Lancashire County Council

Meadowfield House Home for Older People

Inspection report

Meadowfield,
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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Outstanding

Overall summary

This inspection took place over two days on 14 and 20 October 2014 and was unannounced for the first visit and announced on the second visit.

Meadowfield House Home for Older People is situated in Fulwood, a residential suburb of Preston. There is a good range of shops close by and the home is on a bus route into the city centre. The home comprises of three units. Two provide long term residential accommodation whilst the third is short term community beds, providing step up/step down facilities to hospital services and some respite care. A step up/step down service is one where people who may have been treated in an acute setting such as a hospital, are moved to a care home environment where further assessments take place to identify their long term needs. This helps free up beds in the acute setting. All bedrooms are single and contain a wash basin. There are lounge and dining areas in each unit and outside there is an attractive courtyard area.

Summary of findings

The home is registered with the Care Quality Commission (CQC) to accommodate a maximum of 45 people. At the time of our visit there were 44 people who lived at Meadowfield House.

There was a registered manager in place. 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.

All the people we spoke with told us they felt safe and relatives described how they felt certain their relative was looked after well. We were told by one person: "Dad has lived there for about 5 years. Yes he's quite happy and settled, feels safe and at ease". The home had policies and procedures in place to make sure any concerns about people's safety were reported appropriately and in a timely manner.

The provider had systems in place to ensure people received their medication from trained and competent staff. The registered manager checked to make sure staff were competent with administering medication. People we spoke with told us that they received their medication at the time prescribed.

We found there were enough suitably qualified staff on duty to meet people's needs. People we spoke with told us there were enough staff on duty to meet their needs, whilst one relative told us: "There could always be some more staff, but [named relative] still gets help when she needs it, so there are probably enough, and there are a few replacement (agency) staff now and again".

Staff we spoke with told us there were enough staff, although some did say that when agency staff, who had not worked at the home before were used it caused problems for them, as they had to watch them to ensure correct care was provided. The home was actively recruiting more full time staff.

We were shown training records, which confirmed staff had completed essential training for their role and to meet people's needs. Some had completed specialist training in areas such as, diabetes. Staff we spoke with confirmed they received regular training and supervision.

Policies and procedures were in place to guide staff in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA and DoLS are legal safeguards to protect the human rights of those people who may lack the capacity to make certain decisions for themselves. Staff we spoke with had a good working knowledge of this legislation and during our inspection we saw this put into practice.

Meadowfield house had systems in place to identify people who were at risk of poor nutrition and to make sure that the kitchen staff knew about people's specialist requirements. People's weight was monitored and action taken if concerns were raised. We saw that people were offered choices and where people required assistance with eating and drinking they received this support in a gentle and unhurried manner.

Peoples' on going healthcare needs were met. A number of health and social care professionals worked on site at Meadowfield House and where required referrals were made and involvement sought form GPs, dentists and other health care professionals.

People we spoke with constantly told us throughout the inspection that staff were kind, caring and compassionate towards them. We observed good interaction between staff, people who lived there and their relatives. We saw people were treated with dignity and respect.

A full and individual assessment of people needs took place which formed the basis for a person centred care plan. We saw that people and their relatives had been fully involved in this process as well as any subsequent reviews of care.

Relatives and visitors were openly encouraged and a range of activities was provided to support people to remain engaged and involved in the community.

People we spoke with knew how to make a compliant or raise concerns. We were told that complaints and concerns were dealt with in a timely manner. Records we looked at showed this to be the case.

All the people we spoke with told us the registered manager and management team were friendly, accessible and approachable. There was good informal and formal communication processes in place. We were

Summary of findings

told about meetings for residents, relatives and staff, which gave people opportunities to have their views heard. Staff told us they were happy working at Meadowfield House.

The registered manager and the management team had an ambition to constantly improve the service provided.

We found a range of audits in place to monitor and improve the quality and safety of the service. Many of these were person centred and innovative. For example regular checks on people's appearance.

There was oversight and internal inspections by the organisation and regional manager, as well as external audits by accreditation schemes.

Summary of findings

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 home was safe. All of the people we spoke with told us that they or their relative felt safe and at ease. Staff were able to tell us how they would react to and report any allegations or witnessed abuse to protect people.

People told us they received their medication safely and at the correct time. We saw policies, procedures and audits around medication were in place to protect people from errors in their medication.

The home had robust recruitment procedures and had sufficient numbers of suitably qualified staff on duty to keep people safe.

Is the service effective?

Good

The service was effective. Staff told us they received regular training, supervision and support to care for people.

Policies and procedures were in place in relation to the Mental Capacity Act 2005 (MCA). Where people needed to have some restrictions placed on them in order to receive the care they needed, the home acted in accordance with appropriate legislation to protect their human rights.

We found people were supported to receive nutrition and hydration. Peoples' on going healthcare was monitored and where required, referrals were made and advice sought from health and social care professionals.

Is the service caring?

Good

The service was caring. People told us that staff were kind and compassionate towards them and respected their views, which ensured their diversity needs or concerns were sought and addressed.

Staff we spoke with understood the importance of maintaining peoples' privacy and dignity. Staff were able to give us practical examples of how they would do this.

We observed staff spent one to one time chatting with people and that people were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive. Detailed assessments of people's needs were in place. Care planning was inclusive and person centred. People told us they had been involved and options had been discussed with them.

The home recognised peoples needs for social interaction and we saw that visitors were able to come and go as they pleased. A range of activities and trips had been arranged.

People were empowered to complain if they had any concerns about their care. The service user guide contained information for people about how to complain in an easy read format.

Summary of findings

Is the service well-led?

The service is well led. People, their relatives and staff told us the registered manager was approachable and supportive. People and staff were engaged in regular meetings and their views were encouraged.

People who used the service were protected because systems for monitoring the quality of the service were in place. We were shown details of regular audits taking place, many of which were person centred and focused on people's wellbeing.

The home had received a number of recognised awards and certificates, which identified good practice taking place. Examples were, Investors in People, Dignity in Care and The Social Care Commitment.

Outstanding 

Meadowfield House Home for Older People

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 October 2014 and was unannounced. A further visit was done on 20 October 2014 which was arranged with the provider.

The inspection team consisted of one inspector from the Care Quality Commission (CQC) 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. In this case our expert was a relatives main carer for ten years. This included contact with elderly domiciliary and residential care and NHS hospitals and rehab units.

Prior to the inspection we gathered information from our own records and notifications submitted by the provider. The provider also supplied us with a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service and how they feel they meet our five key questions of; Is the service Safe, Effective, Responsive, Caring and Well-led. Before our inspection, we reviewed this information. We contacted the commissioners of the service and two healthcare professionals to obtain their views about the care provided in the home.

We talked with people and their relatives to obtain their views on the home and the care they received. On the day of the inspection visit we spoke with 4 people from the residential units of Daisyfield and Poppyfield, and with 3 people and one spouse/carer in the community beds in the Royal Court unit. After the site visit we contacted and spoke with 4 family members whose relatives lived in the residential units at Meadowfield House for older people.

We spoke with staff, health and social care professionals who also worked at the home, the registered manager and regional manager. We observed the care provided throughout the inspection and looked at three care records for people who lived there, along with a sample of audits and surveys carried out by the service to monitor their quality of service.

Prior to the inspection we contacted commissioners from the local authority and health care teams to obtain their views on the service provided.

Is the service safe?

Our findings

The provider had effective policies and procedures for ensuring that any concerns about peoples safety were reported appropriately and in a timely manner. We were shown the safeguarding log maintained by the registered manager, which included a section to ensure a notification was sent to the Care Quality Commission (CQC) as required by regulations.

All of the people we spoke with told us they felt safe. We were told: “Its very nice here. You get to read about some things that are not, but fortunately there is nothing like that here. I feel safe and well looked after”. Whilst a relative told us: “I’m sure there is no abuse. Mum would definitely tell me. Anything like that stuff you hear about, Mum would tell me”.

All the staff we spoke with could clearly explain how they would recognise and report abuse. Staff confirmed what training they had completed, in accordance with the training records we viewed. These showed staff received regular training to make sure they stayed up to date with the process for reporting concerns. One member of staff was able to tell us how they had reported a concern, which in turn had been reported to the registered manager and appropriate external organisations.

We were made aware of one person who lived at Meadowfield House who regularly behaved in a way which challenged the service and other people. We saw from records that staff managed the situations in a positive way through regular reviews and working with relatives. One relative told us: “I’m confident there is no abuse, though I do think it’s the other way round, because of [named relative’s] behaviour”.

We received consistent feedback from people we spoke with that medication was properly dispensed. Policies and procedures were in place for the dispensing, storage and disposal of medicines. We were shown the storage facilities for medicines, which included controlled drugs. Controlled drugs are those which are controlled by law. Only trained staff administered medication. This was confirmed by talking with staff members. The registered manager confirmed that periodic medication audits took place and showed us the checks completed. This meant there was a system in place to ensure medication was ordered, administered and recorded in line with the home's policy and procedure in respect of medication administration.

We looked at the staff roster and saw that systems were in place to manage and monitor how the staffing was provided to ensure people received the agreed level of support. People who lived at the home told us that there was sufficient staff on duty to meet their needs.

We looked at recruitment records of five staff members and spoke with staff about their recruitment experiences. Many had worked at the home for sometime, but were still able to tell us about the process of recruitment. We found that all relevant checks and references had been obtained before staff were employed at Meadowfield house. This included criminal record checks with the Disclosure and barring Service (DBS) and meant the service had done everything possible to ensure that staff who worked with people who lived at Meadowfield House were safe to do so.

A call bell system was installed. Each room had a call bell whilst portable appliances were installed in the bathrooms and toilets. A large screen in the managers office indicated when a call bell had been pressed and the response time for staff to enter the persons room and the length of time they were present dealing with the situation. These figures were regularly monitored by the manager. During our inspection we witnessed several call bells responded to in under one minute. This showed that people who needed help were responded to quickly to keep them safe.

Staff we spoke with told us there was enough staff on duty to meet people’s needs. Staff and people we spoke with told us that agency staff who worked at the home on a regular basis provided care and support at a level consistent with the permanent staff. However, on occasions new agency staff did not have the same knowledge and understanding, which put additional pressure on the permanent staff who felt they had to spend valuable time making sure these staff performed their role to the level required. One relative told us: “Mum also has a preference for brown bread and they often don’t bring her this, which is a real upsetting thing for mum as she often chooses sandwiches”. This comment was made when talking about new agency staff, which demonstrated how replacement staff could lack specific knowledge about people’s needs.

Is the service safe?

We spoke with the manager about this concern. We were told the home were recruiting permanent staff. In the interim they tried to use the same agency and requested the same staff to provide some consistency. On the day of our first visit out of 11 staff on duty six were from an agency, although three of those six had worked at the home on a regular basis and knew the residents well. We were shown some application forms and interview dates for new staff. We were shown evidence that one new full time member of staff had started whilst others where waiting for the result of recruitment checks before commencing work.

Is the service effective?

Our findings

Staff received the training they needed to carry out their caring role. Staff we spoke with said the training was very good and on going throughout the year. We were told: "In fairness we seem to be having more training than ever". "There is lots of training". And: "I have done all my basic training such as safeguarding, Mental capacity and first aid. I've also done dementia training".

We were shown a new training programme had been introduced. Staff were given work books on various subjects, such as Person centred support, Health and safety and first aid, along with more specialised subjects, such as diabetes. These were handed in once completed and then sent off to the local authority training team. If the required level was reached then certificates in the various subjects were awarded. We were shown some certificates.

Staff we spoke with told us they received regular supervision and appraisals, although supervision did not always consist of one to one meetings. We spoke with the management team about this and were shown records, which indicated each member of staff throughout the year received two periods of team supervision, observation and one to one supervision. Staff told us that appropriate topics were discussed, such as their welfare and training needs. The provider had developed a 'staff support policy' covering induction, appraisals and supervisions. Support for staff included individual development, team meetings and day to day meetings. This meant staff had regular opportunities to have one to one time with their manager and opportunities to give their views about the service.

People were supported to meet their nutritional needs. Care plans we viewed showed that people's weights were recorded on a regular basis. People told us they had their weight regularly monitored. For example, one person said they had lost about 3 pounds which they understood was not a problem. Where significant changes were observed staff had taken action and referrals had been made to dieticians and where required the GP.

People were able to make choices about what they wanted to eat. We saw that there was regular communication between the care staff and kitchen staff. We saw lists in the kitchen, which showed some people's special dietary needs. We found views about the food on offer from people we spoke with reflected peoples' tastes and choices. For example, two people told us food had become more spicy and this was not to their liking. They did however say they felt they ate enough and staff offered them the other choices, and that they had enough food and drink. People told us they could have their meals in their room, which some preferred. Two people we spoke with would have preferred their main meal at lunch time as opposed to the light meal/snack provided. Both residents found the meals not to their liking, because in one case it tended to be a light snack or sandwich at lunch and a hot, somewhat over filling meal for them at tea time, which was the opposite of what they preferred.

We spoke with the manager about these comments. We were informed that people were asked on admission about their dietary preferences, but it was difficult to get the balance right all the time, as many people who lived at Meadowfield House were only there for short periods of assessment following a stay in hospital and needs were constantly changing.

We observed a meal-time and saw that on two of the units people were independent with eating and drinking. However where people required or asked for assistance staff provided help in a patient and friendly way.

We saw from training records that all staff received training on the Mental Capacity Act 2005 (MCA). The MCA give legal protection to those people who may not have the capacity to make some decisions for themselves at the time they are needed to be made. All the staff we spoke with had a good understanding of the MCA and were able to tell us how they followed the requirements of the MCA and it's code of practice.

No person at Meadowfield House lacked the capacity to make all decisions for themselves around their care and support. Two people who previously lived on a unit that cared for people with dementia now lived on one of the residential units. We saw good evidence that, where required formal capacity tests and subsequent best interest decisions had been made.

When required staff and management were able to identify when people may be deprived of their liberty through restrictions imposed on them through their care plan. We saw good evidence of this during our inspection when one person on short stay at the home with a mental health diagnosis decided that they were going to leave. For their own safety the manager immediately put one to one care

Is the service effective?

in place and issued an 'Urgent' deprivation of liberty authorisation in respect of this person and at the same time asked the local authority for a 'Standard' deprivation of liberty authorisation on this person. The Deprivation of Liberty Safeguards (DoLS) form part of the MCA and provide legal protection for the human rights of people, who may have restrictions placed on them to protect them from harm and to make sure they receive the care and support they need. The requests made by the manager would trigger this process.

People were supported to meet their healthcare needs. A range of specialist healthcare professionals employed by the NHS, such as physiotherapists worked on the community beds unit and worked alongside staff from Meadowfield House, to meet peoples' on going healthcare needs after treatment in hospital and to assess their future needs and requirements.

People on this unit and the residential units also benefitted from a Nurse prescribing practitioner, who visited patients under two GP surgeries, which covered the home. This enabled a faster response when people need medication. A nurse practitioner is a nurse who has received extra training and is able to prescribe medication as would a GP.

Records showed that people were referred to their community GP as necessary. For example, one person said they had regular access to doctors and medical staff via the home and the staff kept an eye on her for such things, as how her asthma was being monitored and treated. They also had access to various nursing services who called in, and gave us further examples. These had recently included one for a vitamin injection, another to ensure her heart condition care was maintained and a third for her flu jab.

A relative also told us: "If mum needs a doctor they always get one in right away, but I find that any problems are more with the doctors than Meadowfield. For example, they change things and just do this without warning of difficulties or even that mum prefers this or that, such as giving her soluble or non soluble pain relief then the home find the problems that this causes a few days later. And we all realise this. Mum also has access to other services like the nurses or chiropodists".

Is the service caring?

Our findings

All of the residents and relatives we spoke with told us that staff were kind and compassionate and they gave us examples including how staff helped people, spoke to them and took the time to do things, such as using the hoist or helping people to walk with a frame safety and with dignity.

Throughout our inspection people regularly told us that their views were respected and that relatives were both made welcome, but also heavily encouraged to be involved in the provision of the care for their family members and loved ones. We were told: “The staff are really nice and do their utmost to help you”. “Its not like living in your own home, but its very nice and the staff are very kind”. And: “I think it is fine. The staff are very friendly and helpful”.

A relative we spoke with told us: “The staff have always been polite and respectful to Dad and to me when I visit.”

People could describe how really good communication between staff and themselves ensured their views, diversity needs or concerns were sought and usually addressed. This led to very personalised care for people who lived at the home.

All the people who lived at Meadowfield House were able to talk to us to some degree about their care and support. Therefore, we did not use a specific tool for observation. We observed throughout the two days we were there how staff supported people. We saw that staff were considerate and kind towards people they supported and people responded positively. Staff spent one to one time chatting with people, checked that people were alright and asked if they needed anything.

People were treated with dignity and respect. Staff we spoke with understood the importance of maintaining people’s privacy and dignity. Staff gave us practical examples of how they delivered and achieved this. For example, always knocking on people’s doors before entering their room and keeping people covered up when delivering personal care. One staff member said, “We treat everyone as equally as we can”. One family member said: “The Care is excellent in here. My [relative] has been here over five years, has a clean change of clothes each day, the staff do the laundry, visiting is very flexible I come each day at times to suit me”. And: “Staff respect her choices about these things and for example she does not always want to go to the dining area to eat, so they will provide this in her own room”.

Staff described how they maintained confidentiality. They told us they were aware of the provider’s confidentiality policy. They gave us examples of how they maintained confidentiality, such as not talking about people in public areas and storing people’s personal information securely in the office. People told us that their views were respected and that relatives were made welcome.

Is the service responsive?

Our findings

We saw evidence that a detailed assessment of needs and a care planning process was used to determine what people needed, preferred and had a right to expect. In turn this was matched by evidence that the service was sought to meet the resulting aims and actions set out to assist people who lived at the home. We saw from care plans we looked at that care was based upon initial assessment and on going review.

We spoke with people about these processes. Some people could recall both a care planning process and formal reviews, whilst others could recall one or other or, some informal process which at least involved regular informal contact. One person on the residential unit told us that they had transferred to the home about a year earlier and could recall that staff checked his needs and preferences and that he had a care plan. Whilst one relative told us the home had kept them informed all the time and of the steps being taken to ensure the resident's recovery. Another said: "[Named relative] is now somewhat more withdrawn at the home than she used to be and this is also a result of her medication and the doctors have told us of this. This now means she does not join in as many things as she once did, but at least she is more settled due to the control of her anxiety.

Her personality is less outgoing now. We discuss this when we meet at care reviews and the care plan is used to check these things".

People on the residential units told us that options had been discussed with them and the home had for its part explained how they would be cared for if they moved in. One person said: I know I have a care plan as a result. I can't walk now very well and I get the care here that I need. The staff are really nice and do their utmost to help you".

Another did not recall any regular form of review but they said they were able to speak at any time with staff about things they needed. Whilst a relative told us: "Reviews could include such things as making sure the heating control is up or down and little things like this add up for mum. It's a very good service and we can work with them". Another relative told us: "Her assessments have also checked out the safest ways to assist her and staff are also generally quick to help her, if she calls them. Her room seems to be very good and her laundry is done well. The staff are very aware of the need for this as such things cause her anxiety if they are not done well".

Care planning on the short term community bed unit was different from that on the residential units. This was because people stayed on this unit for a short time and for assessment by healthcare professionals following hospital treatment or rehabilitation. Care plans we looked at showed the assessment and planning process was more condensed and designed to establish their on going needs. For example, whether they could manage at home with a care package or whether they required full time residential care. Plans were centred around achievable goals for people throughout their recovery. The nature of this type of assessment ensured that care planning was tailored to meet individual needs and were person centred.

We found that different levels of assessment or review on the short term community bed unit left some gaps in the satisfaction felt by two people, who otherwise seemed to be receiving very effective care. The two people we spoke with were confused as to what stage they were up to in the process. Both residents had been in hospital and had then transferred to the unit, but they both explained that they did not know why and what came next. One said: "I've heard a rumour that I might be going home, but nothing else". However, both people told us they had no negative experiences of the care itself.

One relative told us there was plenty of good two way communication, but due to the lack of a formal process, they had failed to discuss an issue, which later caused a problem. On further exploration of this concern we found that where there were complaints on the community beds unit this was due to a lack of explanation given to them by healthcare professionals dealing with their assessment process and not the care by staff at Meadowfield house.

We did speak with the registered manager about this and were told that whilst there was good evidence of joined up discharge planning between the different services, the manager felt the admission and on going assessment could benefit from better working together practices. This was subject to a review and on going discussion to improve peoples experiences.

Other than a security lock on the front door for people's safety the home had open access to all areas. The home

Is the service responsive?

recognised people's needs for social interaction and we were told visitors were able to come and go as they pleased. People told us they could come and go and were generally supported to safely do things they wished. One person said: "You can do your own thing here, and no one tells you what to do". Whilst a relative told us: "Staff respect her choices about these things".

We observed a range of visitors coming and going throughout out inspection. One person brought a dog in regularly for its owner to maintain contact with the pet. One person told us he liked his room and had regular visitors, which made it more like home. People regularly told us that their views were respected and that relatives were both made welcome but were also heavily encouraged to be involved in the provision of the care for their family members and loved ones.

The registered manager told us that the service tried to ensure people were able to enjoy a range of activities, which included trips out to keep them active and engaged with the community. Some people we spoke with told us there was often not much going on, though the same people did say there were some activities, which they recalled to us, notably bingo, and trips out which were popular with most people. Some relatives and residents understood that there had been a lack of staff to do more activities and this was now, according to the people we spoke with, being addressed. Some people we met were being supported to do a individual simple activity when we visited them. Others reported that they generally enjoyed their own activity including reading, the TV and music. Others mostly preferred having their visitors or going out with family.

Policies and procedures were in place to enable complaints to be dealt with quickly. People and family members we spoke with knew how to complain if they had any concerns about their care. The service user guide contained information for people about how to complain in an easy read format. We looked at the complaints log and saw that all complaints within the last year had been resolved within the required timescales to the satisfaction of the person who had complained. People we spoke with told us complaints were taken seriously and staff dealt with these to the satisfaction of the people concerned. One family member said: "I have no complaints or concerns currently, but if I did I would not hesitate to discuss with staff or the manager". Whilst another said: "We've never complained but I am able to raise concerns anyway if they arise, so get them dealt with".

Is the service well-led?

Our findings

The service had a current statement of purpose and there were clear lines of responsibility and accountability. All the staff we spoke with were knowledgeable and dedicated to providing a high standard of care and support to people who lived at the home.

There was a registered manager in place, who had registered with the Care Quality Commission (CQC) in February 2014. 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 spoke with people, staff and visiting heath and social care professionals for their thoughts on the leadership of the home. All the people we spoke with commented positively about the management and registered manager of the home and reported an informal, approachable atmosphere in which it was easy to chat or ask about things or to be helped. We observed positive interactions between the registered manager and staff. We observed the manager to be visible throughout the day.

People felt that good informal and formal communication processes were in place at the home, which helped to monitor and drive quality improvement. Relatives told us the registered manager and senior staff were always available to speak with and they found them friendly and helpful. We were told about residents meetings and of some joint team reviews that would involve residents and relatives, as well as health care professionals. We were shown several samples of minutes from such meetings.

Staff told us they were happy working at Meadowfield House and had opportunities to have their views heard. We were shown evidence of staff meetings, which had taken place and staff told us their views were listened to by the management. Staff confirmed the management also carried out spot checks on their practice in the home, which meant people who used the service were cared for by a supervised staff team.

The registered manager and the management team carried out a range of audits in order to monitor the quality and safety of the service. These included medication, staff training and supervisions, health and safety and infection control, as well as checks on the care plans of people who lived at Meadowfield House. Where audits identified shortfalls in the service, action plans were put in place and these were also monitored by the regional manager. We saw copies of completed audits during our visit. A record was also kept of notifications sent to the Care Quality Commission (CQC) as required by regulations. These linked in with our own records.

Many audits were also person centred and showed how the home valued the wellbeing of people who lived there. One particular audit we examined, introduced by the registered manager was around the personal care and well being of each resident. The manager spoke with the person concerned, and or their relative, but also checked on such things as the persons clothes to make sure they were clean, fresh and in good condition. Other checks included the person's nails, hair and skin integrity. This meant the manager had good engagement with people who lived at the home, but could monitor the quality of peoples well being at the same time.

The home was also subject to internal inspections and audits by the organisation. For instance the regional manager visited the home on a frequent basis. Information gathered during these quality monitoring visits was compiled into a report, which set out the developments of the home, as it continued to find ways to improve. Checks were also made on risk assessments, audits on care plans, training, supervision and the home's improvement plan. We noted that a recently completed audit had taken place with evidence of actions plans. The manager told us each month different topics were covered in the home. We were sent a copy of a recent report following the inspection.

The home worked in partnership with and had been successful in gaining recognition in a number of awards that identified positive caring practices taking place. These included amongst others; Skills for Care, Dignity in Care and The Social Care Commitment. These types of accreditation schemes focus on the provider's commitment to good business and excellence in people management.