commented about the availability of hand gel being a positive way of controlling infection at the home. Another visitor told us that the home always smelled nice.

Staff had received training in safeguarding vulnerable adults and safeguarding policies and procedures were in place to guide practice. Staff we spoke with knew how to recognise and report abuse if required. They told us that any abuse would be reported immediately to the manager and they felt confident that the management team would address any issues without delay. Staff had also had sight of the whistle blowing policy and felt comfortable to report any incident of poor practice to the management team, the local authority or the Care Quality Commission.

We saw a separate record, which was kept by the manager to record and monitor the progress and outcomes of any safeguarding concerns. This record showed that safeguarding referrals had been made appropriately to the local authority. It was clear that the service was responding appropriately to any safeguarding concerns to protect people.

We saw that there were enough staff on duty to keep people safe. We discussed staffing with the manager and the deputy manager. We were told there was always a qualified nurse on duty. There were between seven and eight care staff on duty each day, and four to five waking night staff each night. The deputy manager told us there was usually a senior carer on duty in those numbers, which provided additional, senior support to staff. The rotas we saw confirmed this. From speaking with members of the management team, other staff and people who used the service we found this generally met people's needs.

The manager was also a qualified nurse, and was supernumerary to the care rota, along with the deputy manager. There were also two activity coordinator posts. One activity coordinator had recently left and the post had been newly recruited to. Ancillary staff supported the care, such as cooks and kitchen assistants, domestic and laundry staff, administrative staff and a handyman.

The manager had introduced a dependency tool to identify people's needs and the staff required to meet those needs. People told us they did not have to wait long for assistance if they called staff and that there were always staff about to help. During our observations staff were always present in the communal areas and any assistance required was responded to in a timely way. However, we discussed the deployment of staff at lunchtimes with the manager, as the staff we saw supporting people with their lunch were under pressure in trying to meet everyone's different needs and preferences. The manager said that they would review the way staff were deployed at mealtimes.

The staff personnel files we saw showed that sufficiently robust staff recruitment procedures had been followed. Application forms had been completed, two written references had been obtained and formal interviews undertaken. We saw all pre-employment checks had been carried out prior to staff commencing work. The manager told us that staff were not allowed to commence employment until a Disclosure and Barring Service (DBS) check had been received. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

However, we found that of three staff members, who had changed roles within the home, only one had clear records on their personnel file of the process followed and the responsibilities of their new role. For instance, the new deputy manager, who had been in post for two weeks, told us they had been through a very thorough, internal recruitment process, including a formal interview and a written test. However, the records of the recruitment process and their new job description were not included in their file.

Discussion with staff and the records we saw showed the use of agency workers had reduced significantly, as new, permanent and bank staff had been recruited. Some agency staff were still used, and this was primarily agency nurses. The manager said they tried to use the same agency workers, where possible, to help provide better consistency and continuity of approach for people using the service. An agency nurse we spoke with confirmed that this was the case, and had allowed them to get to know the needs and preferences of people who used the service, and work more as a part of the staff team.

We checked the information provided by the supplying agency about the recruitment checks they had undertaken, when they recruited their agency staff. The agency had provided the manager of the home with a profile of each agency worker. These contained information about the worker, such as their DBS check, professional qualifications and experience in care. However, information was not included about the references the agency acquired for each worker, or the checks undertaken about the workers' right to work in the UK. We discussed this with the manager, who said they would request this information for the agency staff working in the home, and ask that all future worker profiles included this information.

We looked at the systems in place for managing medicines in the home. This included the storage, handling and stock of medicines and medication administration records (MARs) for four people. We watched medicines being administered to people on both days of the inspection, by a nurse and by a senior staff member. Both followed good practice, administering people's medicines safely and with sensitivity. The staff we spoke with told us that no staff administered medicines unless they had been appropriately trained and their competence assessed.

We were told that the medication room had been moved, and the new room provided a cooler and more secure environment. We found that medicines were stored safely, at the right temperatures and in a well organised fashion. Clear records were kept for medicines received, administered and returned.

The last supplying pharmacy advice visit was at the beginning of December 2015. Some areas for improvement were identified, such as overstocking and out of date stock. We saw the manager had completed an internal audit at the end of December 2015, which included these areas. The internal audit and the associated action plan addressed any shortfalls, showing that the issues had been addressed. We found no issues or concerns regarding stock medication at this inspection.

Medication charts were checked monthly in an in depth audit and spot checks had been undertaken in between, by the manager and deputy manager. Any errors found were fully investigated. There was evidence that lessons were learned. For instance, some people were prescribed Controlled drugs (CDs), which are medicines controlled under the Misuse of Drugs legislation. We found a weekly CD check was carried out and records maintained about any issues found, along with the remedial action taken. For instance, following one issue being identified, daily medication handover checks had been introduced.

Good

Is the service effective?

Our findings

At our previous inspection in October 2015 the service was in breach of regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Premises and Equipment). This was because not all areas of the premises and equipment were suitable for the purpose, or appropriately located for the purpose for which they are being used. Access to some bathing and toilet areas was difficult.

As part of this inspection we carried out a tour of the service. We found that the environmental issues identified at the last inspection had been addressed. For instance, the bath with chair hoist that was out of action at the last inspection had been repaired and was operating. The main toilet, which had been used for people who required hoisting, had been changed to another room, which provided a bigger space to manoeuvre people safely. The steep ramp in the wet room had modified rails. The manager told us they had checked that the gradient of the ramp was within acceptable limits. They also told us they planned to have the rails on the ramp modified further, to help make people feel safer. In the meantime staff were using it with people who could negotiate the ramp easily.

People we spoke with indicated that staff met their needs, were friendly, helpful and efficient at their job. One person who lived at the home said, "[The staff] are all lovely." Another person said, "[The staff] make it like a 'home from home'." One visitor told us staff seemed to be good at their jobs. They added, "[The staff] are very good to [the person living at the home]."

We found that on the staff had the right skills, knowledge and experience to meet people's needs. Staff received a structured induction when they started to work at the home. This included them receiving information to help introduce and orient them to the home, such as the staff handbook. The manager said new staff also worked with an experienced member of staff until they were confident and competent in their role. We saw new staff had also completed, or were undertaking, training for the care certificate introduced by Skills for Care. The Care Certificate looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

The home sometimes used agency staff and we saw there was an induction form that all agency staff had to complete before they could work at the home. In the case of nursing staff we saw additional information was also provided to ensure they were aware of the home's policies and procedures. The manager told us that agency staff who worked at the home on a regular basis were also encouraged to attend training sessions at the home. They said this ensured they received appropriate training to meet the needs of the people living at the home.

There was a staff training matrix, which demonstrated that the majority of staff had received the company's mandatory training. Topics covered included health and safety, infection control, moving people and objects safely, fire awareness and food hygiene. We noted there were some gaps in the competed training. The manager explained that these were mainly due to staff being new to the service, so they had not yet had the opportunity to complete all the required training, and it was clear that sessions were planned for them.

We also saw where a small number of staff had not completed the required training in a timely manner; the manager had taken action to address this with the individual staff member involved.

We found nursing staff had also completed training and competency checks in topics such as medication administration, syringe drivers, male and female catheterisation and wound management. We also saw Percutaneous Endoscopic Gastrostomy (PEG) competency checks had taken place. PEGs are most commonly used to provide a means of feeding people when their oral food intake is not adequate. These training sessions helped the nurses to maintain their skills and competencies as a qualified nurse. The manager told us they were also trying to access phlebotomy training [the taking of blood samples], but was having difficulty accessing courses.

We saw all staff were encouraged to complete a nationally recognised qualification. The deputy manager told us they had been enrolled on management course to provide them with the additional skills and knowledge they needed for their new job. The manager spoke confidently about supporting nurses to maintain their nursing qualifications. They described how they were planning to support nursing staff with the revalidation process recently introduced for all nurses.

We found that in the past staff had not received regular one to one support sessions, but records showed that since the new manager had started, staff were receiving regular one to one sessions, as well as group meeting where they could discuss changes at the home and expected standards of conduct. We discussed the content of the staff support records with the manager because the ones we saw did not fully reflect the staff member's involvement in the process. The manager told us they would review how these sessions were planned and recorded.

There was also a system in place to provide staff with an annual appraisal of their work performance, as well as their training and development needs. Although records indicated that appraisals had not always taken place in a timely manner in the past, we saw the new manager had begun to address any shortfalls.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), and to report on what we find. This legislation is used to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in their best interests and protect their rights.

The Deprivation of Liberty Safeguards (DoLS) is aimed at making sure people are looked after in a way that does not inappropriately restrict their freedom. Staff had received training in these subjects as part of their induction and we saw an information board on the ground floor told people about the five principles of the Act. It was clear that when decisions had been made on people's behalf, these were made in their best interests. However, the process of who had been involved and how decisions had been reached were not always recorded in an organised way in people's care plans.

Policies and procedures on these subjects were in place and guidance had been followed. We found the service to be meeting the requirements of the DoLS. The manager was aware of the guidance and had reviewed people to ensure this was being followed. People who were subject to a DoLS authorisation had the correct documentation in place. We found several further DoLS applications had been sent to the local authority for their consideration. These were still being considered by the supervisory body.

Care records provided information about people's capacity to make decisions, but we found some lacked detail about specific decisions made in the person's best interest. For instance, two files we checked showed the person had bedrails in place for their safety. Assessments for the use of bedrails had been completed,

which were signed by the nurse who had completed the assessment. However, there was no documentation of any discussions held around how it had been decided that the use of bedrails was in the person's best interests. We discussed this with the manager who said they would take action to ensure best interest decisions were recorded in a more consistent way throughout the care files.

We observed breakfast and lunch being served at different stages during both days of the inspection. We saw some people chose to eat in the dining room, while others preferred to have their meal in their own room. The dining room had a relaxed atmosphere with appropriate music playing in the background. We saw tables were nicely set with tablecloths, cutlery and condiments, and people were offered clothes protection if applicable. At breakfast people had chosen different options. For instance, one person had a full, cooked English breakfast, another had porridge and another had cereal and toast.

The lunchtime menu was displayed on a white board in the dining room providing two main meal options. We also saw photos of meal options were available to help people select the food they preferred. The cook told us if there was any doubt, they would plate up both options, so the person could choose which they preferred.

The meal was served from a hot trolley in the dining room with another hot trolley taking food to the other two floors. Most people in the dining room were able to eat their meal unaided, but where people needed assistance staff provided it. People told us they enjoyed the meals available and knew they could have alternatives if they did not want the planned menu. One person told us, "I am very happy with the food. I have just had sausage casserole and now I'm having Bakewell tart and custard and it's lovely, the meals here always are." Another person said they were having ice cream as they said they preferred it to the hot pudding.

People's care records highlighted any special diet or nutritional needs they required and we saw this information had also been shared with the kitchen staff. The cook described the different diets catered for, these included fork mashable or fully pureed, if someone was at risk of choking or could not chew their food for some reason, and diabetic diets. A variety of hot and cold drinks were also offered to people.

Between meals hot and cold drinks were taken round to people and there were cold drinks available in the lounge so people living at the home, and their visitors, could help themselves or staff could pass people a drink.

We saw people had accessed healthcare professionals such as GPs, district nurses and the speech and language team when additional support was required. A visitor told us, "[The person using the service] has visited the dentist twice, and as [the person] has difficulty swallowing [the staff] involved the dietitian." We also saw that each person had a nutritional screening tool in place which indicated the level of risk and where applicable care plans told staff how this would be managed.

Good

Is the service caring?

Our findings

People who lived at the home, and the visitors we spoke with, told us staff supported people in a caring way while encouraging them to make choices about the care and support they received. One person commented, "I am very happy living here, I wouldn't want to live anywhere else." A visitor described how staff respected people's dignity and offered privacy when they needed it.

The atmosphere in the home was welcoming and relaxed. Staff knew people well and maintained a good relationship with their families. We were told people could visit without restriction. We saw visitors freely coming and going as they wanted to during our inspection.

Overall, people's needs and preferences were recorded in their care files. For instance, one file we looked at told staff that the person would, 'nod towards the clothes they would like to wear.' However, in the file for someone on respite care (short stay) and another person who had recently been admitted to the home, information was basic. We discussed this with the management team who said they could see how additional information would be beneficial. The manager said they were arranging for key staff to attend care planning training and they would take action to improve the information available in these cases.

Throughout our inspection staff demonstrated that they knew people well, and were aware of their preferences. The manager and her deputy also had a good knowledge of people's needs, likes and dislikes. The activities co-ordinator described different people's interests and the activities they likes to participate in.

People who lived at the home looked well cared for, clean and tidy, and their clothes and hair were well kept. We saw staff treated people with dignity and the people we spoke with confirmed their dignity and privacy was respected. We saw staff knocking on bedroom doors before entering and closing them while providing personal care.

We saw people chose where they spent their time with some people choosing to stay in their rooms, and this was respected by staff. We also found people were offered other choices such as meals, which activities to take part in, or not, and what to wear. We saw people's rooms were personalised with small items of furniture, photos and mementos. The people we spoke with said they were happy with their rooms and confirmed they could choose what went in them.

People's cultural needs and religious and spiritual beliefs were included in their care plans and profiles. We saw an invitation on one notice board for people to attend a service and Communion in the lounge, on Sunday mornings with a minister from a local church.

There was a 'dignity board' on the wall of the downstairs corridor, which aimed to promote respect and dignity at the home. It identified which staff were 'dignity champions' at the home were and displayed general information, and posters about promoting people's dignity. We also saw that how to promote and protect people's dignity and privacy was discussed at a recent staff meeting.

Information about how to contact an independent advocacy agency, should people need additional support, was also displayed in the home. Advocates can represent the views and wishes of people who are unable to express their wishes.

Good

Is the service responsive?

Our findings

People we spoke with told us they were happy with the care provided and said the staff delivered their care and support how they preferred. One person told us they were, "Very well looked after." Another person told us they had been to the hairdressers adding, that they were also happy with the food and the activities available. A visitor commented, "I am happy with everything." We also received positive feedback from the external social care professional we spoke with about how responsive staff were to one person's particular, individual needs.

We saw good interactions between staff and people who lived and visited the home. Care workers offered people options about their meal or where to sit, as well as providing the food, drink, or support they knew were preferred. During our visits call bells were answered promptly and staff were responsive when people needed care or support.

Assessments of people's needs had been carried out prior to admission. People we spoke with confirmed they had been involved in formulating care plans. Most people, or their representative, had signed to say they agreed with the planned care, but we found this was not always clearly recorded in the care files of new people who had moved into the home or people there for a short stay.

People's care files contained detailed information about the areas the person needed support with and any risks associated with their care. The majority of files we sampled were well organised and outlined people's needs, a summary of their life history and any risks associated with their care. For instance, one file highlighted that the person was at risk of choking, so needed a 'fork mashable' diet. We saw the care plan reflected this and the information had also been shared with the catering staff. We also saw that if people were admitted with, or developed pressure sores, detailed records, such as body maps, grade of and evaluations of wounds were kept on people's records. We also saw evidence that the progress with the treatment of these was very closely monitored by the management team.

Although most care plans we looked at were person centred, others were not. For instance, we noted that two people's files contained quite generic information. One file was for a person who had recently been for a 'short stay.' We found gaps in the information recorded about the person's preferences and abilities, as well as their belongings and consent to treatment forms.

Another file we saw was for a person who had lived in the home for some time, and some information in their file was not very individualised. We saw the manager had completed audits of care files, which had highlighted some of the shortfalls we found. They told us plans were in place to address these, which included further care planning training for staff to help in making people's care plans more person centred.

Daily records had been completed which recorded how each person had spent their day and any changes in their general wellbeing. We found care plans and risk assessments had been evaluated on a regular basis to see if they were being effective in meeting people's needs, and for the most part, changes had been made if required, although the detail of the evaluations had not always been transferred to people's care plans.

The manager told us the home employed activities co-ordinators to facilitate social activities and stimulation for people. We saw a programme of activities displayed on notice boards on each floor, which told people about the activities planned for the week. Topics included games, art therapy, sing-a- longs and outside entertainers visiting the home. During the inspection we saw people taking part in a sing-a-long and playing bingo. All the people we spoke with said they enjoyed the activities provided. One person said they would be happy to play bingo every day, while another said they liked everything on offer.

People said they also enjoyed attending the hairdressers and occasional outings into the community. The activities co-ordinator told us how they consulted with people about their interests and past hobbies. We saw in most cases this had been recorded to help her plan the activities for the week. They also described how they spent time on a one to one basis with people, especially those who were cared for in their rooms. Staff told us people also enjoyed shopping trips and outings to garden centres and for pub lunches.

The provider had a complaints procedure which was available to people who lived in the home and visitors. We saw eight concerns had been recorded since our last inspection. The ones we sampled recorded the detail of the complaint, what action had been taken, evidence from the investigation in to the concern and the outcome. There was also evidence that the manager used concerns and complaints as an opportunity for lessons to be learned and shared within the staff team. The people we spoke with told us they had no complaints about the service provided, and would feel comfortable raising any concerns with the manager, or any of the staff

Good

Is the service well-led?

Our findings

At the time of our inspection the service did not have a manager in post who was registered with the Care Quality Commission. However, a new manager had been appointed and had applied to become registered.

At our previous inspection in October 2015 the service was in breach of regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance) as not all the management audits carried out were robust or frequent enough to identify issues which posed a risk to people.

At this inspection we found considerable improvements had been made in the way the quality and safety of the service was monitored and managed. We saw that the systems in place had been changed and improved, as a range of new, more comprehensive monthly and bi-monthly audits had been introduced, along with several 'spot checks.' These were used to make sure policies and procedures were being followed and enabled the management team to monitor the quality and safety of the service, how well the home was operating and staffs' performance. They included cleanliness and infection control, premises and equipment, how the kitchen operated, care documentation, complaints management and medication practices, tissue viability and an in depth accident analysis.

There were clear records kept following the audits and, where shortfalls were found actions were identified, documented and followed up. The action taken to address shortfalls had been consistently recorded, to show what had been done. We also saw physical evidence of the remedial action taken, such as the repairs and improvements which had been made.

We saw the recent checks and audits of the environment, equipment and cleanliness in the home. These identified shortfalls, action needed and when the necessary remedial action had been taken. For instance, after being recorded as out of order and highlighted as an action point in the previous week's check, the following week's audit showed that the midi hoist was repaired and in full working order.

A supplementary audit had also been introduced, which recorded general and random bedroom checks to make sure the cleaning staff had carried out their work appropriately. We saw bathroom and wet room audits, which had also been completed to a high standard. There was also a system in place to plan and record the deep cleaning of rooms, which also recorded any repairs needed.

We saw the service had been awarded a five star rating by the local Council's Environmental Health Officer for the systems and equipment in place in the kitchen. This is the highest rating achievable.

People told us the manager was friendly, approachable and visible around the home. One person said, "It's homely living here." One visitor told us the manager was "Brilliant." They said, "[The manager] goes round the home and talks to the residents." They went on to say they felt previous managers had not this done enough. When we asked people if there was anything they felt the home could do better nobody could think of anything they would change. One person said, "There's nothing really. Since the new manager came things are much better."

When we asked staff the same question their responses were similar. Most staff commented about the improvements at the home. One staff member commented, "It's better than when I first came." Another staff member said the new manager worked very hard and was making real improvements. They added that this had had a really positive effect on theirs, and other staff's morale, as they felt that the manager really cared about the people who lived in the home. There was one staff member who told us another staff member could sometimes be abrupt in their manner. We shared their comments with the manager.

We saw the minutes of staff meetings where the manager set clear standards, kept staff informed and involved in the progress with improvements, up to date with those needed, and ensured any lessons were learnt from complaints, accidents and incidents were shared with the team.

There were regular residents' meetings and we saw from the minutes of these that they were also very open and honest. They kept people informed of what the management team intended to do to ensure the service improved, and sought their views on how they could further improve the service.

People relatives had been invited to meetings, although the manager told us they were disappointed at the low attendance, and was trying different ways to encourage people's to attend and be involved. There was a notice board for relatives and visitors with the details of meetings, how to make a complaint and a copy of the most recent CQC inspection report.

The manager told us that it was time that a quality assurance questionnaire was sent out to stakeholders, and this was to be done soon, to help seek everyone's views on more ways the service could be improved.

Whilst it was clear that was clear that the service responded appropriately to safeguarding concerns, and the manager had sent notifications to CQC regarding most reportable incidents, there were a small number of recent safeguarding referrals which had been made to the local authority, but had not been reported to CQC. We discussed this with the manager who reported the incidents to CQC retrospectively, and told us that they would put arrangement in place to ensure this would not happen in the future.