Charis House Limited

Jasmine 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 24 and 25 November 2016 and was unannounced.

Jasmine Court nursing Home is a care home providing accommodation for up to 24 older people some of whom are living with dementia. During our inspection there were 18 people living at the home. The property is set out over four floors and is situated close to the sea front in Weston Super Mare.

The service was last inspected on the 17th September 2015 when it was given an overall rating of 'Requires Improvement.' At that inspection, we found breaches of two Regulations related to consent to care and deprivation of liberty safeguards. We required the provider to make improvements to achieve compliance with these regulations.

The provider sent us an action plan, which detailed the action they planned to take to make the improvements that were required. At this inspection, we found that improvements had been made and legal requirements had been met. The overall rating of the service had improved.

The registered manager had resigned from the home the week before we visited. 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. The provider had already advertised for a replacement manager and was interviewing the following week.

The provider and registered manager from the provider's sister home, who had been supporting the deputy manager and the staff following the departure of the previous manager, were present throughout the inspection.

The staff understood their role in relation to the Mental Capacity Act 2005 (MCA) and how the Deprivation of Liberty Safeguards (DoLS) should be put into practice. 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 confirmed they had been trained in how to identify and report any incidents of abuse they may witness.

Any potential risks to individual people had been identified and appropriately managed. For example, people at risk of pressure wounds had received appropriate nursing care to reduce the risk of their occurrence or recurrence.

People's medicines had been administered and managed safely.

There were sufficient numbers of staff on duty with the necessary skills and experience to meet people's needs.

Staff supported people to eat and drink if required. They ensured people at potential risk received adequate nutrition and hydration.

People were provided with support to access health care services in order to meet their needs.

Positive, caring relationships had been developed with staff to ensure people received the support they needed. They were encouraged to express their views and to be actively involved in making decisions about the support they received to maintain the lifestyle they have chosen.

People and their relatives were encouraged to express their views and make suggestions so they may be used by the provider to make improvements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by sufficient staff to meet their individual needs safely.

People were supported to manage their medicines safely.

There were systems in place to safeguard people from the risk of harm.

People were supported by staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

People's rights had been protected as the principles of the Mental Capacity Act 2005 (MCA) and requirements of the Deprivation of Liberty Safeguards (DoLS) had been followed.

People received effective care from staff who had received appropriate training.

People were supported to have sufficient to eat and drink.

Is the service caring?

Good

The service was caring.

People were supported by staff who were caring and knew people well.

People's dignity, privacy and independence were promoted and maintained as much as possible.

People were treated with kindness and respect.

Is the service responsive?

Good

The service was responsive.

People were involved in their care planning and felt in control of the care and support they received.

People were given opportunities to take part in activities. Plans to further improve the activities available were being implemented.

People knew how to make suggestions and complaints about the care they received and felt their comments would be acted on.

Is the service well-led?

Good

The service was well-led.

The provider operated an open and accessible approach to both staff and people living in the service and actively sought feedback from everyone on a continuous basis in order to improve the service.

Staff said that they could raise any issues and discuss them openly within the staff team and with the provider.

There was an internal quality assurance system in place to review systems and help to ensure compliance with the regulations and to promote the welfare of the people who lived at the home.

We saw that audits were being completed regularly and areas of improvements identified.

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 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 unannounced inspection took place on 24 and 25 November 2016. One adult social care inspector; one specialist advisor with a nursing background and one Expert-by-Experience (ExE) carried out the inspection. 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 10 people who lived in the home, eight members of staff including the provider, the registered manager from Jasmine Courts' sister home, deputy manager, two nurses, four care staff, the maintenance person, the cook and laundry person. We were also able to speak to a health professional and three relatives who were visiting at the time and we observed the interactions of people with staff. We looked at records and charts relating to eight people and six staff recruitment records. We also looked at other information related to the running of and the quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas, meeting minutes and arrangements for managing complaints.

Before the inspection, we reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the home, what the home does well and improvements they plan to make. We also gathered information about the home by contacting the local authority safeguarding and quality assurance team. We also reviewed records we held which included notifications, complaints and any safeguarding concerns. A notification is

information about important events, which the home is required to send us by law.

Good

Is the service safe?

Our findings

The service was safe.

The home kept people safe from harm. The people living in the home and relatives we spoke with felt the home was a safe place to live. One person using the service said, "I feel safe, there is no pressure, and they are all polite." Another person said, "I feel safer here than I did at home." One relative said, "The care here is 101%. There are plenty of nursing homes, some good, some bad but as far as I am concerned my [relative] is well looked after. I have no concerns for their safety." Another relative said, "It's lovely here, my [relative] is happy and the carers are lovely."

Throughout the day, we observed care staff supporting people in a safe and caring manner. We observed safety features around the home, which included non-slip floors in bathrooms and toilets, and windows with restricted opening. There were no obvious hazards and when people were seen walking around the home, they were supported with walking aids and hand rails which were placed along the walls. We observed one person walking down some stairs independently, we saw that staff let the person move at their own pace and only offered a supporting hand to help them feel safe and supported.

The provider had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Whistleblowing is a way in which staff can report concerns within their workplace. Staff were aware of the provider's safeguarding policy and told us that they knew how to recognise and report concerns they might have about people's safety. Staff said that if they had concerns then they would report them to the nurse in charge or manager. If they were unavailable, they would contact external agencies such as the local authority safeguarding teams to ensure that action was taken to safeguard the person from harm. For example, one member of staff said, "If I was to find someone is frightened, I will carry out some observations on them and check for bruising, I will go to the nurse in charge with my concerns." They confirmed that they had not had to do this, but were prepared to act if they found someone was being mistreated.

All the staff we spoke with told us that they had received training on safeguarding procedures and were able to explain these to us, as well as describe the types of abuse that people might be exposed to. The provider also had a full understanding of when and how to make safeguarding referrals to the local authority and of how to notify the Care Quality Commission should the need arise. This demonstrated that the provider's arrangements to protect people were effective.

Records showed us that thorough risk assessments had been conducted for all the people in the home. The risk assessments were contained within the comprehensive care plans held on the Care Management System (CMS) on a computer. The system identified risk in accordance with colour coding, this means that staff could immediately identify if a person was at serious risk of, for example, falls. We noted that if a person had a total of three falls they were referred to the falls management team for advice.

We saw completed risk assessments relating to skin integrity (Waterlow) nutrition and hydration (MUST),

mobilisation, medication, falls, risks in relation to diagnosis and personalised risk assessments. For example one person liked to go outside on a mobility scooter and a risk assessment had been completed which gave information for staff to mitigate the identified risks they might encounter.

All risk assessments were reviewed on a monthly basis and were discussed with the person or their family member. We saw risk assessments gave staff the information they needed to keep people as safe as possible. All people living in the home had access to call bells in their rooms and call bells on pendants that they wore when away from their rooms. This meant people could summon help from anywhere in the home should they need it.

We saw the home maintained comprehensive records of any accidents or incidents that occurred within the home. These were then analysed to determine if there were any patterns or trends, which led to at least one person being referred to the Falls Team.

Environmental risk assessments had also been carried out to identify and address any risks posed to people. These had included fire risk assessments and the checking of corridors for obstructions. All the people living in the home had a personalised evacuation plan that detailed what help support and assistance they would need in the event of needing to evacuate the building. The provider had purchased an escape chair that could be used when carrying people down the fire escape. Staff told us that when they had been shown how to use it, they had also been lifted in it to be shown what it felt like to be carried down the fire escape. They said this experience would help them support people better in an emergency. The home had received a visit from fire and health and safety specialists who had found the home fire safe three weeks prior to our visit. The provider was working through the actions that had been suggested, such as reducing the number of staff fire drills from weekly to monthly in order to stop staff becoming complacent.

The home had an emergency file that detailed staff telephone numbers, relative phone numbers and other important numbers in the event of an emergency and the provider was considering purchasing equipment for a 'grab bag' such as a torch, spare batteries, a mobile phone with pre-set emergency phone numbers, space blankets, medicine records and high visibility vests.

On the day of our inspection, there were sufficient staff employed at the service to support people safely and people we spoke with felt that there were enough staff to support them. Staff we spoke with agreed there were enough staff but said that at times they could be stretched. One member of staff said, "We could do with more staff on the morning shifts as we have quite a few residents that are supported by two staff, which means that some days we are really rushed." Another member of staff said, "We have a good team here but we could do with some extra staff during mornings to help cover our double ups." When we spoke with the provider, they said they had recently introduced a twilight shift to support people at tea time and help people go to bed if they needed any support. They also stated that if the number of residents went beyond 18, they would put more staff on shifts to reflect the numbers and need. They said that the dependency tool used was based on the figures given by the case management system.

Staff employed by the service had been through an effective recruitment process before they started work, to ensure they were suitable and safe to work with people who lived at the home. Records showed that all necessary checks had been made and verified by the provider before each member of staff began work. These included reference checks, Disclosure and Barring Service (DBS) checks and a full employment history check. This enabled the manager to confirm that staff were suitable for the role to which they were being appointed.

People told us that they received their medicines on time. Staff told us they thought the system of

administrations of medicines was safe. Medicines were ordered, stored, dispensed and disposed of in a safe way and in accordance with the homes medicine policy. Only trained nurses' dispensed medication and received on going observations of their practice to ensure competency.

We found a random check of medicine administration charts (MAR) to be correct. We found a random check of blister packs to be correct. We also found a random check of medicines that needed extra security to be correct. All medicines contained in the drugs trolley had been labelled with the date of opening, this included eye drops, inhalers and packs of tablets.

We noted that all the MAR charts had photographs of the person on them. This is important due to the dramatic change in appearance that accompanies physical decline and ensured that any agency or new members of staff who may be unfamiliar with the person were able to recognise that it was the correct person when dispensing medicines. The provider told us that they were going to date the photographs', so that they were kept up to date. MAR charts also had the details of any known allergies and the contact details of the person's GP.

No one was receiving covertly administered medicines and no one was self-medicating, though the providers medicines policy contained the process for staff to follow should this be necessary.

The home had a medicine policy that had been reviewed in April 2016. This ensured that information contained in the medicine policy was up to date and reflected best practice. A Homely remedy policy had been agreed with a local GP, dated 11 November 2016, and included reasons for the administration of homely medicines and stock balances.

Medicine audits had been conducted on a monthly basis and action had been taken to secure improvements. A Master signature list was available; this ensured that in the event of an error the dispensing practitioner could be quickly identified from the MAR chart initials. Staff told us, and records confirmed, that there had been no medicine errors in the previous six months and that a pharmacist had visited the home in April 2016 to make sure medicines were being administered correctly. We noted that residents with Diabetes had regular blood sugar testing recorded.

Fridge and room temperatures had been recorded daily to ensure the optimal storage of medicines, such as those used for diabetes.

One person living in the home had a confirmed bacterial infection and another person was being tested for it. We noted that in both cases appropriate precautions were being taken to prevent the spread of infection.

Good staff hand washing signage was prominent in the staff toilet, emphasising the importance of correct hand washing techniques and the importance of hand washing to prevent the spread of infections.

People and visitors commented on how clean the home was and the lack of unpleasant odours. One person said "It smells so fresh here, well done the cleaner".

We observed infection control audits that had been conducted three monthly, most recently on 18 November 2016. These audits covered areas such as the kitchen area, equipment, clinical practice, bedroom cleanliness, treatment room, bathroom, waste disposal, toilets and sluice. Where issues had been found we noted that appropriate action had been taken.

The home had a nominated infection control member of staff but that person had recently left the

employment. The managers were considering nominating a registered nurse to undertake the role so that teaching could take place emphasising the vital importance of infection control.

Good

Is the service effective?

Our findings

The service was effective.

During the inspection in September 2015, we found a breach of regulation 11, where people's rights were not fully protected because the correct procedures were not being followed where people lacked capacity to make decisions for themselves and regulation 13; people were being restricted without the correct authorisation. The provider sent us an action plan, which advised the improvements that needed to be made to meet requirements. At this inspection, we saw that the required improvements had been made.

Staff did have a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When 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.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

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.

People we spoke with confirmed they had capacity to give consent to the care they received. They also advised us they had been involved with planning their care and making decisions about how it should be delivered. There was clear documentary evidence of this in care plans we looked at. The provider told us a number of people had been assessed as lacking capacity to give consent for themselves and they had made DoLS applications to the relevant authority. We were also advised some people had granted Power of Attorney (POA) to a relative or to a close friend. All these were recorded on the care plan system. This meant

that, should it be necessary, the named relative or friend had legal authority for making decisions and for giving consent on the person's behalf. Staff we spoke with demonstrated they understood the principles of the MCA, and were able to describe how they related to the needs of people accommodated. They also told us they had received training to ensure they understood the principles of the MCA 2005 and how DoLS should be applied.

People who were at risk of dehydration and malnutrition had been identified clearly within care records and had fluid and food charts in place so that intake and output could be monitored for any changes. Fluid and food charts examined were up to date and had been consistently completed. The support and interventions required for each person had been appropriately recorded and were in line with advice and guidance provided by healthcare professionals. Care records also enabled individual people's weights to be monitored. Where people were at risk of losing a significant amount of weight we saw this had been quickly addressed, and the trend reversed. Where people were at risk of choking we saw the local Speech and Language Therapy (SALT) team had been contacted for advice on how to ensure risks were minimised for each individual.

We observed the lunchtime meal both within the dining area and also for people who chose to remain in their rooms. We saw the dining chairs had good support and arms that enabled people to change position, sit, and stand more easily. Dignity napkins were used to prevent food spillage and we saw that some people were using plate guards to assist independent eating. There were no cruet sets on the table and glasses were plastic. Most people in the dining room had a plastic drinking cup. We asked the provider why there were no cruet sets on the tables and the use of the plastic cups and they told us they would put cruets on the table and revise the use of plastic cups for those people who did not need them.

We noted people were asked if they wanted various juices with their lunch. The food looked appetising and smelt delicious. The provider told us and we saw that two members of staff were always available to assist people in the dining area so that they could enjoy a relaxed and pleasurable meal and assist those people who needed extra support, with another member of staff delivering meals to those people choosing or unable to come into the dining room.

When most people in the dining room had eaten, one member of staff assisted people in their rooms. This meant there was sometimes a small delay in assisting people to eat in their rooms but each tray was brought up separately so the food remained hot.

People and relatives told us they were very happy with the food provided. People told us, "The food is very good" "The food is very good actually, very nice, I enjoy it". One relative said, "Food is excellent, I eat here occasionally and I shall eat here on Christmas day." The provider's PIR stated, 'Nutritional risk assessments are in place and reviewed monthly. Residents' weight is monitored and actions taken when there is any increase or loss. Those at risk of malnutrition and weight loss are referred to the GP and dietician, are weighed weekly and a food diary commenced.' Our own observations indicated people were given enough time to ensure they had eaten and drunk sufficiently to meet their needs.

People and relatives confirmed staff were appropriately trained. A relative told us, "The staff are very kind and caring. The younger staff have lot to learn, but, on the whole the staff are competent." From our observations, nursing staff and care staff conducted themselves professionally and courteously when providing care to people. Staff on duty confirmed the training and induction training they had received. This included moving and handling, first aid, fire safety, health and safety and infection control. In addition, they had been awarded the Diploma in Health and Social Care at Level 2 or Level 3. This is a nationally recognised award for staff who worked in registered care services. Staff also confirmed that the training

provided enabled them to understand what was expected of them and how they should provide the care and support people required. Training records we looked at confirmed staff had received this training. When we asked about their role, one member of staff told us, "We assist people with their day to day personal needs. We help them with washing, dressing and eating their food. We are there for what they can't do for themselves." Another said, "We care for the residents. We make them safe, comfortable and happy." A trained nurse told us, "I am fully responsible for the residents' care." All staff also demonstrated they were knowledgeable about the needs of individual people, their wishes and preferences with regard to how care was to be delivered.

All staff confirmed they received individual supervision from the registered manager or a more senior member of staff. They found this provided them with the support and guidance they needed to carry out the work that was required of them. Supervision sessions on a regular basis are an important way of supporting staff, gathering new ideas and feeding back on performance. We saw evidence of both planned and on the spot supervisions plus a list showing planned dates when staff would receive supervision. The home had a supervision and appraisal policy. The provider was asked to amend the policy as it incorrectly stated information regarding the CQCs position on supervision and appraisals.

We only saw one appraisal and the provider admitted to not having completed annual appraisals for all staff working in the home. . Annual appraisals give both managers and staff the opportunity to reflect on what has gone well during the year and areas for improvement or further training required. The home was in the process of interviewing for a new registered manager so this situation would soon be remedied. The provider told us of plans to develop a 'live' computerised supervision document that could be used during supervision sessions. This would involve documenting and rating every shift and analysing data for trends. This would mean that people would benefit from better monitoring of staff who would have improved supervision and support

People and relatives told us they had been supported to maintain good health by having regular access to health care services. A relative told us, "The staff are brilliant. When I asked about my loved one seeing a GP this was acted on very quickly." We saw evidence of effective working relationships with a number of external professionals. The home was prompt in securing external advice and support when required. This ensured that residents had appropriate treatment and staff received advice and support from specialist professionals.

We saw staff implemented the treatment recommendations from external professionals including GPs, district nurses, dieticians, physiotherapists and staff from the enablement team. We noted that a 'non-nursing' individual required a particular injection to be given by district nurses on a three monthly basis. We saw that this had been recorded in the diary to remind staff that the drug would need to be ordered in advance and the district nurses requested to visit and administer the medication on a certain date. This ensured that the person received the medication at the appropriate time without any delays that would result in their condition being adversely affected.

Good

Is the service caring?

Our findings

The service was caring.

We saw the atmosphere at the home was warm and welcoming. From our observations, we could see that people were relaxed in the presence of staff and appeared to be happy. We saw that staff were attentive and had a kind and caring approach towards people. A person said to us, "The staff are kind and try and help me as much as possible". A relative we spoke with said, "Staff are always very thoughtful".

We saw the provider supported people to express their views so they were involved in making decisions about how their care was delivered. We saw people and their relatives were involved in developing care plans that were personalised and contained detailed information about how staff could support people's needs. A person living at the home told us, ""The care here is OK, no complaints, fine, lovely actually ". A relative we spoke with told us that staff were considerate and asked their family member about their care and support likes and dislikes. They told us, "The girls here are so caring, loving and genuine, they are marvellous ".

A member of staff told us how people using the service (and their relatives) completed a profile which was kept in their care plan for staff to read, so they could familiarise themselves with a person's life story. Staff were able to meet peoples care and support needs consistently because they knew people's needs well. We saw that care plans were regularly reviewed and updated when people's needs changed. We saw that people were supported to make decisions about what they did, where they went and what they liked to do. A person we spoke with told us, "The staff are helping me and have asked me and my family about what I like and what I need". During our visit, we saw people making choices about what they were doing, either in the communal lounge or in their own rooms.

The home had an identified member of staff known as a 'dignity champion' this member of staff was responsible for ensuring that all staff treated residents with dignity and respect. We spoke with this member of staff and they were knowledgeable regarding the responsibilities of the role. Staff we spoke with and observations we made showed us people were treated with dignity and respect. A person we spoke with told us," I have never worried about my privacy and they [staff] seem to respect what I say" A relative we spoke with said, "We don't have any privacy worries. We can either stay in the lounge or go to her [family members] room if we prefer". A member of staff we spoke with explained to us how they promoted people's privacy and dignity by doing personal and nursing care in the privacy of people's rooms. Another staff member we spoke with gave an example of how they promoted people's dignity whilst supporting with personal care, "We [staff] try to change [continence] pads as quickly as possible to maintain people's dignity". They continued, "We [staff] talk to them [people using the service] all the time when we're supporting them".

We found people could spend time in their room so they had privacy when they wanted it. We saw staff always knocked on people's bedroom doors and asked to be allowed in before entering. Staff told us how they supported people to be as independent as possible. A member of staff we spoke with said, "We [staff]

encourage people to do their own personal care if possible, for example; using the flannel to wash their own face". Staff we spoke with explained to us the importance of ensuring that peoples' right to confidentiality were maintained. A staff member told us, "We [staff] don't share their information unless they [person using the service] gives permission. If it's serious, then we'd explain to them why we need to tell the manager".

Everyone we spoke with told us there were no restrictions on visiting times. A relative we spoke with told us, "We don't have restricted visiting times". This meant that people were supported to maintain contact with people who were important to them.

Good

Is the service responsive?

Our findings

The service was responsive.

People's needs were assessed before they began to use the service and reviewed regularly thereafter. People's assessments considered all aspects of their individual circumstances their dietary, social, personal care and health needs and considered their life histories, personal interests and preferences. People had assessments for daily living and long-term outcomes. Care plans reminded staff that all outcomes should be met through positive, individualised support.
Staff knew how people wanted their care to be provided, what was important to them and how to meet people's individual needs. People received personalised care that met their needs. For example, where people had medical conditions, which required a special diet plan, they received the diet set out in their plan.

During this inspection, we looked at the activities that were provided for people who lived at jasmine Court Nursing Home. We found that there was not a dedicated staff member employed to do this as the provider booked outside entertainments for people, such as singers and aromatherapy. People told us "I don't get bored it's all going along alright lovely" and "I do knitting and I read so I have enough to do. It's very nice here". However, three people, one relative and two staff members told us that more could be done for people who were unwilling or unable to leave their rooms to engage them in activities. Relatives also felt there should be greater opportunities for people to leave the home. We spoke with the provider and they told they would look into involving specific staff with arranging more one to one in house activities if people wanted to do them and arranging more trips out of the home.

People were satisfied with the care and support they received. People's comments included, "I'm content", "I'm very happy here", "I have no complaints. They look after me well" and "Overall I'm happy". Relatives commented, "We are very pleased with the way [the person] is being cared for" and "I have no complaints." People had opportunities to give their feedback on the care and support they received. These included surveys as well as resident's and relative's meetings. Records indicated not all people attended these meetings, despite, the provider told us, being encouraged and asked, but a variety of issues were discussed by people and their relatives such as, whether they were happy with the food, what the service was doing well and what could be improved, development plans for the service, activities and staffing.

The service gave people and their relatives' information on how to make a complaint. We looked at the process for recording, logging and acting on complaints and found clear procedures were in place. The provider said they tried to deal with issues as soon as possible and we saw records of conversations with relatives and action taken by the provider to address issues and concerns raised. The provider confirmed that any lessons learnt from complaints were discussed with staff to reduce any likelihood of the same happening again.

People told us they knew how to make a complaint and would do so if the need arose. One person told us, "I did have a complaint and it was sorted out." A relative told us, "I haven't made a complaint as such but

when there has been something I'm not happy with I mention it to staff and they take care of it." On arrival in the home people were given a brochure that included details of who to complain to if there was a problem. We noted that in the previous six months the home had received five complaints. We noted that action had been taken and recorded for each complaint. We saw evidence that comments from relatives questionnaires had been acted upon.

A number of thank you cards had been received and included the following comments; "returned feeling very happy and contented", "Thank you for all the love you showed." "Thank you for being so caring towards [name] and making her stay with you comfortable and happy" "The attention you gave [name]during her last days was second to none" and "The care [name] received was exceptional".

Good

Is the service well-led?

Our findings

The service was well led.

There was no registered manager in place as they had left the week before the inspection, but the provider was interviewing for a replacement manager the week following the inspection. The provider, registered manager from the providers sister home were providing support to the deputy manager and staff in the interim.

The provider told us information about safety and quality of the service provided was gathered on a continuous and on-going basis via feedback from the people who used the service and their representatives, including their relatives and friends, where appropriate. They 'walked the floor' regularly in order to check the home was running smoothly and that people were being cared for properly. The provider also told us the deputy manager was involved in delivering care and they often worked a shift on the rota as a staff member. The provider conducted regular night spot checks.

We asked the people living in the home how it was managed and run. Comments included, "They are very caring and the manager comes round to see how I am doing from time to time". We spoke to relatives and they told us, "I have nothing to compare it with but I think the place is reasonably well led".

The provider advised they held staff meetings shortly after the resident and relatives meetings in order that they could discuss issues raised at this meeting and try to address these. We could see from the minutes of previous staff meetings that this was the case and we saw these meetings were held on a regular basis. The meetings enabled managers and staff to share information and/or raise concerns. Staff had the opportunity to discuss a variety of topics including staffing, breaks, supervisions, food and cleaning.

The provider conducted an annual survey with the people living in the home. We were able to view the survey from 2015. We saw people were asked about the standards of care in the home, how they were treated, whether they felt staff understood them as an individual as well as questions about the food and laundry. The survey found that overall 95% of people were happy living in the home and were satisfied with the standard of care in the home. 100% of people agreed they were satisfied with the standard of care in the home. In the reception area, there was a suggestions box inviting ongoing feedback and leaflets from carehome.co.uk that provided an independent website for people to post comments about care provided.

The provider had a quality assurance system and the manager was required to produce a report each month for the provider, who conducted regular visits. At these visits they checked the environment, looked at complaints, what audits has been completed in the last month and what meetings had taken place and then an action plan was put in place that was reviewed at the next visit.

The previous registered manager had conducted monthly audits of care plans, medicines, residents at risk and accidents and incidents as well as periodic audits of home presentation, safeguarding and kitchen audits. We were also able to view an audit conducted by the previous registered manager, which identified

that supervisions and appraisals were not up to date and the provider was aware of this, and taking steps to address these shortfalls. This demonstrated that the quality assurance systems in place had identified the same issues that we had during our inspection and the manager was in the process of taking action to address these shortfalls. In addition to the above, there were also a number of maintenance checks being carried out weekly and monthly. These include the water temperature, equipment such as wheelchairs and bedrails as well as safety checks on the fire alarm system and emergency lighting. We saw that there were up to date certificates covering the gas and electrical installations, portable electrical appliances, any lifting equipment such as hoists and the lift.

Staff members we spoke with had a good understanding of their roles and responsibilities and were positive about how the home was being managed and the quality of care being provided and throughout the inspection we observed them interacting with each other in a professional manner. We asked staff how they would report any issues they were concerned about and they told us that they understood their responsibilities and would have no hesitation in reporting any concerns that they had. They said that they could raise any issues and discuss them openly with the registered manager. Comments from the staff members included, "[Name] (previous registered manager) was approachable, really supportive ", "[provider] is great; You can go in and say anything within reason" and "They are lovely, I have no issues." Staff also told us that the provider was always willing to help if he could.

Periodic monitoring of the standard of care provided to people funded via the local authority was also undertaken by the local authority's contract monitoring team. This was an external monitoring process to ensure the service meets its contractual obligations to the council. We contacted the contract monitoring team prior to our inspection and there were no major concerns highlighted. As part of the inspection, all the folders and documentation that were requested were produced quickly and contained the information that we expected. This meant that the provider was keeping and storing records effectively.