Bupa Care Homes (ANS) Limited

Meadbank Care Home

Inspection report

Parkgate Road
Battersea
London
SW11 4NN

Tel: 02078016000

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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

We conducted an inspection of Meadbank Nursing Centre on 4 and 5 April 2016. The first day of the inspection was unannounced. We told the provider we would be returning for the second day.

We undertook an inspection of this service in November 2014. During that inspection we identified concerns in relation to infection control, people's social and emotional needs being addressed appropriately, the recording of fluid intake and some issues with a lack of signage in the building to help people with dementia orientate themselves. The provider sent us an action plan after this inspection setting out how they were going to address these issues. We conducted this inspection to check that improvements were being sustained in accordance with the provider's action plan. We found all areas had been addressed appropriately.

Meadbank Nursing Centre is a care home with nursing for up to 176 people, with a particular emphasis on providing palliative care. There are four units at the home each named after a famous bridge in London and each had its own unit manager. Albert Bridge unit which is based on the ground floor is home to older people with some early onset dementia and Westminster Bridge Unit which is on the first floor is a nursing unit. Chelsea Bridge unit which is located on the second floor is home to those with palliative care needs and Lambeth bridge unit is home to those with advanced dementia needs.

There was a registered manager at the service. 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.

We found that there were some issues with regard to the safe administration of medicines. Staff had completed medicines administration training within the last year and were clear about their responsibilities. However, we found that people being prescribed medicines that were labelled 'do not crush' were having their medicines crushed prior to administration thereby placing them at risk of unsafe administration. Some PRN or 'as needed' medicines protocols were not detailed enough to adequately instruct care staff. We also found that some people with higher than expected blood glucose levels were not being referred for further medical advice or assistance as expected.

The provider had good systems in place for the prevention and control of infection. We found all previous issues with regard to the external storage of waste had been addressed. The provider maintained a clean home environment and staff members were aware of their responsibilities with regard to infection control.

Risk assessments and support plans contained clear information for staff. All records were reviewed every month or where the person's care needs had changed.

Staff demonstrated knowledge of their responsibilities under the Mental Capacity Act 2005. Mental capacity

assessments were completed as needed and we saw these on people's files. Where people were at risk of having their liberty deprived, applications were sent to the local authority for Deprivation of Liberty authorisations.

Staff demonstrated an understanding of people's life histories and current circumstances and supported people to meet their individual needs in a caring way.

People using the service and their relatives were involved in decisions about their care and how their needs were met. People had care plans in place that reflected their assessed needs.

Recruitment procedures ensured that only staff who were suitable, worked within the service. There was an induction programme for new staff, which prepared them for their role. Staff were provided with appropriate training to help them carry out their duties. Staff received regular supervision. There were enough staff employed to meet people's needs.

People who used the service gave us good feedback about the care workers. Staff respected people's privacy and dignity and people's cultural and religious needs were met.

People were supported to maintain a balanced, nutritious diet. People at risk of malnutrition had appropriate assessments conducted and were referred to the community dietitian as appropriate. Advice was implemented by care staff and the kitchen staff who were also aware of people's dietary needs. People were supported effectively with their other healthcare needs and were supported to access a range of healthcare professionals.

People using the service felt able to speak with the registered manager and provided feedback on the service. They knew how to make complaints and there was a complaints policy and procedure in place. Care staff gave excellent feedback about the registered manager and gave us examples of improvements that had been implemented and sustained by her.

People were encouraged to participate in activities they enjoyed and people's participation in activities was closely monitored. People's feedback was obtained to determine whether they found activities or events enjoyable or useful and these were used to further develop the activities programme on offer. The activities programme covered five days a week and included a mixture of one to one sessions and group activities. There was limited provision for activities over the weekend, but special weekend activities were arranged every two months.

The organisation had good systems in place to monitor the quality of the service. Feedback was obtained from people through monthly residents meetings and we saw feedback was actioned as appropriate. There was evidence of auditing in many areas of care provided as well as significant monitoring from senior staff members within the organisation.

Since the publication of this report, the name of this service has changed to Meadbank Care Home.

During this inspection we found one breach of regulations in relation to medicines administration. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe. There were some issues with regard to the administration of medicines that meant people's medicines were not always being managed safely. We found that people being prescribed medicines that were labelled 'do not crush' were having their medicines crushed prior to administration thereby placing them at risk of unsafe administration. Some PRN or 'as needed' medicines protocols were not detailed enough to adequately instruct care staff. We also found that some people with higher than expected blood glucose levels were not being referred for further medical advice or assistance as needed.

Previous concerns in relation to infection control had been addressed in line with the provider's action plan. The service had good systems in place for implementing and maintaining a clean and tidy home.

The service was not consistently safe. There were some issues with regard to the administration of medicines that meant people's medicines were not always being managed safely.

Previous concerns in relation to infection control had been addressed in line with the provider's action plan. The service had good systems in place for implementing and maintaining a clean and tidy home.

Risks to people's health were identified and appropriate action was taken to manage these and to keep people safe.

Procedures were in place to protect people from abuse. Staff knew how to identify abuse and knew the correct procedures to follow if they suspected abuse had occurred.

There were enough staff available to meet people's needs and we found that recruitment processes helped to ensure that staff were suitable to work at the service.

Is the service effective?

Good

The service was effective. The service was meeting the requirements of the Mental Capacity Act 2005 (MCA). Staff

demonstrated a good knowledge of their responsibilities under the MCA. Mental capacity assessments were completed when required in relation to specific issues and where people were at risk of having their liberty deprived, applications were made to the local authority for authorisations.

People were supported by staff who had the appropriate skills and knowledge to meet their needs. Staff received an induction and regular supervision, appraisals and training to carry out their role.

People were supported to maintain a healthy diet. Previous issues regarding the inadequate recording of people's fluid intake had been addressed. People were supported to maintain good health and were supported to access healthcare services and support when required.

Is the service caring?

Good

The service was caring. People using the service and relatives were satisfied with the level of care given by staff.

People and their relatives told us that care workers spoke to them and got to know them well.

Staff took account of people's social and emotional needs and care records documented this. We found all previous issues in this area had been addressed.

People told us their privacy and dignity was respected and care staff provided examples of how they did this. People's cultural diversity was respected and celebrated.

Is the service responsive?

Good

The service was responsive. People's needs were assessed before they began using the service and care was planned in response to these.

People were encouraged to be active and participate in activities they enjoyed. There were five dedicated activities coordinators who ran an activities programme that covered five days a week. There was limited activities provision over the weekend, but special weekend activities were organised every two months. The activities programme included group activities, one to one sessions and outdoor visits.

People told us they knew who to complain to and felt they would be listened to.

Is the service well-led?

Good

The service was well-led. Staff gave excellent feedback about the registered manager and the changes she had implemented since joining the service.

Quality assurance systems were thorough. Feedback was obtained from people using the service in person through monthly residents meetings. The registered manager completed various audits and further auditing of the quality of the service was completed by senior management within the organisation.

Meadbank Care 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 and sustaining improvements previously made to the service, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 4 and 5 April 2016. The inspection team consisted of two inspectors, two specialist advisors and a pharmacist inspector. On this inspection the specialist advisers were a nurse with expertise in dementia care and mental health and a GP with specialist experience in infection control. The first day of our inspection was not announced, but we told the provider we would be returning for a second day.

Prior to the inspection we reviewed the information we held about the service. We contacted a representative from the local authority safeguarding team and spoke with one more professional who worked with the service to obtain their feedback.

During the inspection we spoke with 14 people using the service and four relatives of people using the service. Some people could not let us know what they thought about the home because they could not always communicate with us verbally. We therefore used the Short Observational Framework for Inspection (SOFI), which is a specific way of observing care to help us to understand the experience of people who could not talk with us.

We spoke with 12 care workers, three nurses, two activities coordinators, the chef, the clinical services manager and the registered manager of the service. We looked at a sample of 21 people's care records, 20 staff records and records related to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were delivered on a monthly basis for named individuals by the same pharmacy. Some medicines which were labelled as 'do not crush or chew, swallow whole' were being crushed by nursing staff before administration. This may have placed people at risk of unsafe administration of their medicines.

Staff monitored blood glucose levels for people prescribed medicines for diabetes. Although this monitoring was carried out daily, there was no written evidence that staff had taken action when three people's blood glucose readings were much higher than expected. This may have placed people at risk, because poor control of blood glucose levels increases the risk of diabetes complications.

Safe arrangements were in place to dispose of medicines. However, we noted that staff did not always record the quantities disposed of for liquid medicines, so staff could not check that these had been used correctly.

Patch application records were in place for medicines prescribed as topical patches, to record the site of application, and evidence the rotation of the patch site to reduce the risk of side effects.
However, we noted that the provider's patch application record did not require that staff record if and when the old patch had been removed. We also noted that one person's patch was not rotated every three to four weeks as required on their medicines information leaflet.

Protocols were in place for medicines prescribed to be given 'as needed' (PRN) such as pain relief, so there was information for staff on how to administer these safely. Pain assessments were carried out to assess people's level of pain so we were assured that people's pain was adequately controlled. However, on one floor, we noted that these protocols were not sufficiently detailed. For example the protocol did not state whether the person was able to request their pain relief, or whether staff had to carry out a pain assessment to determine if a dose needed to be administered.

The above issues constitute a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Controlled medicines were stored safely for each person in a locked cupboard within a medicines storage room along with other medicines. We saw the temperature in the medicines storage rooms was controlled, monitored and recorded on a daily basis. The temperature was at a safe level on the day of our inspection.

Copies of the most recent prescription were kept with people's medicines records. We saw that all prescribed medicines were correctly listed on people's medicines records. Medicines records were completed clearly, with no omissions and people's allergies were prominently identified. The start and finish time of each medicines round was recorded, which provided assurance that people were consistently receiving their medicines on time and as prescribed. There were no gaps in the recording of administration on any records.

People's medicines were reviewed regularly, and there was very little use of anti-psychotic medicines or sedating medicines used for agitation. When people were prescribed anti-psychotics, this was justified, and the need reviewed monthly.

We saw copies of daily and monthly checks that were conducted of medicines which included controlled drugs. This included a physical count of medicines as well as other matters including the amount in stock and expiry dates of medicines. However, the checks we saw did not identify the issues we found.Nurses had completed medicines administration training within the last two years. When we spoke with the nurses, they were knowledgeable about how to correctly store and administer medicines.

At our previous inspection which took place in November 2014 we found there were some concerns in relation to infection control. At this inspection we found all inconsistencies had been addressed and the service was following safe practices for the implementation and maintenance of a hygienic home. At our previous inspection we found the external bin storage area was untidy as bin liners were not properly inside bins and waste was spilling out. At this inspection we found issues with the external bin storage area had been fully addressed.

There were good arrangements in place for keeping the service clean and hygienic and to ensure that people were protected from acquired infections. The provider maintained a clean environment by carrying out a management audit on a monthly basis and these monthly audits were reviewed by an independent infection control expert every six months. The six monthly review covered 17 areas including hand hygiene, the environment and guidance and policies amongst other matters. Each unit was scored in terms of their infection control compliance rate and this created healthy competition between the units to improve their score. We found the home to be scoring highly in terms of their compliance levels and the audits outlined areas for improvement within an action plan which had timescales for the improvements.

The provider maintained and followed policies and procedures in line with current relevant national guidance regarding infection control. We spoke with staff members about the 10 criteria for prevention and control of infection as outlined in the Health and Social Care Act 2008 Code of Practice. Staff were aware of their roles and responsibilities in relation to infection control and hygiene. Care staff had training in infection control which was renewed every six months. There was an approved flow chart which outlined areas of responsibility in respect of infection control which staff knew well. Hand-washing technique was assessed monthly and the handling of laundry bags was monitored daily. The floor managers were responsible for ensuring such hygiene measures. The home had appropriate policies and procedures in place that formed the basis of the infection control training of members of staff.

The physical environment was well maintained. Beds were washed down and mattresses turned between residents. Each room was cleaned every day and underwent a deep clean once a week. People commented positively on the hygiene within the home. One person told us "Every day they clean my room and mop my floor, I am happy the place is tidy."

The provider followed good practice in terms of reporting of infections such as urinary tract infections and methicillin resistant Staphylococcus aureus (MRSA) to nurses, care workers and family members. MRSA is a type of bacterial infection that can be more difficult to treat than other bacterial infections. Some types of infections, such as those of the urinary tract or chest, were managed by isolating the person using the service in their bedroom, while more contagious infections like the norovirus were dealt with appropriately by more extensive isolation and extra care to prevent spread of the infection by nursing staff. Norovirus is a stomach bug that causes diarrhoea and vomiting.

Those at risk of developing an infection were promptly identified as a result of weekly GP visits. The provider also requested tests from the local hospital where required and the results were sent to the GP for further action when needed. A GP visited all the people using the service at least once a month and more often where needed. Any issues regarding infection were identified at this time in addition to other visits.

The registered manager had implemented a more stringent infection control programme since coming into post and made immediate changes which included doubling the number of domestic staff and the number of maintenance staff, and replacing cloth-upholstered armchairs with armchairs covered in a new type of upholstery that facilitates cleaning. The registered manager conducted a weekly 'walk around' of the home, looking at floors, walls, furniture, cupboards, toilets among other areas and developed an action plan to be carried out by the unit managers on any aspects identified as deficient.

People told us they felt safe using the service. Comments included "I absolutely trust the staff" and "I do feel safe here, if I don't I will just ring my call bell and someone will help me."
The provider had a safeguarding adults' policy and procedure in place. Staff told us they received training in safeguarding adults as part of their mandatory training and demonstrated a good understanding of how to recognise abuse. Staff knew how to report safeguarding concerns and explained the various signs of abuse and different types of abuse. One care worker gave us a specific example of one person who had been the subject of a safeguarding investigation by the local authority safeguarding team. They were aware of what had happened and what further actions had been implemented as a result of the investigation. They told us, "If I ever had any concerns I would report this. I know exactly how a concern is supposed to be investigated and we usually get told what has happened when a safeguarding has been investigated. If I didn't hear anything alarm bells would ring." The care worker explained that the service had a whistle blowing policy in place and how they could use this. Whistleblowing is when a care worker reports suspected wrongdoing at work. A care worker can report things that are not right, are illegal or if anyone at work is neglecting their duties, including if someone's health and safety is in danger. We spoke with a member of the safeguarding team at the local authority and they confirmed that staff were receptive to advice and said they had good working relationship with them. The representative confirmed that they did not think there were any safety concerns with the care provided at Meadbank Nursing Centre.

Staff received emergency training as part of their mandatory training which included what to do in the event of an accident, incident or medical emergency. Staff told us what they considered to be the biggest risks to individual people they cared for and they demonstrated an understanding of how to respond to these risks. Care workers told us the biggest risk to people was the risk of falling. They told us how they would respond to a person falling and this included assessing them, calling for extra help and reporting the incident. There was an emergency call bell system in place to alert all staff in case of an emergency and this could be heard by staff in the entire building. We saw call bells were in place in people's rooms and that these were within reach and working.

We asked nurses about what they would do in the event of a medical emergency and they explained what training they had done to respond to these situations. Nurses were aware who was for and was not for resuscitation. These details were in people's files on 'Do not Attempt Resuscitation' forms which had been signed by the GP.

We looked at 21 people's care records. Information about the risks to people was included in an initial 'pre-admission' assessment which provided an initial trigger to staff about what were the biggest risks to individual people. These were in depth and covered numerous areas related to the person's physical and mental health.

This information was used to prepare care plans and risk assessments in specific areas of the person's care including 'moving around, 'choices and decisions over care', 'eating and drinking' and 'lifestyle' among others. Each section began with an initial risk assessment which included standardised questions to help staff identify the specific areas of risk. The information from the risk assessment triggered the use of further assessments and tools and this information was used to prepare a comprehensive care plan. For example, the initial 'moving around' risk assessment included questions which triggered whether the person needed to be referred to a community healthcare professional and triggered the usage of a specific falls risk assessment if there was evidence of any risk associated with falls. The information from both these risk assessments and additional input from healthcare professionals was then used to create a comprehensive care plan. Each section of the person's care needs included detailed guidance about what the person could do and should be encouraged to do for themselves as well as the exact nature of the assistance that care staff could provide. Each care record was reviewed on a monthly basis to identify whether the person's needs had changed and care records were updated accordingly where necessary.

Staff told us they felt there were enough of them on duty to do their jobs properly. Comments included "Everything is fine" and "Yes there are enough staff." The registered manager explained that senior staff at the service assessed people's needs on admission to determine what their level of dependency was in terms of care and support from nursing and care staff. Staff were then matched according to their skill set and the rota for a particular unit was assessed to ensure the correct skill mix of staff was present at every shift. Individual staff members were allocated particular people and this 'allocation list' was kept on individual units. Each unit was staffed by two nurses and approximately one care worker for every six people except on the palliative care unit where there were additional staff as people's needs were higher. We reviewed the staffing rota for the week of our inspection and this tallied with what we had been told. Our observations of the number of staff on duty during our inspection also tallied with the rota.

We looked at the recruitment records for 20 staff members and saw they contained the necessary information and documentation which was required to recruit staff safely. Files contained photographic identification, evidence of criminal record checks, references including one from previous employers and application forms. Records for nurses also included their Nursing and Midwifery Council registration details.

Good

Is the service effective?

Our findings

At our previous inspection which took place in November 2014 we found there were some concerns in relation to signage within the building and there were some gaps in the recording of people's fluid intake. At this inspection we found these issues had been addressed.

There was adequate signage for each room within the building. We also found there were large murals or paintings to help people to identify their location and orientate themselves.

People were encouraged to eat a healthy and balanced diet. People's care records included an 'eating and drinking' section which included risk assessments and a comprehensive care plan that included information and guidance to care staff about people's dietary requirements and details about their likes and dislikes. We saw records that detailed people's nutritional needs and allergies. This included completion of a Malnutrition Universal Screening Tool (MUST) which identifies whether people are at risk of malnutrition or dehydration. Where people were identified as being at risk of dehydration we saw records to indicate that their fluid intake was appropriately monitored and recorded.

We also found details of involvement from multi-disciplinary teams where required which included dietitians, and speech and language therapists. Where referrals were required, we saw from records that these were appropriately progressed and advice was obtained and implemented. Where monthly monitoring was required, for example monthly weight checks, we saw this was done and recorded.

People told us they liked the food available at the service. Comments included, "It's very lovely. We get chops and all sorts" and "The food here is good, I even have second helpings." We spoke with the chef about the food available. They explained that they obtained feedback about the food from people using the service and catered for their preferences and cultural requirements. The chef was aware of people's specific healthcare requirements which included those people with diabetes. The chef altered the menu each month depending on the feedback received and we saw a copy of the menu for the month of our inspection. Food was seasonal and variations were made according to the season. We sampled the lunch on the first day of our inspection. The food was appetising, of a good portion and served at the correct temperature.

Care records contained information about people's health needs. The service had up to date information from healthcare practitioners involved in people's care, and senior staff told us they were in regular contact with people's families to ensure all parties were well informed about peoples' health needs. When questioned, care workers demonstrated they understood people's health needs. For example, care workers were able to identify existing healthcare concerns that people had.

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. 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.

We checked whether the service was working within the principles of the MCA, and found that the provider was meeting the requirements of the MCA. Staff had received MCA training and were able to demonstrate that they understood the issues surrounding consent.

Care records contained a specific section entitled 'choices and decisions over care'. This included an initial risk assessment that prompted staff to undertake a mental capacity assessment in relation to specific decisions where this was needed. We saw mental capacity assessments in people's care records which demonstrated that specific decisions were made in accordance with the Act and that the least restrictive option was being implemented.

People told us staff had the appropriate skills and knowledge to meet their needs. One person said, "They're very good. We have very clever staff." The registered manager told us, and care workers confirmed, that they completed training as part of their induction as well as ongoing training. Records confirmed that all staff had completed mandatory training in various topics as part of their induction. These topics included safeguarding adults, medicines administration and nutrition and hydration among others. There was also more specialist training available with regards to pressure ulcers and the use of bedside rails. Care workers confirmed they could request extra training where required and they felt that they received enough training to do their jobs well. One care worker told us, "We get enough training. We also get refresher training."

Staff told us they felt well supported and received regular supervision of their competence to carry out their work. We saw records to indicate that staff supervisions took place every month. We were told by the registered manager and care workers that they used supervisions to discuss individual people's needs as well as the staff member's training and development needs. The registered manager told us annual appraisals would be conducted of care workers performance once they had worked at the service for one year. Staff who had worked at the service for over a year told us they had received an appraisal of their performance and we saw records to demonstrate this.

Good

Is the service caring?

Our findings

People who used the service gave us good feedback about the care workers. Comments included "They are very lovely" and "They are wonderful."

Staff demonstrated a good understanding of people's life histories. Senior staff and care workers told us they asked questions about people's life histories and people important to them when they first joined the service and we saw evidence of this information included in people's care records. Care records included a section entitled 'lifestyle' which included details about whether the person preferred a male or female care worker for support with their personal care, if they had any specific or cultural practices that staff could assist with and details about their life history. Information about people's life histories was detailed on a separate form which was filled in by the activities coordinator. This included information about people's families, their previous occupation and their childhoods. Staff members told us details about people's lives and the circumstances which had led them to using the service. They were acquainted with people's habits and daily routines. For example, staff were able to tell us about people's likes and dislikes in relation to activities as well as things that could affect people's moods.

People we spoke with told us they were able to make choices about the care and support provided and told us their wishes were respected. One person said "They do whatever I ask of them." Care staff told us they respected people's choices and encouraged them to be as independent as possible. Their comments included "We will offer choices to people to encourage their involvement" and another care worker told us "People think that if you do everything for a person you are being nice and caring. But you're actually taking away their independence and I would never do this. I am here to encourage and support people to do things for themselves."

We saw good levels of interaction from care workers during our inspection. We observed the lunchtime period and saw staff helping people with their food and having conversations with them as they were doing so. We saw people's relatives visited the service throughout the day and they also appeared to be on familiar terms with staff.

People we spoke with told us their privacy was respected. One person told us, "They respect me."
Care workers explained how they promoted people's privacy and dignity. Their comments included "When I'm giving personal care I will draw the curtains and talk to people about what I am doing and if it is ok with them" and "I always knock on people's doors before going in and always ask their permission before I help them with anything." We observed staff speaking with people with respect and knocking on doors before entering their rooms.

Care records demonstrated that people's cultural and religious requirements were considered when people first started using the service. There was an initial assessment and also a written record of people's cultural and religious needs recorded in the 'lifestyle' section of their care records. A number of religious services were held at the home for people. The provider also had links with religious leaders from other faiths so care staff could support people who practised other religions.

Good

Is the service responsive?

Our findings

People told us they were involved in decisions about their care. One person told us, "They do what I ask. I get the help I want."

People were encouraged to express their views and be involved in decisions regarding their care. People were given information when first joining in the form of a welcome pack and this included details about the service provided. Residents and relatives meetings were on a quarterly basis. We saw minutes from the previous meeting which included details of the matters discussed, updates on previous action points and future actions to be taken. Care records also included details about people's views and staff explained that they prioritised people's choices in relation to their care. For example care workers gave us numerous examples of how they respected people's choices in their daily lives. Staff told us about how they met people's food preferences, their preferred routines and their preferred activities.

People's needs were assessed before they began using the service and care was planned in response to these. Assessments were completed in various aspects of people's medical, physical and social needs. The care records we looked at included care plans in areas including eating and drinking, continence and moving and handling. Care records showed staff prioritised people's views in the assessment of their needs and planning of their care. Care plans included details about people's likes and dislikes in relation to a number of different areas including nutrition and activities. People's progress was reviewed every month and care plans were updated to reflect any changes in people's needs.

People were encouraged to participate in activities they enjoyed and people's feedback was obtained to determine whether they found activities or events enjoyable or useful. The service had a full time activities coordinator on each unit. There was an activities programme on each separate unit which included both group and individual sessions and this included two sessions every weekday. There was limited provision of activities on the weekend, but special weekend activities were organised every two months. Types of activities on offer included films, a men's club where men were encouraged to meet and have group discussions in a communal room with a pub style bar, nail care and games and puzzles among others.

The activities coordinators spoke with people and obtained their feedback in relation to activities. People's involvement in activities was recorded in the 'lifestyle' section of people's care records. Activities coordinators recorded which activities people attended, their level of involvement in activities as well as their mood whilst they were participating. This was recorded as high, neutral or low. The information recorded was then used as part of the monthly evaluation of the 'lifestyle' care plan and activities coordinators formulated different goals depending on changes to people's needs or likes and dislikes.

The provider had a complaints policy which outlined how formal complaints were to be dealt with. People using the service told us they would speak with a staff member if they had reason to complain. We saw records of complaints and saw these were dealt with in line with the provider's policy. Care workers we spoke with confirmed that they discussed people's care needs in their supervision sessions and their team meetings. They told us if there were any issues or complaints they would discuss them at these times, but

could also approach their team leaders or the registered manager at any other time.

Good

Is the service well-led?

Our findings

The provider had an open culture that encouraged people's involvement in decisions that affected them. Staff gave excellent feedback about the registered manager. They told us she was available and listened to what they had to say. Comments from staff included "She is fantastic. I'm really impressed", "She does what she says she'll do. She likes to be challenged and wants staff to be honest with her" and "She's a very nice person. She's arranged breakfast for the staff. She arranges drinks for everyone. She really tries her best." We observed the registered manager interacting with people using the service and care staff throughout the day in a friendly manner.

The registered manager told us various staff meetings were held daily, weekly and monthly. Handover meetings took place every day so care staff finishing their shift could feed back important information to care staff who were starting their shift. A daily 'take 10' meeting was also held between the clinical services manager, the unit manager and heads of other departments including the kitchen staff and housekeeping. We observed the 'take 10' meeting on the first day of our inspection. The clinical services manager queried the heads of departments about various matters including call bell response times, whether all facilities including the toilets were in working order and any other matters. Additional full staff meetings were also held on a quarterly basis. We saw the minutes of the previous full staff meeting which had taken place in March 2016. There was a record of the issues discussed and an action plan for further actions to take. Staff told us they felt able to contribute to these meetings and found the topics discussed useful to their role.

We saw evidence that feedback was obtained from people using the service, their relatives and staff. Feedback was received during residents meetings. People told us they found these meetings helpful and felt comfortable speaking in them. The registered manager told us that if issues were identified, these would be dealt with individually and we were given an example of when this had happened.

We saw records of complaints, and accident and incident records. There was a clear process for reporting and managing these. The registered manager told us they reviewed complaints, accidents and incidents to monitor trends or identify further action required and we saw evidence of this. They told us all accidents and incidents were also reviewed by senior staff within the organisation who also monitored the results for trends and made further recommendations where required.

Information was reported to the Care Quality Commission (CQC) as required. We spoke with a member of the local authority and they confirmed that they did not think there were any safety concerns with the care provided at Meadbank Care Centre.

Staff demonstrated that they were aware of their roles and responsibilities in relation to people using the service and their position within the organisation in general. They explained that their responsibilities were made clear to them when they were first employed. Staff provided us with explanations of what their roles involved and what they were expected to achieve as a result. We saw copies of staff job descriptions and the details within these tallied with what staff had told us.

The provider had thorough systems to monitor the quality of the care and support people received. We saw evidence of numerous audits covering a range of issues such as medicines, falls, deaths, weight loss, complaints and care plan reviews among many others. The registered manager reported on these numerous issues in a monthly report which included statistics and other explanatory information to the area manager of the organisation. The area manager used this information to conduct a 'monthly home review' of the service. This report was linked to the Regulations within the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The report included an action plan with dates for completion. We looked at the report for March 2016 and saw all further actions had been completed. The registered manager showed us an example of the work she had completed to address one of the actions. This involved significant analysis of data and planning before the issue could be remedied.

We saw evidence of other checks which were conducted of the home. The registered manager told us she completed a 'weekly walk round' of the home to check on areas including infection control and health and safety matters. We saw a copy of the standardised check list she used which included a detailed list of areas she checked. It included an improvement plan for further actions required and we saw these were in the process of completion. The registered manager also told us she completed an unannounced 'nightly visit' of the home on a quarterly basis. These were also recorded and we saw a copy of the checks she had conducted in March 2016. These included a record of the observations she had made of the night staff in their performance of their work. The last checks did not identify any issues of concern.

The provider worked with other organisations to ensure the service followed best practice. We saw evidence in care records that showed close working with local multi-disciplinary teams, which included the GP, Trinity Hospice and local social services teams among others. We spoke with one health care professional and they commented positively on their working relationship with staff at Meadbank Care Centre.