Advinia Care Homes Limited

Stonedale Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 26, 27 and 29 November 2018. The first day of inspection was unannounced.

Stonedale Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection.

Stonedale Lodge is a purpose-built home comprising of six separate units, situated within a residential area of Croxteth. The service has two residential units and one nursing unit dedicated to people living with advanced dementia. There are two further units for people with general nursing needs, as well as a residential unit. The service can accommodate up to 180 people. At the time of the inspection, there were 151 people living at the home.

This is a large setting and to achieve a fair and proportionate rating for the service as a whole, we inspected all six units, then compared findings to make our judgements. This means we identified what the service did well overall, but also where there were themes of improvement needs or concerns. We also checked whether any individual examples of the care people received were particularly good or equally put the person at risk.

At this inspection we found breaches of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. These related to themes we found in different parts of the service, regarding the safety of the home's environment, as well as record keeping and auditing aspects. You can see what actions we told the provider to take at the end of the full report.

The service had no registered manager when we visited, as the previous manager had left the provider's employment prior to our inspection. A registered manager is a person who has registered with CQC 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.

In the absence of a registered manager, the two deputy managers were leading the home, together with the provider's improvement manager for the North West. We found all three demonstrated passion about the quality of people's care in the way they engaged with people, relatives and staff. Their focus was to achieve improvement by promoting a caring, dedicated culture within the service. From development plans it was clear that there was much to do in the way of improvement, but it was also clear that the team had worked hard over the last months towards making those improvements.

This was our first inspection of the service since Advinia Care Limited became its registered provider. We found that the service was still being developed under the new provider and was in a 'step-by-step' transition when we inspected, to introduce changes gradually.

We found that the personalisation of people's care varied across the service. This was both in the planning, as well as the delivery of care. Information in people's care plans was not always clear or correct. At times, information needed to be more accessible for people.

We considered that the adaptation of the service to make it dementia-friendly, as well as activities on offer to meet people's needs and provide stimulation also varied and needed improvement.

We found that recorded complaints were managed well. However, we considered that at times the service needed to develop how they listened to those who had an improvement wish, but did "not want to complain".

There was enough staff to meet people's needs and keep them safe. The service had taken measures to significantly reduce the use of temporary workers and create greater stability.

Safeguarding concerns had been recorded and investigated appropriately. Staff were aware of their responsibilities to keep people safe and had confidence that managers would address any concerns.

The provider had introduced new risk monitoring systems, including for people's falls. These were used to learn lessons from previous accidents, with an aim to protect people against reoccurrence. At times, the actions taken to respond to risk needed to be recorded more clearly.

The service overall managed people's medicines well, including complex prescriptions. We identified a few areas for improvement.

The management team had worked to improve the application of the Mental Capacity Act throughout the service, to protect people's rights regarding decision making. Overall, we found good evidence of this, but a few areas needed clarification.

Residents' and relatives' meetings were sporadic and we considered that especially at times of change these needed to take place more often, to keep people and their families involved and informed. The provider had recently carried out surveys to obtain the views of people using the service, relatives and visiting professionals.

Team meetings were also infrequent, however staff praised managers and felt well supported. Staff received induction, training and supervision to guide them in their role. However, this was not always robust and it was an area the management team were focusing on improving.
The service worked effectively with a range of other professionals to achieve good outcomes for people. This included a very good example of project working with the North West Ambulance Service.

People had enough to eat and drink. People overall thought the food was satisfactory. We considered support for people with special nutritional requirements at times needed to be clearer, but staff were knowledgeable about this.

Throughout our inspection and across the units, we observed kind, caring and patient interactions between people and staff. Many staff had been at the service for a long time and knew people well.

There was evidence that people and their relatives had been involved in the planning of their care. The service clearly advertised advocacy services for those who needed an independent person to protect their best interests.

Staff treated people with dignity and respect. We discussed with the team at times they needed to have confidence to ask external staff to also maintain people's dignity, especially in communal areas.

The service planned to provide care to people at the end of their life in a dignified and respectful way. People's own wishes needed to be documented more clearly.

Staff used the word "family" to describe Stonedale Lodge and we observed this culture of closeness. The majority of people's and relatives' comments were positive.

Managers had submitted relevant statutory notifications to CQC in line with their legal requirements.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The safety of the environment and cleanliness of the service needed to be improved to protect people more consistently.

The service generally managed people's medicines safely, with a couple of aspects needing improvement.

Safeguarding concerns were documented and investigated appropriately. The service analysed incidents and learned lessons from identified risks.

There were enough staff to meet people's needs and staff had been recruited appropriately.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The service had put a focus on improving staff's training completion, which needed significant improvement. Overall staff received regular supervision.

The service was working in partnership with a variety of health professionals to achieve good outcomes for people.

The service's application of the Mental Capacity Act overall was good, with a few areas needing review.

People had enough to eat and drink. People overall thought the food was satisfactory.

Is the service caring?

Good

The service was caring.

We observed staff treating people with kindness, patience and respect.

Many staff had been at the home for a long time and it was clear they knew people well.

People and their relatives were involved in the planning of care.

The service's staff promoted people's confidentiality.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

The personalisation of people's care across the service varied significantly. Information in people's care plans was not always clear and correct.

Activities were on offer, but these needed to be improved across the service to provide meaningful variation and stimulation for people.

Recorded complaints were managed well. However, we found that the service could at times improve the way it listened to people and their relatives.

The service planned and provided care to people at the end of their life in a dignified and respectful way. People's own wishes needed to be documented more clearly.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The quality in the care people received across the service varied greatly. The service had a variety of quality assurance processes, but their effectiveness needed to be improved.

Record keeping across the service needed to be improved, as it was not always clear, organised and robust.

Staff, residents' and relatives' meetings needed to take place more often to keep everyone involved and informed, especially during periods of significant change.

The provider's improvement manager and the service's deputy managers actively looked to strengthen the culture and quality of the service with their own clear passion.

Stonedale Lodge 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 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 26, 27 and 29 November 2018 and was unannounced.

The inspection team included two adult social care inspectors, two medicines inspectors, two specialist advisor nurses 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.

Before our inspection we reviewed information we held about the service. This included the statutory notifications sent to us by the registered provider about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the commissioners of the service to gather their views.

We used all of this information to plan how the inspection should be conducted.

We spoke with 17 people who lived at the home, as well as seven of their family and friends.

During the inspection we spoke with 20 different staff across the service, this included managers, as well as

nurses, care assistants, maintenance staff, kitchen staff, domestic staff and activities coordinators.

We looked at the care files of 16 people receiving support from the service. We sampled five staff recruitment files, two agency worker profiles, as well as staff rosters. We checked daily communications, records and charts relating to people's care, as well as medicine administration records and audits. We also looked at the service's incident and accident forms, safeguarding records, regular safety and maintenance checks, quality assurance processes, meeting minutes, as well as training and supervision information.

We walked around the service on all days of our visit and observed the delivery of care at various points during the inspection

Requires Improvement

Is the service safe?

Our findings

The safety of the service's environment needed to be improved to protect people more robustly. During our walks around the service, we found in shared bathrooms on three different units that support rails for people to hold onto were at times missing or were not secure. A person who lived at the service told us, "I have to walk all the way down here, because the bathroom near me does not have the rails to hold onto."

When we checked the service's safety certificates, we found a letter from the local fire service. This confirmed the service's fire safety was of a reasonable standard. It also stated that to sustain a good standard of fire safety, gaps and holes in the service's kitchen doors needed to be in-filled to offer better protection. We understood that this letter had been sent in 2017 before the new provider began the management of Stonedale Lodge. The service was aware of these repairs needing to be done, however they were still outstanding at the time of our visit.

During our walks around the service, we found on two units that sluice room doors had not been locked and the rooms were accessible to people, including those living with dementia. The room doors clearly stated that they must remain locked at all times. Due to the nature of items stored in sluice rooms, they may be dangerous for people to access unsupported.

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

We discussed our findings with the management team, who confirmed to us following our inspection that the necessary repairs had been made.

Aspects of the service's infection control and cleanliness needed to be improved to protect people's health. We observed strong unpleasant smells on entering different units and within corridors at different times of the day, although this was not the case on all units. Bathrooms and shower rooms people shared, including toilet seats and shower chairs, needed to be cleaner at times. When we walked around the service with the deputy managers, they agreed that the level of cleanliness needed to be improved.

We note that we observed domestic staff working throughout our visit to keep the units clean and hygienic. There were also hand sanitizing stations available at regular points across the units. We considered with managers how the service could utilise daily checks differently to identify areas in particular need of attention regarding cleanliness and to review the locations of deep cleans.

There were enough staff to meet people's needs and keep them safe. During our visit we observed staff assisting people in an unrushed way and call bells were answered in good time. Staff felt that early mornings could be very busy at times. People and their relatives thought this could be the time when staff were more rushed. A couple of relatives felt that staff at times needed to take their time more when assisting people to move safely. The provider had arranged for moving and handling trainers to observe staff at different times of the day, to offer guidance for improvement.

When shifts needed covering due to vacancies or short-notice absence, the service relied firstly on their own staff. As a last resort, staff from other services or agency workers covered shifts. The service had greatly reduced the use of agency staff, from around 485 hours per week in September 2018 to 120 hours per week at the time of our visit. The service had achieved this by incentivising their own staff in different ways, for example through additional pay, to help cover shifts with permanent, consistent staff.
Through an 'open day' held at the service and recruitment drive, the provider was making further improvements to the stability of the staffing. Recruitment procedures involved appropriate checks to ensure staff were suitable to work with people who may be vulnerable as a result of their circumstances.

We found that overall staff assessed and managed care and health risks for people appropriately. In all of the care files we checked, we found that staff had completed risk assessments for people. This included those around falls, malnutrition and weight loss or the risk of pressure sores. Risk assessments, with a couple of exceptions, had been reviewed monthly to stay up to date.

In a couple of cases, we found that information about people's risk or what had been done to reduce it needed to be recorded and communicated more clearly, to people, relatives and staff. This included information about people's seizure activities, falls prevention or responses to weight loss. This was important to provide consistent and effective information to all concerned and to keep staff up to date in such a large service. We considered this further under the question whether the service was responsive and well-led.

However, we also found examples that staff had used information from people's accidents and incidents well to manage their risks, for example of falls. We found that the analyses of falls broke down possible causes and looked at what lessons needed to be learned. The service sought input from external professionals to help with this. Senior management were made aware of all incidents at the service and these were discussed at board level. We saw in people's care plans examples of how staff were to keep people safe in a personalised way. This included encouragement to use safe footwear or how staff would observe the person to keep them safe.

We asked people if they felt safe living at Stonedale Lodge. One person told us, "You have always got somebody to go to if you are feeling unsafe. I am frightened of the dark and glad of somebody being around at night time, checking you are all right. I feel safe here." Another person said, "[I feel safe because] the staff are always looking after us. You are well looked after here."

A staff member described their responsibility to keep people living at the service safe to us by saying, "These are all my nans and granddads. Their safety is the most important thing to me."

We found that managers recorded and investigated safeguarding concerns appropriately. This included the identification and recording of a concern, referral to appropriate bodies and an internal investigation, followed by appropriate actions.

Staff we spoke with were aware of the service's safeguarding procedures and were confident to use them. A member of staff told us, "I would speak to [deputy manager] and she would deal with it. I have confidence she would address any concerns." Staff also told us they would be confident to whistle-blow to other organisations, such as the local authority or CQC, if appropriate. This was supported by the provider's whistle-blowing policy.

We found that medicines were managed safely. All medicines were stored securely and at the correct temperature, treatment rooms were visibly clean and tidy. Medicine records were clear and people received

their medicines as prescribed. Additional information was available to help staff administer medicines properly.

Care staff recorded when thickener powder was added to drinks for people with swallowing difficulties, however records for the application of creams were not always completed. We found one person's eye drops were still being administered after the 28-day expiry.

The staff completed regular medicine audits and actions were taken to address any issues found. There was evidence that learning was shared with staff when errors occurred. Staff competency checks were done regularly following national guidance.

Requires Improvement

Is the service effective?

Our findings

When we considered whether the service was effective, we found very good examples that it was. However, robust training of skills underpins an effective service. The significant gaps in staff training led to our judgement that the service's effectiveness required improvement.

Staff completion in the provider's identified mandatory courses ranged between 18% and 76%. For fairness, we recognised that some subjects, such as Safeguarding, had become due again for most staff around the dates on which we inspected. Others, such as Health and Safety, had been overdue for a couple of months.

However, we acknowledged that the provider was addressing this. The service had incentivised staff to complete their training sessions and this had led to some improvements. We found that the provider had arranged several classroom sessions for December to improve staff's learning around the Mental Capacity Act. Following our inspection, we also learned that six members of staff were being trained to become 'in-house' trainers in moving and handling, to assist staff with the day-to-day development of this. As the service was "in transition", the new provider was introducing their own courses step by step.

Staff overall received regular supervision meetings. On one of the six units the frequency of these needed to improve. However, staff we spoke with told us they felt well supported and their managers were always available to help and guide them in their role.

Staff received an induction during which they were enrolled onto the Care Certificate. This is a recognised induction standard for staff working in health and social care. Staff worked with more experienced colleagues during their induction period.

The service was working in partnership with a variety of health professionals to try and achieve good outcomes for people. We found that referrals had been made for people to support their well-being. This included referrals to dieticians, speech and language therapists, district nurses, GPs or specialist doctors, as well as mental health professionals. External professionals provided input into people's care plans.

The service had worked together with the North-West Ambulance Service on a project. This was a very good example of working together to promote good health support for people using the service. The project focussed on teaching staff to assess people's arising health needs effectively in a 'triage' style, to direct their next actions. This increased staff confidence and reduced reliance on ambulance staff if they were not needed.

We found that plans around people's nursing care needs were clear in their direction to staff. At times the recording of referrals and the monitoring of people's weights or how much people ate and drank needed to be improved. We considered this further under the question whether the service was well-led.

The service's application of the Mental Capacity Act to protect people's rights regarding decision-making overall was overall good, with a few areas needing review. The Mental Capacity Act 2005 (MCA) provides a

legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

We found that appropriate applications had been made to the local authority. Where authorisations had been granted, these were included in people's files and supported by relevant care plans. It was clear from improvement plans we saw that this had been a recent area for the service's development. We saw good examples of staff supporting people to make decisions, as well as relevant assessments and records of best interest decisions. This included decisions around restrictions, such as the use of bedrails. In a couple of files, we found information needed to be reviewed to be consistent regarding the person's capacity.

People had enough to eat and drink. People overall thought the food was satisfactory, but feedback varied. One person said, "[The food is] very good. There is something different on the menu each time for you to choose from. I have 'sugar' diabetes so I do not have sugar in tea etc. You get plenty of drinks; I have orange juice and tea." Another person said, "The food is all right, and it is enough. You have got to grin and bear it, take what they give you." We understood the provider had conducted a survey to get people's opinions on the food and make relevant changes.

Staff we spoke with were knowledgeable about people's specialist diets, but we considered that information in care plans at times could be clearer. We read in different care plans for example, "modified diet", but we discussed with managers that this could be interpreted in different ways.

We saw that the service had recently developed an overview of people's preferred and specialist diets. This was detailed and available for the kitchen staff to view. The chef told us about actions he had taken to improve fortifying the diet including increasing green vegetables and focussing on offering a variety of sweet foods. The chef and his team had undergone training about how dementia may affect people's taste.

When we walked around the home, we found that parts of the units had been adapted to make them supportive for people living with dementia. Units were decorated and furnished to provide some familiarity, such as wallpaper, pictures or ornaments. There were also 'reminiscence' areas in most units, although their use and amount of detail varied from one unit to another.

All units but one had large, clear pictorial signs on doors, to support people with identifying specific rooms. Some rooms had individualised reminiscence boxes by the door. The service had four dementia champions to assist with the further development of this. The champions were also at hand to develop staff's dementia awareness, as a course in line with the new provider's requirements was yet to be rolled out.

Good

Is the service caring?

Our findings

We observed staff treating people with kindness, patience and respect. We saw this on our walks around the service over the different days of our visit. Staff were calm and sympathetic in their approach when giving or offering support to people. They used a respectful tone of voice and language throughout.

We asked people who lived at the service if staff treated them with kindness and respect.

One person told us, "The staff are kind, yes; I have no complaints about them at all. I am happy with being called [by first name]; I feel part of things then." Another person said, "The staff are lovely and I have never met one who is not. I tell them to call me [by my first name]. They never talk about you and they always listen if you have got any problems."

A relative told us, "The staff are all very nice, and very patient with the people here."

When people were engaged in activities, we saw them laughing and chatting. We saw staff assist people to move in a calm, unrushed way.

Many staff had been at the service for a long time and they spoke warmly about people. Staff we spoke with showed that they knew people. For example, a member of staff said about a person living at the service, "That is her favourite chair and her favourite view."

When people needed emotional support or became distressed, we observed staff supporting them in a personal, yet professional way and with compassion. People's descriptions of this included, "[The staff] know when I am upset and they try to cheer me up" and "If ever I am upset [staff] always come and cheer me up. I cry a lot and I have always found them lovely."

A third person said, "The staff are alright and they will listen if I have got a problem. They treat you just ordinary – as a person."

At lunchtime, there was a pleasant and relaxed atmosphere, with chatting and joking between people who lived at the service, as well as between people and staff. We observed a sociable, pleasant atmosphere. The TV was left on a music channel, which kept some people happy and occupied, as they were singing along. Tables were prepared with flower arrangements and place mats, cold drinks in jugs and glasses. Care staff and managers attended to and served people. Food was offered verbally to each person. The activities coordinator in attendance said that people had been asked for their meal choices in the morning. This was to give a broad guide as to quantity needed, but people were free to change their minds at the point of being served.

We found evidence in care plans that people and their relatives were involved in the planning of their care and made choices about it. Not everyone we spoke to was sure about this, but people told us the service supported their choice-making. This included for example whether they preferred a male or female member

of staff to help them with personal care needs. The service advertised local advocacy services, for people who needed independent support from someone to speak up on their behalf.

When staff needed to have a conversation about people, due to arising needs, they were mindful of protecting their confidentiality and dignity. Staff spoke quietly to people when offering and giving support. Nothing private was shared in front of other people. People and relatives we spoke with confirmed that staff were mindful of people's confidentiality.

We discussed a few considerations to promote people's dignity further with the management team. This included the service needing to show confidence in asking external staff, including visiting health staff we observed, to also maintain people's respect and confidentiality, especially in communal areas. We also pointed out that while meant as part of one of the beauty salons, a tub of hairbrushes looked as if they were being shared between different people, which may affect people's dignity. The service removed this straightaway.

Requires Improvement

Is the service responsive?

Our findings

The personalisation of people's care across the service varied significantly. Information in people's care plans was not always clear and correct. We found examples of this across different units. It is important that information is recorded clearly and correctly, so it guides all readers effectively to support people consistently, based on their current needs.

We found that a person had a sensor mat in place, but this had not been recorded in the relevant care plans and risk assessment. For another person, there had been a change in their weight gain support, but this had not been updated in their care plan.

We also found that one person's communication abilities and support had not been recorded correctly. This stated the person was not able to communicate verbally, which was not the case. In this example, this could also affect how the person's diversity and understanding of information was supported.

A person and their relative told us that their call bell was not always easily available. We found that information about this was contradictory in the person's care plan. This both stated that the person was able to use the call bell independently, as well as that they were not. Staff we spoke with explained that this depended on "the day [the person is] having", but this was not clarified in the plan for all readers.

The above examples are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed that at times those staff helping out the regular team at the service did not readily engage with people they were sitting next to. We considered that the knowledgeable core staff could support them to get to know people better.

However, we also found good examples of the service's responsiveness to people's needs and preferences. Staff recorded this clearly on other units. We saw, for example, person-centred information about people's personal care routines. This noted whether they would rather have a shower or a bath, which products they liked and whether they preferred female or male staff. We also saw personalised information about people's interests and lifestyles.

We found some good examples of personalised care plans to support people to eat well and plans to support people who may present behaviours that challenge. In these, we saw how diversional techniques and staff engagement were used to lessen risks. This was good evidence of more person-specific support.

People received an initial assessment of need and managers reviewed each person's level of dependency on care on a monthly basis.

Activities were on offer, but these needed to be improved across the service to provide meaningful variation and stimulation for people. This was an area for development the provider was aware of and working on.

There were no regular trips out for residents taking place at the time of our inspection, although some people had been to the theatre recently.

A person told us, "Sometimes you get bored. It is quiet, but I suppose it is peaceful." Another said, "I like reading but I cannot do it anymore because of my eyes and you get a bit melancholy sometimes, just sitting; I feel useless. They have games now and again [at the home], like Bingo [but] I do not play. I like the films we have on TV."

We discussed with managers how tools used to assess people's mental wellbeing, once completed, could be used more effectively. We considered together how these could help more clearly to identify care approaches to support individuals in person-centred ways to feel better.

People did not always feel activities staff came to engage with them if they stayed in their rooms. However, we also heard from people that they had made friends with others living at the service and went to visit them.

The level of activity varied across the service and staff took people to other units if they wanted to join in with things taking place there. The service also had a small pub, which people from other parts of the home visited. There was a team of seven activities coordinators, who took turns to visit different units. We observed them putting up Christmas decorations with people living at the service. When we observed one of the activities lead, there was lots of joking and laughter while three residents joined in with the arts and crafts project. There was music playing, which one of the people living at the service had chosen.

A relative told us, "My [relatives] were initially provided with rooms across from one another, which is what they asked for. Now [one of the relatives] has had to move onto [another] unit [due to their needs], but the staff made sure they arranged help with visits [between my relatives], as often as possible. It means they can be together still after so many years of being married."

When service managers received complaints from people or relatives, they recorded, addressed and resolved these well. However, we found that the service could on occasion develop the way it listened to people and their relatives.

A few relatives told us they were not sure if concerns or comments they had raised with staff on the units had always been passed on. We also discussed with the management team that at times people may have wishes and needs for change, but did not want to "make a formal complaint". An example of this was the person who told us they had to walk a longer way to get to a suitable bathroom. We considered with managers that the service could utilise its skills to engage with people in a person-centred way to develop conversations about needs and changes. This could be in a natural way, as part of day-to-day care, in addition to regular surveys.

A person we spoke with said, "It is very rare I have any complaints. I suppose I would talk to one of the nurses". There were complaints procedures displayed for people and these were available in larger, accessible prints. We discussed with the management team that information, such as the daily menu, also required review. We found that on units this was handwritten or in small print and difficult to read. The service was addressing this.

The service planned and provided care to people at the end of their life in a dignified and respectful way. People's own wishes at times needed to be documented more clearly, as at times plans gave limited information about this and referred to relatives for all decision-making. We understood from our discussions

that service managers focussed on emotional support not just for people using the service, but also their loved ones. The service worked with other professionals to respond when people needed to be cared for at the end of their life. At times, the plans and resources put into place needed review as the person's needs changed.

Requires Improvement

Is the service well-led?

Our findings

The quality in the care people received across the service varied greatly. This was clear from the range of examples we saw across the units and we discussed this with managers. The passion the deputy managers and improvement manager had for developing the service was clear. The service used a variety of quality assurance processes, but these needed to be used more effectively at times to achieve a more consistent standard.

For example, care plan audits needed to be done across all of the units, to ensure a good standard. We understood that the new provider aimed to have their new formats in place by February 2019 and staff were waiting for these. However, we found that care plans we had found issues in at times had not been audited in 2018. For other care plans we found that issues had been identified and an action plan put into place. However, these were not always completed or not completed in a timely way to achieve improvement.

To support the deputy managers to maintain an oversight over the service, information needed to be recorded and kept in an easily accessible way. This was not always the case, for example with regards to referrals, repositioning charts, weight monitoring, food and fluid charts or staff supervisions. We understood managers were aware of issues, but there were not always records to back this up effectively for their review.

The organisation of information needed significant improvement. This included the deteriorating condition of care files, as well as where important information that was needed at a glance was kept, such as professional visit logs.

The service's monthly overview had identified the need for the kitchen doors to be replaced. It stated appropriate risk assessments were in place, however this had not led to timely action. We checked the repairs book on one of the units where we found issues with the bathroom rails, but these repair needs had not been recorded. We also considered that these issues were very visible and should have been identified and remedied through robust auditing.

The above examples are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, we also found good evidence of other health and safety checks being completed regularly and at times more often than expected.

There was no registered manager in post at the time of our inspection. The previous registered manager had resigned a month before our visit and left the provider's employment. The provider had recruited a new manager, who was set to start in early 2019. In the meantime, the provider's improvement manager for the North West was supporting the service on a day-to-day basis.

We recognised that the provider's improvement manager and the service's deputy managers were already

making positive changes to the quality of people's care. We found they actively looked to strengthen the culture and quality of the service with their own, clear passion. We could see from the improvement manager's overviews that they had prepared a comprehensive action plan to develop the service. It was also clear that when comparing these overviews 'month-on-month' that progress had been made. Managers were honest and transparent with us about the improvement needs and responsive to our feedback. Managers explained, and we understood, that improvements were looking towards lasting change. Their focus was on improving staff morale and culture, to help with the stability of the service, rather than making "quick fixes".

Examples of these were the use of staff recognition and incentives, to help improve training completion and create consistency, loyalty and reliability in staffing.

We found that with a view to the ongoing changes and developments, staff, residents' and relatives' meetings needed to take place more often. We considered, especially during periods of significant change, this would help to keep everyone involved and informed.

A general staff meeting had been called at the beginning of October 2018, but this had not been well attended. Very few staff meetings had been recorded and notably those that were for the same two units. We did not see records of unit staff meetings since the summer. Relatives told us they were aware of a meeting they thought had taken place since the new provider began managing Stonedale. We did not see records or minutes of relatives and relatives' meetings since dated later than 2017.

However, there were regular meetings for the heads of departments that took place every month, as well as a daily "take 10" meetings for unit and department leads to provide updates. We observed deputy managers completing unit walkarounds, during which they met with the shift leads to discuss any concerns or issues. We also found that managers had completed night visits to quality check the care people received at those times.

Although people and relatives told us about some areas for improvement during this period of change, the majority of comments from people and relatives were positive. We discussed with managers any areas of concern, for the service leads to look into and address. A comment from a relative summarised what we heard with regards to the service's aim to improve and stabilise. "Their heart is in the right place and the regular staff are very caring."

A person told us, "I think it is run well. [The staff] all seem to get the work done. I really enjoy it here." Another person said, "The staff are brilliant; I would recommend them any time."
The provider had also recently carried out a survey for people, relatives and professionals, to get their views on different aspects of the service. These had not been fully evaluated at the time of our visit, but we recognised the provider's efforts to involve stakeholders in the service's development.

Staff had access to a variety of policies to guide them in their role. These were still "in transition", as the new provider was introducing them gradually. We discussed with managers that to ensure staff awareness of all changes in policy, staff confirmation sheets would be useful to maintain oversight, once policies had been issued to units.

We looked at some of the provider's policies, including their equality and diversity policy. The provider's training plan noted this as an area of focus and improvement regarding course completion. However, the policy offered clear direction to staff regarding their responsibility for ensuring that there was no unlawful discrimination, based on people's age, disability, gender reassignment, race, religion or faith, sex, sexual

orientation, marital status or civil partnership, maternity or pregnancy. Managers explained that they provided support to people of different faiths and we discussed that there were other opportunities to celebrate and equally embrace people's diversity.

Staff at different levels and on different units talked about the service as "a family" and we observed this closeness at various points. A staff member told us, "When I come here, I do not come to work, I come to see my family."

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The service had not always ensured that premises were safe to use. Fire safety and mobility support rails were in need of replacement and repair. Doors that needed to be locked to protect people were not always secured.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes to assess, monitor and improve the quality and safety of the service had not always been operated effectively. Records about service users were not always accurate, complete and contemporaneous. Audits and quality processes had not identified or remedied issues we found during our inspection. Information in people's care plans was not always clear or correct. Charts, monitoring records and information were not always completed fully and easily accessible.