Cedar House Care Home Limited

Meadowbank Residential Care Home

Inspection report

44 Braywick Road
Maidenhead
Berkshire
SL6 1DA

Tel: 01628781186
Website: www.meadowbankcare.com

Date of inspection visit:
18 January 2018

Date of publication:
28 February 2018

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

Meadowbank Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. We regulate both the premises and the care provided, and both were looked at during this inspection.

Meadowbank Residential Care Home can accommodate 22 people across two floors, each of which has separate adapted facilities. The service cares for adults, including people living with early stages of dementia. The premises are modern and purpose-built. People live in their own bedrooms and have access to communal facilities such as dining, lounge and activities areas. At the time of our inspection, there were 20 people living at the service.

The provider is required to have a registered manager as part of their conditions of registration. 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. At the time of our inspection, there was a registered manager in post.

People's safety was maintained. This included protection from the risks of abuse, neglect, discrimination, injuries and accidents. People's care documentation and the support they received ensured their maximum safety. The risks from the building and premises were mitigated, but the provider was required to update some assessments after out inspection. There were sufficient staff deployed to meet people's needs. People were protected from the risk of infections. The service was clean and well-maintained. The management of people's medicines was robust.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Staff induction, training, supervision and performance appraisals ensured workers had the necessary knowledge and skills to effectively support people. People's care preferences, likes and dislikes were assessed, recorded and respected. We found there was appropriate access to other community healthcare professionals. People were supported to maintain a healthy lifestyle. People had adequate nutrition and hydration to ensure their wellbeing.

Staff had developed positive relationships with people who used the service and visitors. There was complimentary feedback from most people who used the service and their families. People told us they were able to participate in care planning and reviews and we saw evidence of decision-making that promoted people's independence. People's privacy and dignity was respected when care was provided to them.

The service provided person-centred care. Care plans were thorough and contained information of how to support people in the best possible way. We saw there was an appropriate complaints system in place. There were regular meetings and surveys to ensure respective points of view could be conveyed to the service. People and their families had a say in the everyday decision-making and operation of the service.

There was a clear focus on the quality of care at the service. This was outlined in the provider's statement of purpose. The nominated individual and registered manager were dedicated and committed to ensure that people received the best possible care. Staff described a positive workplace culture where their contribution was recognised. The service regularly checked the safety and quality of care through audits. Action plans were developed to ensure that any improvement required were completed. There was continued investment in the service to increase the satisfaction of people that lived at Meadowbank Residential Care Home. The provider met the conditions of registration and complied with other relevant legislation related to the adult social care sector. The service had a good relationship with community stakeholders who supported people that used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff protected people from the risks of abuse or neglect.

Appropriate risk assessments about people's care were completed and regularly reviewed.

There were sufficient staff deployed to meet people's needs.

People's medicines were safely managed.

People's injuries were recorded, reported and acted on to ensure their wellbeing.

Is the service effective?

Good

The service was effective.

There was good staff support, with satisfactory staff induction, training, supervision and performance reviews.

People's nutrition and hydration needs were effectively met.

The service was compliant with the Mental Capacity Act 2005. People were assisted to make informed decisions or decisions were made in their best interests.

The premises and decoration were suitable for adults in a residential environment.

The service worked well with other community healthcare professionals.

Is the service caring?

Good

The service was caring.

People and relatives told us staff were committed and friendly.

People's independence was respected and promoted.

People's choices about care were encouraged and protected.

People received care in a dignified way.

Is the service responsive?

Good

The service was responsive.

People's care was tailored to their needs.

People's care was reviewed and changed, when required.

People and relatives knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

People and relatives told us the service was well-led.

There was a good workplace culture with clear organisational goals and objectives.

Staff were involved in the operation of the service and had good access to the management team.

Relevant audits were completed to ensure safe, quality care.

The service was compliant with their conditions of the registration.

Meadowbank Residential 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, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Our inspection took place on 18 January 2018 and was unannounced.

This was our first inspection since the provider of the service changed.

Our inspection was completed by two adult social care inspectors and an expert-by- experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert-by-experience had knowledge of adults living in residential care settings.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also checked feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House, the Information Commissioner's Office (ICO), the Food Standards Agency (FSA) and the local fire inspectorate.

We spoke with 10 people who used the service and three relatives who visited during our inspection.

We spoke with the nominated individual, the registered manager, the team leader, the chef, the cleaner and maintenance person and the visiting hairdresser. We also spoke with five care workers about people's support and treatment.

We looked at four people's care records and other records about the management of the service. After the

inspection, we asked the registered manager to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Good

Is the service safe?

Our findings

One person said they felt, "Safe living here". She explained the doors and windows were checked every night before bedtime at 10pm and that she sees this being done. She said she has had no falls since moving to the service and, "Loves it". All relatives were asked if people felt safe and that they, as relatives felt safe leaving them at the service. All responded that they had no issues with safety and security and comments included, "I have no doubt she (the person) feels safe. I am absolutely confident of her safety" and "From my point of view, Meadowbank has been a godsend from a safety point of view". The relative said this as their mother was having falls at home and told us the person had not had one fall since moving in.

We observed that people had call bells within reach in their rooms. Some people were not able to operate their call bell. They had regular safety checks instead. We saw records of care interventions in a room folder. When we visited a person who was cared for in bed, we saw that they were comfortable. Staff we spoke with told us they had undertaken training in safeguarding adults. A care worker told us they completed this training. The team leader also told us that staff had completed it.

Care workers were able to discuss types of possible abuse. One carer referred to, "Physical, sexual, neglect, verbal (abuse)." They told us that signs of concern might include, "If I see someone doesn't look at my eyes" or "Looks upset, scared, shaking." They added that they would be concerned if a person had a bruise that a person, "Couldn't do himself." Staff were aware of their responsibility to report and record concerns. A care worker explained, "As soon as I notice, I am telling the senior (staff)." Senior staff would decide on further action such as contacting the GP. The team leader told us they would contact the local authority safeguarding team if they had a query. They said, "We always call them if we are not sure what to do."

People's care folders included risk assessments for falls (the falls risk assessment tool or FRAT), moving and handling and the malnutrition universal screening tool (MUST) assessment. MUST is designed to monitor for weight loss risks. We saw that people also had risk assessments for skin integrity (a Waterlow assessment). Risk assessments were reviewed as needed or at least monthly. We saw that people had personal emergency evacuation plans (PEEPs) for emergency use. These would be used in the event of an evacuation. These indicated the assistance required to reach a safe zone. Some people's fluids were thickened to decrease the risk of choking. We saw that a container of fluid thickener was left on top of a chest of drawers in a person's room. We spoke with the team leader about the potential risk posed by thickener and the importance of storing it safely. The team leader removed it promptly and placed it in a kitchen cupboard.

Some risk assessments related to the maintenance of the premises and building required improvements. We pointed this out to the registered manager. They organised contractors to come and complete visits and provide new reports. We were sent copies of the updated documents which were satisfactory. The provider gave us a reassurance that the checks would be completed regularly by the creation of a schedule, overseen by the registered manager. Basic checks to ensure people, staff and visitor safety were already in place. This included fire safety, gas safety, portable appliance testing and checks on hoists and slings for moving people.

The building was arranged in two floors and staff were allocated specific people to care for on each shift. At the time of our inspection, twenty people resided at the service which operated at its full capacity. People had a range of needs, including those related to dementia and to support with mobility. Some people required the support of two carers, for example to transfer. The service had a complement of a senior care worker and three care workers staff during the day. This did not include the registered manager. On the day of our inspection, the team leader was also present, making a total of six care staff. A senior care worker and two care workers were on duty at night. There was sufficient staff deployed to safely attend to people's needs. Staff told us there were enough workers to meet people's needs. When we asked about this, a carer told us, "Yes, definitely, five (staff) in the daytime."

Systems were in place that showed people's medicines were managed consistently and safely by the care workers. Medicines were obtained, stored, administered and discarded appropriately. We observed staff during the administration of medicines to people, and found their practise was safe and in line with local and national guidelines. The care worker who administered the medicines placed tablets in a plastic pot and was then asked to do something. She unlocked the cabinet with keys she obtained from her pocket, placed the pot of tablets in the cabinet and locked it back up, and put the key back in her pocket before leaving the station. One person said that the prescriptions and medicines were locked away but the staff bring it, "When it is time." Another person explained that her medicine was put in a, "Little round plastic cup" and that staff tipped the tablets onto her hand. One person said he gets his medicines but always asks what it is for. He said he felt staff answered his questions and he has always taken his medicines.

All areas of the service were very clean, including communal areas, bathrooms and toilets. There were hand sanitisers and hand gels available throughout the premises in communal areas and appropriate handwashing signage was displayed in toilets and bathrooms. Staff wore personal protective equipment (like gloves and disposable aprons) when they delivered personal care and at meal times. Staff said they received training on infection control and the management team said they conducted regular spot checks to ensure that infection control procedures were being followed correctly. One person said, "There's nothing smelly here." There were no malodours and this was supported by two relatives, who added, "We looked at lots of care homes and chose this one for its cleanliness and no bad smells, including antiseptic." We observed the cleaner who was wearing apron and gloves. She explained the chemical items were safely kept in a locked cupboard.

Accident and incident reports were completed when injuries occurred to people. Copies were sent to the registered manager and maintained in people's files. We saw the registered manager completed investigations and made appropriate changes to systems, processes and people's care to prevent the recurrence of incidents. The registered manager sent us a copy of an apology letter sent to a relative after a serious injury. This showed transparency and candour when things went wrong with care.

Good

Is the service effective?

Our findings

We saw examples of effective care, such as two care workers assisting a person to transfer from wheelchair to armchair using a stand aid. This was in accordance with the person's care plan for moving. We saw that another person had a pressure relieving mattress in place. This was set according to the person's weight, and to prevent and pressure ulcers. The registered manager told us people had the right to choose whether they would like a male or female care worker to attend to their needs. People were also treated equally and made to feel comfortable wherever they were situated within the building.

The team leader told us that new care workers were shadowed during all the various shifts at the home, namely early, late, 'long day' and night shifts. Staff completed mandatory training and updates including safeguarding, moving and handling, fire safety and infection control. Some training such as moving and handling was delivered practically, with competency checks to ensure staff were able to complete the manoeuvres correctly. Training updates were taken regularly. The training matrix maintained by the registered manager demonstrated this. The registered manager said, "More face-to-face" training was being provided including some training from the local authority. They referred to training in mental capacity and deprivation of people's liberty. Training on dementia awareness and dignity was also provided.

A care worker told us that, "As soon as I started" they had completed training including first aid, safeguarding, dementia and end of life care. They added, "Tomorrow I'm going to do food hygiene." The care worker said, "I was amazed about the staff; how they helped me with training." Newly-appointed staff worked towards the Care Certificate, which is a set of fifteen standards for staff in social care. The registered manager told us that staff had achieved or were undertaking diplomas in health and social care. Eight staff were completing a diploma in end of life care with a local hospice team.

People received appropriate nutrition and hydration. One person told us she had a choice of what she ate at mealtimes. She said "They bring you a book and you are asked what you want for lunch and sweets." She explained there were usually three or four items to choose from. There was also a choice of breakfasts available. This was supported by a relative who said their mother-in-law, "Loves the food here. It's great food. He (the chef) makes fresh pies. He is excellent and has looked after my mother-in-law by giving her scampi and curries." One person said they, "Never get enough custard". Staff we observed asked people if they had enough. Another person peeled the vegetables every morning. She told us she enjoyed doing this as, "It makes me feel useful". She also added she, "Could not go in the kitchen as I could get scalded".

A person said that all her health needs were met. She had developed chest infections and staff called the GP for her, who had visited her and prescribed antibiotics. She added, "Sometimes you don't have to say anything; the staff just know when something's wrong." She said that a physiotherapist supported her once a week to stand up and was, "Trying to loosen my shoulder". She said there was a care plan which was put in place, "Before hospital." She added, "I could have input if I wanted." A range of professionals were involved in assessing, planning, implementing and evaluating people's care and treatment. Professionals such as dietitians and speech and language therapist were involved in assessing people's needs. A person had monthly podiatry appointments. We observed that district nurses provided interventions for a person's skin

integrity. A person had three visits weekly for dressings to their wound. Another person's care plan stated, "Staff to monitor and inform the district nurse or GP." We saw that GPs made regular visits to the service.

The service was refurbished to provide a comfortable and pleasant environment. The provider explained further investment would be made to update more rooms and communal areas. There was a suitable garden and outdoor areas for people to enjoy during warmer months. Inside, there was a large communal area with smaller private spaces for people who wanted a quiet spot to relax. There was access to a large-screen computer for calling relatives and a projector screen for movies.

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 so that they can 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.

Care workers showed a good understanding of the principles of consent. A care worker told us that, "I will explain to the person" and sought permission before giving personal care. The service used a mental capacity assessment tool. We also saw that best interest meetings were recorded, for example for covert administration of medicines. A care worker referred to acting in people's best interests if they were not able to make a particular decision. They said they would do, "What is best...for the residents." In a person's care plan we saw that the objective was, "To ensure that (the person) is assisted to make decisions in her best interest within her capacity." We also saw that it was important to, "Recognise that (the person's) capacity may fluctuate."

Staff told us they had completed training on the MCA. Staff we spoke with were also aware of DoLS and conditions of them. The team leader told us there were, "A couple" of DoLS authorisations in place. We saw a reference to a standard DoLS authorisation for a person in their care plan. Conditions had been applied previously by the supervisory body but the current authorisation had no conditions. We saw that a lasting power of attorney was referred to in care plans for two people and in another care plan, there was an enduring power of attorney in place for property and affairs.

A relative said there was a DoLS in place for her mother which was assessed by "social care" and has been signed. She explained she has "legal power of attorney" but has involved an independent person (an advocate) in all the paperwork that goes with it. Another relative said that twice her mother was discharged from hospital, "Worse than when she went in", so together they developed an advance directive order by recording, "She (the person) is only to go to hospital as a last resort."

Good

Is the service caring?

Our findings

We observed that people had a good relationship with the care staff. A person told us the service was, "A really good caring home" with "Plenty of privacy." They added, "They're (staff) such a good lot." A care worker told us they thought care provided was "Excellent." They told us, "I love bringing joy to the residents. The staff treat individuals perfectly." They added that, "I treat them (people) like my own family; the way I'd want to be treated." The team leader told us that staff used photographs to help people to remember "If they forget a person (staff or family member)." We observed that a person had a telephone with large, easily visible buttons in their room. This was so their independence was promoted to call people without the assistance of staff.

The registered manager introduced us to people who used the service, some of whom were having breakfast at the time. She placed her hand on the shoulders of one person as she explained why we were present and the person responded by laughing and saying, "They're (staff) all lovely." Throughout our inspection, people and visitors were pleased to meet us and wanted to tell us about their experiences of care.

Most of the people and family members we interacted with spoke highly of the staff. The most used word to describe them was "friendly". This was supported by the hairdresser who used the same phrase. One relative said, "We are more and more impressed with the home." She said that she, and her husband, felt the staff treated her mother with dignity. Another person and their relative both used the word "jolly" to describe staff and a further person said, "Carers treat you as a human being and don't snub you." A person said the staff were, "So good. They're so friendly, so nice. Nothing is too much trouble. They don't mind being asked. I didn't choose to come here but I love it." A further person said staff were, "Kind and considerate. You can come and go at any time and it's always like that." All the relatives we spoke with and most of the people said the staff were approachable and that they could speak with any of them. However, the registered manager and activities coordinator were particularly named in these sentiments.

People's independence and right to choose was respected and promoted. One person said, "I have the freedom I want and can go out." She said that she has a television in her own room and could, "Watch what I want when I want. There are no rules." Another person said that she had no complaints and, "I go to the loo by myself and am quite independent." She added, "Staff have control of my medicines." We asked her if she would like to look after them herself to which she replied, "I wouldn't like to look after my own. It's too complicated. I'm quite happy the way things are." This was supported by another person who said she did not want to look after her own medicines and were happy for staff to.

People's care was provided according to their needs. Two people who were a couple, used one of their rooms as their lounge but liked to sleep in separate bedrooms through their choice. They explained that one person moved to the service first after a serious injury, and then her husband moved in with her as he suffered a serious injury. She explained they use one of their rooms as a lounge as it has a television in it. She said, "It gives us as much privacy as possible, but it's not quite the same as being married for 60 years!" She went on to say that she was generally happy. The person said the staff were, "Very friendly. They do care because I watch how they deal with people. They are so patient."

One person appeared to have some memory loss, so we asked the care worker if she knew what her condition was. The care assistant said that the person was encouraged to walk but she sometimes said "no". Staff explained to the person that walking would promote her physical health, but staff had to transport her around the building in the wheelchair. We observed the person asking to go outside later in the day, and she started getting up when there was a mobile tray in the way and she did not have her walker. The activities coordinator clarified with the person what she wanted and supported her to stand safely while another staff member attended with the walking frame. The person was supported to walk outside and came back in after 10 minutes with a flower in her hair. She was then supported to walk around the house with her walking frame at her request. We observed obstacles being moved out of the way and the staff member waking at the pace of the person, close by her with her hand behind her back but not touching it.

One person said she had lost her "independence and freedom" and that she "relies on others coming and taking us (her) places." She said family members take her and her husband to church every Sunday which was "brilliant." The person said the rest of her family came to visit when they want. A relative said, "There are always relatives here and they can come anytime and are always welcomed." She said she was always offered tea and cake and that she could have a meal with her mother if she wanted. She said that she could, "Join in with the activities." Another relative supported this as he had joined in with the physical activities and a sing song. There was evidence of this throughout the day as relatives were seen to come in and go as they pleased and either meet with their relative in the lounge or in their bedroom. They were offered drinks and biscuits.

There were relatives' meetings every three months with the nominated individual, registered manager, team leader and the activities coordinator. Information was emailed to all relatives. We examined the minutes from the November 2017 meeting. They showed a discussion around the building refurbishment work, staff training, the Christmas party, planned activities and demonstrated a mutual conversation took place. Newsletters were also completed every month and emailed to relatives. We looked at the October 2017, December 2017, and the Christmas party newsletters. They included the religious services that were planned, activities going on, welcoming of new people and staff, birthday celebrations, training staff had done and an update on the building plans.

People's privacy and dignity was protected and promoted. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. We observed that people's doors were closed when staff were in the room to provide care. We also noted staff knocked on closed doors before they entered and announced their arrival and asked permission if a person's door was open.

Confidential information about people who used the service and staff was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record keeping. People and staff's confidential information was protected.

Good

Is the service responsive?

Our findings

One person told us, "Staff know what I like and don't like. They know they can't get me to do silly exercises that don't do anything for you." When we asked what she meant she added "wiggling your fingers." She was observed reading her paper in the lounge without interruption. Later, she was upstairs in the bedroom with her husband watching snooker. She said that her family arranged for her and her husband to have a subscription television service, as they like watching sport. The person said that she and her husband spend most of the day watching sport, so this was very important to them.

We noted the bedrooms were personalised. One person was a world champion in squash and we observed their trophies on the shelves. The person's relative said "She has as many pictures as she can have and photo albums." Some people were observed folding the laundry. One person explained this made her feel "useful." The activities coordinator later explained the person does not tend to join in with activities, so this gave her something to do. The person's relative said that her mother, "Does the laundry and loves feeling useful...this is a big issue." One relative stated that her mother used to grow things outside and had birdfeeders but was no longer able to do so. We passed this information to the care workers so that they could speak with the person and their relative about this.

We looked at the activities folder which the activities coordinator explained to us. She showed us her plans for the rest of the year. The service provided some external entertainers and day trip activities at no cost to people. A religious organisation visited every month to tell stories; there was a flier for the activity in January 2018 called "The 12 Spies". A physiotherapist visited every Friday afternoon, the hairdresser every Thursday afternoon, along with other varieties of entertainment. Outside activities include trips to the garden centre or a meal at a restaurant. Each person had a page in the folder of what they have achieved, for example a knitted sweatband with the name of the person underneath and lots of drawings and colouring.

The activities coordinator carried out the knitting activity that was planned and people were given the choice of joining in or not and their choice was respected. She arranged the chairs in circle. One person said "no" but the activities coordinator gave her some knitting and asked her to deal with a problem in the pattern. The person started knitting and continued the whole session. The activities coordinator explained she knew this person often wanted to join in and that "no" did not always mean "no". Another person was unable to knit but had been given some wool and seemed to be content pulling it through her fingers and back. Another person did not want to knit but she sat in the circle painting. The activities coordinator referred to the person as "an artist". The person was engrossed in her painting and was very much included in the group despite the activity not being the same. A person said he did not, "Always join in with the activities as I feel they are [female] orientated." His wife reminded him of the quizzes to which he said, "Yes, I enjoy the quizzes" and throwing the basketball to which he said, "Yes, I step it up a gear."

People's care documentation was individualised. There was an initial pre-admission assessment. The team leader told us there was a six-week review that included people's families. They added that care plans were reviewed monthly and as required. The family would be updated on changes. A carer told us there was "always updating" of care plans. We also saw records of care plan review meetings with family involvement.

Care plans were comprehensive and we saw evidence of monthly evaluations. We reviewed three care plans. These included care plans for breathing, eating and drinking, communication, personal cleansing and dressing, mobility, risk of pressure and special equipment and behaviour (if appropriate).

We also saw a room folder that contained daily observations for a person. We saw a record of hourly care interactions for a person. It contained information on repositioning, and food and fluid intake. We also saw records of checks of the person's pressure areas and of their pressure relieving mattress. Observations made included safety checks, mattress checks, repositioning and application of topical cream, including a body map illustrating the areas for application).

We saw examples of care plans for specific individual needs, for example a diabetes care plan. Its objective was, "To ensure that (the person's) blood sugar level is within the normal range." The person's safe blood glucose level was also recorded. Guidance included administering the person's twice daily oral medicine and providing "small, frequent feedings (and) drinks in between." The diabetes care plan included advice to report to the person in charge for any signs and symptoms of hypoglycaemia. We saw advanced decision care plans ('living wills') for two people. Another person had a care plan for "death and dying." These plans documented people's wishes including preferred place of care. The manager told us there was no one receiving end of life care at the time of our inspection. In the care plans we reviewed, we saw that "do not attempt cardiopulmonary resuscitation" orders were in place, and these were discussed with the person or relevant others.

An appropriate complaints management system was in place. There were posters and other literature that explained how to make a complaint. The registered manager was able to explain how complaints would be handled and showed us the documents they used to record concerns or complaints. We also saw examples of the communication between the service and a complainant, which ensured the reported matter was resolved amicably.

Good

Is the service well-led?

Our findings

The provider for this service changed in April 2016. This meant changes occurred when the new limited company took control. We saw that the provider expected staff to ensure that the care provided to people was of a high standard. The registered manager and nominated individual explained the new aims and objectives of the service to us, and these were also reflected in the statement of purpose (a document required by the legislation setting out key information). The registered manager was employed at the service for some time, prior to the change in provider. Before they reached the managerial position, they had engaged in their own development to gain the role. Due to their length of service, their knowledge of the service, people, staff and care was excellent. They had developed their insight over the years that they had worked at Meadowbank Residential Care Home The nominated individual could clearly explain their plans for the continued improvement of the service, which included an expansion of the number of beds.

The registered manager explained their role in managing staff performance, what they did when care was below the service's expectations and how they could drive staff improvement. Appropriate procedures were in place for investigations, staff grievances and disciplinary matters. Staff meetings were held regularly and workers were able to raise any topics for discussion. We looked at the last staff meeting minutes and saw this included the distribution of information to staff, as well as answering any questions that were raised. A staff survey was completed in February 2017 and we looked at the results. This showed 14 staff had responded and were satisfied or very satisfied with working at the service.

There was positive feedback from people and visitors about the management. One person said that the registered manager was, "Good and approachable" and that, "She seems to understand." This was supported by one of the family members who also said management were, "Making it (care) more structured, as in activities." The relative said "(The manager) goes out of her way to sort out any issues that arise." Another relative told us that her mother said she wanted to go home and that the manager had put a "plan of action in place" to deal with it. The relative explained they found this to be very supportive. One person said, "(The care home) is better run with the new owner." One relative said, "If sons and daughters are putting their parents into homes, which is a very hard decision, it helps when people like here make it easier."

There was an underlying equality policy and procedure which staff were aware of. The provider also clearly displayed this in the service and showed the principles they subscribed to. People were respected by staff regardless of their cultural, religious, or linguistic backgrounds. People's characteristics were protected by staff and the management team. The registered manager also told us the principles applied to the workforce and we observed this. Staff treated each other with respect and dignity. The chef demonstrated a good knowledge of special dietary requirements and staff knew specific end of life regimes for different cultures or religions. The service had satisfactorily assessed and implemented the principles of equality, diversity and human rights in the provision of care and the daily operations.

A number of quality audits and checks were used to gauge the safety and quality of care. These were completed according to an audit calendar set by the registered manager and provider. We saw areas that

were audited included the kitchen, laundry, maintenance and repairs, medicines, infection prevention and control, staff training and people's care documentation. The audits resulted in an action plan which was required to be completed by the registered manager. We saw any areas identified for improvement were always reviewed, and closed off with a signature of the responsible staff member and the date.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. In the corridor there was a large activity plan on the wall. It was in picture format, with the name of the activity. At the time of our inspection, knitting was planned and the hairdresser was due. Knitting had the written word and a picture of a piece of knitting and there was a picture of a hairdresser. People's bedroom doors, toilets and bathrooms had signage that was used to explain the purpose of the room. The use of pictures in communications demonstrated that people had access to the information they needed in a way they could understand it, and the service met the principles of the Accessible Information Standard.

There were times when the service was legally required to notify us of certain events which occurred. When we spoke with the registered manager, they were able to explain the circumstances under which they would send statutory notifications to us. We checked our records prior to the inspection and saw that the service had notified us of relevant events.

The service worked well with community organisations. The local authority reported that from their quality monitoring visits they had "no concerns" about the quality and safety of care. The clinical commissioning group contacted us regarding the 'hydration project' that was in place at the service. The purpose was to prevent people developing urinary tract infections and avoid unnecessary hospital admissions. This meant staff had to ensure there were at least seven drinks rounds each day, that people were frequently encouraged to take fluids, and that the consumption of drinks was appealing to people. We saw the service had a period of 244 days without a person developing an infection. The commissioning group pharmacist commended the service for their participation in the project and the outcome.