Meridian Healthcare Limited

Stamford Court

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out over three days on 22, 25 and 26 February 2016. Our visit on 22 February was unannounced.

We last inspected Stamford Court in April 2014. At that inspection we found that one of the five regulations we assessed was not compliant. We carried out a follow up inspection in August 2014 and found that the regulation previously found non-compliant in April 2014 was compliant.

Stamford Court is registered with the Care Quality Commission to provide nursing and residential care to a maximum of 40 people, primarily to older people with various disabilities. At the time of our visit 34 people were using the service.

There was a registered manager in post. 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 identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Staff we spoke with had a clear understanding of the role and responsibility in protecting people and making sure people remained safe and free from potential harm.

Those staff who we asked confirmed that before they were allowed to administer medicines at the home they received appropriate training and training records seen confirmed this. At the time of our inspection only nurses administered medicines.

We found staff recruitment to be thorough and all relevant pre-employment checks had been completed before a member of staff started to work in the home.

Staffing rotas showed that there were consistently enough nurses and care staff on duty with the right competencies, experience and skills to keep people safe.

Suitable arrangements were in place for the prevention and control of infection. All bathrooms and toilet areas seen were found to be clean and hygienic and all contained a wall mounted liquid soap and paper towel dispenser.

People who used the service and the visitors we spoke with were positive and complimentary about the attitude, skills and competency of the staff team. Individual care was assessed and planned and was subject to regular review.

Nursing staff we spoke with told us they were supported to maintain their clinical knowledge and skills. We looked at five staff training files to confirm training had taken place and certificates that had been issued. Staff told us that the training provided was good and met their job role expectations.

Staff gained people's consent and cooperation before any care or support was offered or given. Where people were unable to give verbal consent, staff knew by the person's body language or facial expression if they did not agree with the action being suggested .

We spoke with the chef who told us that they received training specific to their role and had good knowledge around specialised diets for people.

People's healthcare needs were considered as part of the care planning process and we saw and were told that good relationships were had with visiting healthcare professionals such as doctors and other community health services.

We saw that the needs of people receiving end of life care had been recorded and kept under review.

People's individual preferences and independence was promoted by the team of staff and we saw and heard care staff encouraging people to make choices about their daily life style.

The provision of 'spot' beds in the home to people requiring support before returning home meant that people using that service on a permanent basis had their daily lifestyle and privacy intruded upon by the visitors and visiting health care professionals to those people using the 'spot' beds.

We looked at the care records for one person admitted into one of the 'spot' beds. The dependency rating for this person was rated 'high' but no care plan had been formulated and no information was therefore available to guide staff when supporting this person.

The service had a written complaints policy and people using the service, who we spoke with, were confident that any complaints or concerns raised would be dealt with appropriately.

We saw evidence that systems were in place to demonstrate that regular checks had been undertaken on all main aspects of the management of the service.

The provider supported the home manager to provide a consistent service.

At the time of our visit the service was changing documentation records from the previous provider to the new.

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 who used the service told us that Stamford Court was a safe place to live.

Arrangements were in place, including safeguarding training for staff to safeguard people from harm and abuse.

Staff working in the home had been recruited following an appropriate recruitment process.

Medicines were managed safely.

Prevention and control of infection was managed well.

Is the service effective?

Good

The service was effective.

The staff had knowledge and skills to support people who used the service and regular and appropriate training meant they could update their skills.

Staff supervision had been inconsistent but action had been taken to rectify this.

Arrangements were in place to make sure people received good nutrition and hydration.

Nutritional assessments had been carried out and people who used the service could make choices about their food and drink.

Arrangements were in place to request the support of health and social care specialists to keep people well.

The manager and staff had received training that included an understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People living in Stamford Court were very complimentary about the caring and supportive attitude of staff working in the home. Both a visitor and health and social care professional also spoke positively about the caring attitude and approach of the staff.

Staff on duty demonstrated that they knew and understood the needs of the people they were supporting and caring for.

Staff encouraged people to make choices about their daily life style.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Due to the provision of 'spot' beds being used in the home, people using the service on a permanent basis could have their privacy and preferred life style intruded upon.

We looked at the care records for one person admitted into one of the 'spot' beds. The dependency rating for this person was rated 'high' but no care plan had been formulated and no information was therefore available to guide staff when supporting this person.

Risk assessments were not always in place for those risks identified.

Limited activities were available for people to participate in.

A 'Resident of the Day' had been introduced to encourage the person using the service and their relatives to be more involved in the care planning and review of care processes.

Is the service well-led?

Good

The service was well-led.

A manager registered with the Care Quality Commission was managing the service and systems were in place to monitor and assess the quality of the service being provided.

People who used the service told us that the registered manager, nurses and most care staff were approachable and helpful.

A visiting relative, who we asked, told us they felt confident in approaching the manager or any of the staff in charge and felt that any concerns they raised were listened to and acted upon.

Home managers were supported with information by the provider to help maintain a consistent service.

Stamford Court

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 was carried out over three days on the 22, 25 and 26 February 2016. Our visit on 22 February 2016 was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the previous Care Quality Commission (CQC) inspection reports about the service and notifications that we had received from the service. We also contacted the local authority commissioners of the service to seek their views about the home. They provided us with some information that helped us to review and evaluate the service being provided.

Part of the information gathering included a request to the provider to complete and return to us a Provider Information Return (PIR). This is a document that asks the provider to give us some key information about the service, what the service does well and any improvements they plan to make. The provider completed this document and returned it to the CQC prior to our inspection visit.

During our visit we spoke with the registered manager, the operational manager, a registered nurse, three care staff, a domestic and the cook. We also looked around the building, watched staff interacting with and supporting people, examined five people's care records, six medicine administration records, four staff personnel files, staff training records and records about the management of the home such as auditing records.

Good

Is the service safe?

Our findings

People who used the service, who we spoke with, told us they felt safe and secure living in Stamford Court. One person said, "Of course I feel safe and well cared for." Another person told us, "Oh yes, I definitely do feel looked after and safe, we're all treated like super stars."
We also spoke with a relative who visited the home on a regular basis who said, "I know my [relative named] feels safe enough otherwise I would know."

Staff who we asked told us they believed people living in Stamford Court were kept safe and they also demonstrated a good understanding of their role in applying safeguarding procedures in the home. Staff were provided with annual safeguarding training and training records seen confirmed this. Staff had access to a safeguarding policy and were able to describe the process the registered manager should take once a safeguarding matter had been reported or disclosed to them. Staff also demonstrated an understanding of the need to be vigilant about the possibility of poor practice by their colleagues. One member of staff told us, "I would have no hesitation in following the whistleblowing procedure if I needed to. It just wouldn't be acceptable if staff didn't look after people safely and in a way they would want their mum and dad to be cared for."

A visiting health care professional whose opinion we asked told us "I have no concerns about the safety of any of the people living in Stamford Court."

We looked at the personnel files of four people employed to work in the home, one of which only started working in the home on our first day of inspection. The files contained a Disclosure and Barring Service (DBS) enhanced disclosure check. The DBS carry out a criminal record and barring check on applicants who intend to work with vulnerable people. There were also application forms that included the applicant's employment history and two appropriate written references. The manager confirmed that all new staff were subject to a probationary period and the satisfactory completion of a full induction to the service. Such checks help employers to make safer recruitment decisions and to minimise the risk of someone unsuitable being employed to work in the home.

We reviewed the receipt, storage, administration and disposal of medication. The storage was appropriately secure, including the appropriate and specific storage of controlled drugs. Medication was supplied to the home by a local pharmacy on a monthly basis using a Monitored Dosage System (MDS). Medication was checked on arrival at the home. Any unused or spoilt medication was returned to the pharmacy for disposal. However as the service was a nursing home, controlled drugs could be disposed of using a denature kit and then be consigned to a licensed waste disposal company. We looked at six medication administration records (MAR) and found these to be appropriately maintained, including controlled drugs being signed by two staff using a controlled drugs register and the MAR. There was photographic identification held on each person's MAR. Using such processes in a consistent manner helped to make sure the right person received the right medication in the right dose and at the right time. No person was self-medicating at the time of our inspection and the registered manager confirmed that no person was receiving their medication covertly (a person being administered medicines without their knowledge).

Staff who we asked confirmed that before they were allowed to administer medicines at the home they received appropriate training and training records seen confirmed this. At the time of our inspection only nurses administered medicines.

We looked at a sample of records relating to the assessment of needs and care planning for people who used the service. Where required, each care plan had an appropriate risk assessments, including risks associated with mobility, moving and handling and nutrition. We saw that these assessments were reviewed on a regular basis and updated when necessary. One visiting health and social care professional told us that staff were very supportive when individual reviews were being carried out for people living in the home.

Three members of the staff team were accredited moving and handling assessors having completed 'train the trainer' in this subject. Having accredited trainer's readily available, helped to make sure that moving and handling practices used in the home were safe.

Evidence was available to demonstrate that a falls team meeting took place in January 2016. This meeting was attended by all heads of staffing teams including the operational manager of the service. Following this meeting a falls analysis was completed and falls awareness training was identified for all staff to attend. At the time of our inspection visit, this training had still to be arranged.

We spoke with three people who used the service and regular visitor about staffing levels in the home and did they think enough staff were on duty at any one time. One person using the service told us, "Some day's staff are busier than others. I do have to wait sometimes (for assistance) but they always come and tell me why." Another person said, "The staff are very good, they help each other when they are busy. You don't wait very long for help." The visitor we spoke with told us that at times, staffing levels did appear to be lacking and sometimes lounges were left unattended. However, they also told us that since the new manager has been in post, staffing levels had become more consistent. The manager told us that staff were deployed to make sure appropriate staffing levels were maintained at all times and that extra staff would be added to the rota if the needs of people who used the service required extra support or were particularly unwell.

During our visit we saw that staff on both downstairs and upstairs units were kept particularly busy with little time to spend in providing one to one stimulation with people using the service. There were three carers on each unit with both units having a registered nurse in charge. We did see that some people required the support of two carers which left one carer and a nurse in the lounge areas to monitor the remaining people. One staff member we spoke with told us, "We have good staffing day's and some difficult days too. I find that the meal times are the most difficult to manage and we sometimes have to rely on the cook or domestic staff to help out."

We discussed this with the manager who confirmed that she had already taken action to make sure any shortfalls in staffing levels were covered appropriately either by using staff employed by the service or agency staff. The manager told us the same agency staff were used on a consistent basis and were only used when a registered nurse was required, not care staff.

We undertook a tour of parts of the home. This included a selection of people's bedrooms, communal areas and toilet and bathrooms. Although some furnishings and carpets had recently been replaced, other furnishings were showing signs of wear and tear, in particular, the armchairs in the upstairs lounge area. The manager told us that she had received the permission of the operational manager to order some new armchairs for that particular lounge.

Staff who we asked had no concerns about the way in which the environment within the home was being

maintained. We looked at a sample of records and safety certificates relating to the maintenance of the equipment used and the building. The information seen confirmed that, where necessary, equipment, including the lift, hoists, fire detection and alarm system, was regularly checked and serviced. Health and safety assessments of the premises had also been carried out and these were reviewed on an annual basis.

During our discussion with the cook it was confirmed that any equipment or utensils that became faulty were either repaired or replaced quickly. The home had received a five stars rating from the Food Standards Agency's at their last inspection of the service in February 2015.

Suitable arrangements were in place for the prevention and control of infection. During our tour of the building no unpleasant odours were detectable and all areas were found to be clean and hygienic. Cleaning schedules were in place for both domestic and kitchen staff and were designed to be followed on a daily, weekly and monthly basis. Soap and paper towel dispensers were available in all areas accessible to people using the service, staff and visitors. The last infection control visit by the Stockport Health Protection and Control Infection Unit in September 2014 found the service to be 94% compliant. The manager confirmed that the action required following that visit had been completed.

Good

Is the service effective?

Our findings

People who used the service spoke positively about the attitude and skills of the staff. Comments included, "I think the staff are wonderful. They are kind, caring and know what they are doing", "I know they [staff] use a computer when they are doing training, [named carer] has told me about it" and "The staff work hard, some more than others." One visiting relative said, "The staff seem to know what they are doing and are able to tell me all about [relative] whenever I visit, which keeps me up to date."

New staff had been provided with induction training. This training was to make sure new staff would know what was being expected of them in their role and to make sure they received training that was relevant to their role. We spoke with a total of six members of staff who told us they had received a variety of training that included, safeguarding, emergency procedures, infection control, health and safety, person centred care, six steps end of life, medication and understanding the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Nursing staff we spoke with also told us they were supported to maintain their clinical knowledge and skills. We looked at five staff training files to confirm training had taken place and certificates that had been issued.

We were shown the training matrix (chart) which showed that staff had access to a wide range of appropriate training opportunities. Most training was completed using on-line units via a training service known as 'Touch'. The manager had provided staff with access to a computer and allowed staff time to keep their individual training needs up to date. Staff each had a user name and password to access the use of the computer and each received an alert when refresher training was due. An email was also sent to the manager to keep them informed of each staffs completed and due training. Staff told us they were very happy with the training opportunities they had.

Staff we spoke with told us that although they received supervision from their line manager, this could sometimes be inconsistent in frequency. They also told us they had opportunity to attend team meetings and had received an annual appraisal. The manager was able to show us an action plan which indicated that appraisals had been arranged for all staff during the coming months. We discussed staff supervision with the manager who told us that arrangements had just been put in place to make sure all staff received at least four formal one to one supervisions per year and full team meetings would be held every three months. We saw that this had been discussed and recorded in the minutes of the last team meeting held.

Arrangements were in place to make sure people received good nutrition and hydration. We looked at four care plans and found that they contained detailed information on their dietary needs and the level of support they needed to make sure they received a balanced diet. Risk assessments such as the Malnutrition Universal Screening Tool (MUST) had been used to identify any risks associated with people's nutrition. These assessments were being reviewed on a regular basis and where people had been identified as at risk of malnutrition, referrals had been made to the dietician for advice. We spoke with the chef who told us that they received training specific to their role and had good knowledge around specialised diets for people. People who used the service, who we asked, told us they were happy with the food provided and the choices made available to them.

All the interactions between staff and people who used the service, which we observed, were seen to be carried out in a calm and relaxed manner. We observed staff gaining people's consent and cooperation before any care or support was offered or given. Staffs interactions with people showed they knew people very well and we could see that where people were unable to give verbal consent, staff knew by the person's facial expression or body language if they did not agree with the action being suggested, for example, one person did not want to go to the dining table for lunch and refused to move from their armchair. The carer spoke kindly to the person and brought a small table to them so they could sit and eat their meal in the armchair. This was a positive move and the person responded by eating their meal.

We saw that people's healthcare needs were considered as part of the care planning process and from our discussion with staff and records seen, it was apparent that staff had developed good and professional links with other community health care professionals and specialist to help make sure people using the service received prompt and effective care. A visiting community healthcare practitioner said, "The manager here is very good, very responsive to people's health needs and keeps us informed of any concerns in a timely manner."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity do to 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 who lack capacity can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Mental capacity assessments to determine if somebody hade fluctuating capacity, and to determine the best time and way to support them, were in place for 22 people, although still awaiting confirmation of authorisation from the local authority.

In the returned Provide Information Record (PIR) the registered manager told us "The [staff] team has a good knowledge of the MCA and DoLS and 91.7% of colleagues have been trained in this area. We have 22 residents who currently have a standard authorisation pending for a DoLS order and they have a relevant representative whose details are clear in the Residents Care Plan. All of our Residents with pending DoLS have access to an advocate through Tameside Advocacy Services." Those staff we spoke with, confirmed they had received such training and were able to describe a basic understanding of the MCA and DoLS procedures.

Good

Is the service caring?

Our findings

People living in Stamford Court were very complimentary about the caring and supportive attitude of staff working in the home. Both a visitor and health and social care professional spoke positively about the caring attitude and approach of the staff. One person using the service told us, "Staff are very kind and look after you really well. I especially like [named nurse] and [named keyworker], they know how I like things." Other comments from people using the service included, ""This is a good place to live" and "You don't have any problems here, the girls [care staff] are really nice and know how to take care of you."

Staff we spoke with were very clear about the expectations of their work role and that is was based around meeting the individual needs of each person using the service, by having a flexible approach to care, respecting the person's right to choice, privacy, dignity and respecting the person's decision if they have capacity. We asked the staff how they would make sure that a person without capacity would have appropriate decisions made on their behalf. One member of staff told us, "You have to respect any decisions that have been made in the person's best interests and constantly review those decisions in case any changes are needed."

People's individual preferences and independence was promoted by the team of staff and we saw and heard care staff encouraging people to make choices about their daily life style. Staff told us they tried to spend some one to one time with people but that could be limited on how busy the day was and the numbers of staff available. Staff also told us that the care plans provided them with relevant information to meet the person's needs on a day to day basis. They also told us that care plans and related documentation were reviewed on a monthly basis and we saw evidence of this on those care files were looked at.

Care plans included a booklet called 'Remember Me'. This booklet provided people using the service with an opportunity to record details of their past life style and things that were and are still important to them. We asked care staff how they provided people with person centred care. The staff we spoke with were knowledgeable about people's individual needs and were familiar with the contents of people's care plans and associated records, such as the 'remember me' booklet. They were able to provide examples of how they promoted people's independence and choices and during our observations we saw positive interactions taking place between staff and people who used the service. The atmosphere in the home was relaxed and the interactions of staff with people who used the service were friendly, helpful and discreet.

We looked at the arrangements in place for supporting people at the end of life. We saw that the needs of people receiving end of life care had been recorded and kept under review. During our visit one person using the service was on an end of life pathway and we saw the manager and staff dealing with the situation caringly and sensitively, taking into account the needs of the person's family as well. Staff confirmed they had received training and understood their role when dealing with such a sensitive matter. A recent 'thank you' email to the home read: "My dad lived at Stamford Court for eight months until he passed away. During this time my dad was very happy, the care he was given was exceptional, the staff made sure that my dad's needs were met with a smile and nothing was too much trouble. The warmth and kindness the staff showed me and my dad was there in everything they did of us. I was able to go and see my dad at any time during

the day or night and always found him being cared for and happy and safe. Thank you to all the staff at Stamford Court."

Requires Improvement

Is the service responsive?

Our findings

The service offered by Stamford Court also provided the local hospital with a total of six 'spot beds' between this and another home. These beds were used to provide support to people who were well enough to leave hospital, but not quite ready to return home or to another care setting. These beds were coordinated and monitored by a registered manager from another service, who rang Stamford Court on a daily basis to find out bed availability. If a bed was available, details would be passed to the hospital and arrangements made for anyone waiting for discharge from hospital but not ready to return home, to be admitted into Stamford Court. This was usually done by a telephone call to the registered manager of Stamford Court by the coordinator of the beds, giving brief details of the persons needs with paperwork being brought when the person was admitted. Based on the information shared, the registered manager would make a decision if the persons needs could be met by Stamford Court. In our discussion with the registered manager we were informed that these beds were consistently used on a day-to-day basis which took time to arrange.

The provision of this 'spot' bed service was provided in the main body of the home, not on a separate unit. This meant that people using that service, their visitors and visiting health care professionals had to intrude on the lifestyle and privacy of people who permanently lived at Stamford court.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at a sample of care records relating to the identified needs of individuals who used the service. The records we viewed included care plans, risk assessments and other care related documentation. Each record we looked at had been reviewed on a regular basis and updated when necessary. We found some care plan details more person centred than others. At the time of our visit the service was changing documentation records from the previous provider to the new. We looked at the care records for one person admitted into one of the 'spot' beds. The dependency rating for this person was rated 'high' but no care plan had been formulated and no information was therefore available to guide staff when supporting this person. In another care plan it identified the person was at risk of becoming isolated, but no risk assessment or management strategies were in place.

One person using the service on a permanent basis, who we asked, told us that they knew they had a care plan and that 'sometimes' they were asked about it but also stated, "but I'm not sure really."

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

In our discussion with the registered manager, we were told that in order to encourage people who used the service to become more involved in their care planning and review process a 'Resident of the Day' had been introduced. Each person using the service was allocated a specific day of the month where they are 'Resident of the Day' to encourage and record the involvement of the person, their relative(s) or advocate in the review of care. The person is made aware that they are the 'resident of the day' as the cook will go and

talk with them to ensure they like the meals provided. The maintenance person will also talk with them to ensure everything is working properly in their rooms. Their bedroom will be deep cleaned by the domestic staff and the nurse or senior care staff would review the person's care file and ask the person to sign (if able) to confirm their file details are up to date and person centred.

We saw that the service had a written complaints policy which included the option for people to take their complaint outside the service if they were dissatisfied with the response they received. One person using the service told us, "If I had a worry or a complaint I would speak to the staff and tell them I wanted to speak with the manager." Another person said, "I'm confident that if a I had complaint it would be dealt with properly." A visiting relative said, "Any worries or concerns I would speak with the manager first. If there was no action then I would take it further using the complaints procedure."

At the time of our inspection visit there was no activities coordinator in post although the vacant post had recently been advertised. People using the service, who we asked, told us that activities did take place but not very often. Comments included, "I don't join in anyhow, I prefer to stay in my room", "I like the singing and things like that" and "Sometimes we get entertainers in, but not very often." One visiting relative told us, "I know there are activities but these are very limited, they really could do with more."

It is recommended that consideration be given to providing appropriate activities on a regular basis.

Good

Is the service well-led?

Our findings

At the time of this inspection visit there was a registered manager in post. The manager was registered with the Care Quality Commission (CQC) on 27 October 2015. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The management team also consisted of a clinical lead that provided leadership to all other staff. People who used the service told us that the registered manager, nurses and most care staff were approachable and helpful. One person using the service told us, "The staff and the manager [named] are really very good, nothing is too much trouble." Another person said, "They all [staff] know what I need and always do their best for me, but some are more helpful than others."

A visiting relative, who we asked, told us they felt confident in approaching the manager or any of the staff in charge and felt that any concerns they raised were listened to and acted upon. During our visit we observed the interactions taking place between the manager, staff team and visitors to the home. We noted that these interactions were open and transparent.

We asked a number of staff on duty what they thought about the management of the home. Comments we received included, "The manager [named] is firm but fair. Both the manager and clinical lead are brilliant, very approachable, I have no complaints or concerns", "[Name] is a very good manager. Some staff don't like the stricter management approach but it is needed." Other comments included, "I find the manager difficult to approach", "I think the manager doesn't always listen to me" and "I stay out of their way." We discussed the feedback we received with the registered manager who said that there was and still is a lot of work to do in the service and a stronger management approach was needed. They also said that they would think about their tone when dealing with staff to make sure staff didn't feel intimidated and feel able to approach them.

The registered manager sought feedback about the service through annual surveys, formal meetings, such as individual service reviews with people's relatives and other health and social care professionals and joint relative and resident meetings. No annual service user survey had been conducted at the time of our inspection visit but we did see minutes from meetings held with people using the service and their relatives in May and September 2015.

We asked the registered manager to tell us how they monitored and reviewed the service to make sure people received, safe, effective and appropriate care. We saw evidence that systems were in place to demonstrate that regular checks had been undertaken on all main aspects of the management of the service. The registered manager provided us with written evidence of some of the quality checks carried out. These included monthly medication audits and daily medication stock audit, daily 'walk around' checks looking at people's care, infection control, dining experience, professionals' feedback and relative's feedback. Whenever a manager from the organisation visited the service they had to complete a report of the findings from their visit. This was to make sure a high quality service was being maintained. We saw

evidence that a total of six visits had been recorded since late November 2015 with reports being completed.

The registered manager of the service had been provided with a booklet detailing how to maintain Quality Assurance in the service. Each manager working in a Meridian service had been provided with this booklet. The information provided home managers with Core Activities to be carried out on a day-to-day basis to maintain a quality service. This helped managers to provide a consistent service.

Monthly catering audits had been carried out and, at the last audit in January 2016; no issues of concern had been found or raised.

We saw evidence that quarterly health and safety audits had been conducted in September and December 2015 and risk assessments for the premises had been reviewed in June 2015.

Any known accidents were recorded on a reporting form then entered onto a computer system known as 'Datix'. The Datix system allocated a number to the record which then came back to the registered manager in order to complete an investigation. Once the investigation had been satisfactorily concluded, the process would then be closed. There was also an incident reporting flow chart in place. Both reported accidents and incidents were reviewed by the operational manager of the service on a monthly basis.

We saw that 'handover' meetings took place at the change of each change of shift to help make sure that any changes in a person's condition and subsequent alteration to their care plan was properly communicated and understood.

People using the service and their relatives were provided with the statement of purpose and a service user guide for the home. These included the information about the aims and objects of the service and some information about the facilities on offer.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans did not always contain relevant information to provide staff with person centred information to appropriately support the person using the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's right to have their dignity and privacy respected was not always maintained.