Somerset Care Limited

Stockmoor Lodge

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 and 14 March 2018. The first day of the inspection was carried out by two adult social care inspectors and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by two adult social care inspectors and was announced.

This was the first inspection since the service registered in March 2017. No concerns were identified during the registration process.

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

Stockmoor Lodge is registered to provide personal care and accommodation to up to 90 frail older people, or people living with Dementia. Accommodation is provided in a purpose built new building. The building is divided into six units for fifteen people. This meant people could still experience a homely approach to care and support enabling them to build relationships within their community.

At the time of the inspection 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.

People received care that was responsive to their needs and personalised to their wishes because regular staff knew their likes, dislikes and needs. However, there was a risk that staff who were new or did not work with the people on a regular basis would not have the information they required to be responsive to people's needs. Staff records in care plans were recorded inconsistently. We saw care plans did not contain all the information required and that some of this information was later recorded in a risk assessment. This meant there was a potential for staff not to know which area to find the information. People were able to make choices about all aspects of their day to day lives.

An activities programme was displayed within the home and people were informed of the activities available to them. However as the home occupancy had grown faster than expected the activities staff were not able to ensure all people who choose not to go to group activities would have access to other choices as they concentrated mainly on the groups. Activities staff explained that they did try to ensure one to one activities were carried out but also relied on care staff to support people on their units.

People told us they felt safe living in the home. One person said, "Yes I feel very safe", a relative told us, "[The person] is safe here I don't have to worry when I go home I know they will be alright."

There was sufficient staff to safely meet the needs of people living in the home. However there were times when personal care was being carried out requiring two staff that other people living in the home needed to wait. The registered manager said staff could be used from another unit if this occurred. There was an on-going recruitment programme and the registered manager explained how they had made arrangements with the agency they used to ensure they only had regular agency staff who knew the home and the care needs of the people living there.

There were systems and processes in place to minimise risks to people. These included a robust recruitment process and making sure staff knew how to recognise and report abuse. All staff spoken with were confident action would be taken by the registered manager and provider to address any issues they may raise. They also knew they could go to external organisations to raise any concerns.

Medicines were managed safely, securely stored, correctly recorded and only administered by on duty nurses and team leaders that were trained and assessed as competent to give medicines.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out health and safety checks within the home.

Risks to people in emergency situations were reduced because, a fire risk assessment was in place which was reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared: these detailed what room the person lived in and the support the person would require in the event of a fire.

People received effective care from staff who understood their needs. Staff were able to tell us about people's specific likes and dislikes. People told us they thought staff were well trained and understood them well. The registered manager and staff were very pro-active in arranging for people to see health care professionals according to their individual needs.

People told us staff supported them to remain as independent as possible and only acted after they had sought consent. One person told us, "It is all about me, if I say it is ok then they can go ahead."

People and relatives told us that the food was good. We reviewed the menu which showed that people were offered a variety of healthy meals. We saw that food and mealtimes were discussed and recorded at resident meetings.

All staff attended induction training before they started to work in the home. All staff said they had plenty of opportunities for training and the organisation also promoted dementia awareness training for all their staff.

People said they received care and support from caring and kind staff. Comments included, "The staff are very caring." And "They are all very nice and respectful."

People told us they could talk with staff and the registered manager if they wished to raise a concern. One person said, "The manager is about every day I can talk to them if I need to". A relative said the manager's door was always open and they could pop in for a chat if necessary.

People were supported at the end of their life to have a comfortable pain free death. Care plans showed people's advance decisions were taken into consideration and acted upon.

There were formal and informal quality assurance systems in place to monitor care and plan on-going improvements. There were audits and checks in place to monitor safety and quality of care.

The registered manager had a clear understanding of the management of the home and how to lead staff by example. They had high standards that they aspired to and progress in developing the new home could be seen. They and the provider were committed to continuously improving the service. This was apparent when they spoke about future plans for the service in the local community.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were supported by staff who had been recruited to make sure they were safe to work with vulnerable people.

There were sufficient staff to maintain people's safety and meet their needs. However when two to one care was required at times units were left short of staff to meet other people's needs.

People's medicines were safely administered by staff who had received appropriate training to carry out the task.

Is the service effective?

Good

The service was effective.

People's health and well-being was monitored by staff and advice and guidance was sought from healthcare professionals to meet specific needs.

People had access to a good diet and food was provided which met their specific needs and wishes.

People received care with their consent or in their best interests if they were unable to give full consent.

Is the service caring?

Good

The service was caring.

People were cared for by staff who were kind and patient.

People's privacy and dignity were respected and they received support in a way that respected their choices.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were able to take part in organised activities or choose to occupy their time in their preferred way. However there were not

enough activities staff to ensure all the people living in the home could attend or take part in an activity of their choice.

Care plans were not completed consistently. This meant some information was recorded in areas where they should not be and other information was not recorded at all.

People were able to make choices about their day to day lives.

People said they would be comfortable to speak with a member of staff if they had any complaints about their care or support.

Is the service well-led?

Good

The service was well led.

The registered manager promoted inclusion and encouraged an open working environment.

Staff received feedback from the management and felt recognised for their work.

Quality monitoring systems were in place which ensured the management had a good oversight of service delivery

The home was led by a management team that was approachable and respected by the people, relatives and staff.

The home was continuously working to learn, improve and measure the delivery of care to people.

Stockmoor Lodge

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 13 and 14 March 2018. The first day of the inspection was carried out by two adult social care inspectors and an expert by experience and was unannounced. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The second day was carried out by two adult social care inspectors and was announced.

This was the first inspection since the service registered in March 2017. No concerns were identified during the registration process.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the service before the inspection visit.

During this inspection we spoke with 20 people living at the home, 10 members of staff and seven visiting relatives. We also spoke with the registered manager and the regional manager. We spent time observing care practices in communal areas of the home.

We looked at a number of records relating to individual care and the running of the home. These included seven care and support plans, three staff personnel files, training and supervision records and minutes of meetings held at the home.

Good

Is the service safe?

Our findings

People received care that was safe and protected them from harm. People told us they felt safe living in Stockmoor Lodge. One person said, "I Feel safe here all of the time." another person told us, "I am safe and secure here all of the time," Another person said "My bedroom is on the ground floor, no problems from outside, I feel safe here." A relative said, "[The person] is safe here I don't have to worry when I go home I know they will be alright."

Systems were in place to identify and reduce the risks to people living in the home. People's care plans included risk assessments however some care plans lacked clear guidelines; for example one person at risk of pressure ulcers did not have a risk assessment or care plan to show how staff could manage the risk safely. We discussed this with the registered manager who said they would look at it straight away. We also looked at the care plan for another person who had been assessed as being at high risk of developing pressure ulcers. They had a risk assessment in place and there were very clear guidelines for staff to follow to keep them safe. Staff had contacted appropriate professionals to make sure they had suitable pressure relieving equipment in place.

Staff understood the support people needed to promote their independence and freedom, yet minimise the risks. We saw evidence of other risk assessments relating to, nutrition and hydration and the risk of falls. When people needed transferring there were clear guidelines about which type of sling and hoist should be used. One relative who was also a health care professional said, "They [the staff] use very good practices in the use of the hoist and wheel chair mobilisation."

The provider had systems and processes which helped to minimise risks of abuse to people. These included a robust recruitment process and ensuring staff understood how to recognise and report concerns. The staff we spoke with had completed training about how to recognise and report abuse and all were confident that anything reported within the home would be dealt with to make sure people were safe. One member of staff said, "I have every confidence in [the registered manager], I know anything mentioned would be dealt with immediately. The organisation as a whole would make sure things were done correctly."

There were sufficient numbers of staff to keep people safe and meet their needs. However some times of the day when care was being carried out staff felt they did not have sufficient staff on the units. For example, on the first day of the inspection we observed two staff members were supporting a person to bathe. When people returned from their activity one person required the toilet but there were not enough staff to take them as they were still providing the two to one care for the other person. The person was then assisted by the activities coordinator. Staff members told us they felt they usually had enough staff but there were times they would prefer, "another pair of hands." We discussed this with the registered manager who agreed they would look at specific times of day to see if the deployment of staff could be revised to support staff when they were providing care on a two to one basis.

The registered manager showed us how they calculated the numbers of staff needed to safely meet people's needs. This clearly showed how staff levels had increased as more people moved into the home or their

needs changed. The registered manager explained they had a recruitment programme in place and where recruiting new staff. They had an arrangement with the agency they used to ensure they had regular staff who knew people and could build up a relationship with them. One relative said "There does seem to be plenty of staff around, but some of the staff are from the agency and don't know [the person's] little ways." Another relative said "Staff are lovely and so many of them around the place."

People who spent time in their rooms had access to call bells which enabled them to summon assistance when they required it. People said if they rang their bell staff came quickly, meaning that people did not wait for extended periods of time when they wanted help.

People were protected against the risks of the spread of infection because all areas of the home were kept clean. There were handwashing facilities throughout the home and alcohol gel was available for staff and visitors to use. There was clear guidance in toilets on hand washing and staff had received infection control training. Staff had access to personal protective equipment such as disposable gloves and aprons which also helped to minimise risks to people.

Registered nurses were responsible for the management of medicines. We observed a registered nurse on part of a medicine round. They demonstrated an awareness of the needs and preferences of the people they administered the medicines to. When administering medicines the nurse wore a, "Do Not Disturb" tabard which meant they were free to concentrate on administering the medicines safely.

We saw systems were in place to ensure people's medicines were managed consistently and safely by staff. Medicines, including controlled drugs were obtained, stored, administered and disposed of appropriately. Controlled drugs are medicines which have special requirements about storage and recording. The registered nurses checked the use of medicines that the GP needed to review. Where people had been prescribed medicines on an 'as required' basis, such as pain relief, plans were in place for pain management, including the use of pain scales to identify the severity of pain in people who could not verbally communicate. People told us they received their medicines on time and when they requested if in pain. One person said, "I get my medication when I need it." Another person said, "I have my tablets in the morning and they never keep me waiting."

Medicine competency records of individual staff who were responsible for administration of medicines were thorough and detailed. The provider recorded when staff last had a competency assessment on their training matrix and this meant people could be confident staff who administered medicines were competent and up to date in their practice.

To ensure the environment for people was kept safe specialist contractors were commissioned to carry out fire, gas, water and electrical safety checks. There were risk assessments in place relating to health and safety and fire safety.

Risks to people in emergency situations were reduced because, a fire risk assessment was in place and arrangements had been made for this to be reviewed annually. Personal emergency evacuation plans (PEEP's) had been prepared: these detailed what room the person lived in and the support the person would require in the event of a fire.

There was a system in place to record any accidents or incidents that occurred. These would be reported directly to the registered manager so appropriate action could be taken. The time and place of any accident/incident was analysed to establish any trends or patterns and monitor if changes to practice needed to be made.

Good

Is the service effective?

Our findings

People received care and support from staff who had the skills and knowledge to meet their needs. People said they felt all the staff were well trained and knew their needs well. One person said, "They know what they are doing." Another person who was receiving oxygen said, "I trust everyone here, they know what they doing."

New staff received an induction including information relating to the Care Certificate and shadowing more experienced staff. The Care Certificate was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The certificate is a modular induction and training process designed to ensure staff are suitably trained to provide a high standard of care and support. Staff confirmed they had spent time in induction training and shadowing other staff before working unsupervised. During the inspection we observed mentors marking a Care Certificate work book and providing feedback to a junior colleague. We also observed training information displayed within the staff room and on other locations around the home.

Staff received the training they required to safely fulfil their roles and effectively support people. The provider had a training matrix which showed when staff had completed training and when up dates were required. This helped to make sure people received care and support from staff who had up to date skills and knowledge to meet their needs. The provider also supported registered nurses to maintain their registration through continued personal development.

Staff told us they had received enough support from the registered manager to meet people's care needs. The registered manager completed an annual appraisal for each member of staff to discuss their performance, training needs and where improvements were required. They also completed one to one supervision meetings on a more regular basis as well as regular team meetings when wider issues could be discussed. For example, we saw evidence of discussions around how people consented to care, and how staff encouraged people to remain independent whilst supporting them with their care needs.

People were complimentary about the food served. Comments included; "The food is good," "Not bad." One person said, "The food is not bad but too much of it." Another person said, "The food fluctuates, last week the portion size was a bit small, but now it's okay, the food tastes nice and looks nice." Whilst another person said "The food is always lovely, you always get plenty to eat." A relative told us, "The food looks good, and tastes good I have eaten here in the past."

We observed mealtimes in the home and saw people were supported with respect and dignity. Staff sat with people when they supported them to eat and explained what the meal was and when they were helping them. The dining room tables were laid with a table cloth, cruet sets and cutlery. We saw one person was offered a clothes protector, whilst all of the people were provided with a linen napkin. The people were offered a choice of food earlier in the day to assist the catering staff with the proportions served. Vegetables were served to each table in a serving dish to enable people to be independent and help themselves; the other parts of the meal were served by the staff from a hot trolley. Fruit juices, squash, wine and beer was

offered during the meal and a hot drink was made available after everybody had eaten.

People had their nutritional needs assessed and were supported to have a good diet. Staff sought appropriate advice regarding people's food and fluid needs and put recommendations into practice. For example: one visitor explained how their relative required a dairy free diet. They told us the chef had spoken to the person and had arranged a suitable diet to meet their needs. The registered manager also explained how they supported another person who required a gluten free diet. Staff told us they were aware of people's dietary needs. One staff member spoke about how they could access information to support dietary needs required by people's religious beliefs. We saw people also had access to decaffeinated drinks if they wanted them.

Staff worked with other professionals to make sure people received the care and treatment they needed. A registered nurse was always on duty with care staff to ensure people's nursing needs were monitored and met. Care plans evidenced that people's health and well-being was monitored and the staff sought advice and guidance where necessary. People told us they had good access to healthcare professionals according to their individual needs. One person told us, "I see the physiotherapist twice a week I am doing okay." A relative said "[Person's name] is seeing the consultant at the hospital." Another relative said, "[person's name] is seeing the dentist, the nurses arranged this after talking to the doctor." Care records showed people had access to a range of professionals to promote their health and well-being such as GPs, nurses, opticians and dieticians.

People only received care and support with their consent or in their best interests if they were unable to give consent. We heard staff asking people if they wished to be helped and staff respected their decisions. Care plans we looked at showed people's ability to make specific decisions had been assessed. Records showed how the staff had tried to involve people as far as possible in decision making. People told us they felt they maintained control over their care, one person said, "My choices are always me." Another person said, "I am asked if I agree to everything in my care plan." Whilst another person said "My choice, no means no." One relative said, "I have not been asked to comment on the care plan but [the person] has full capacity, they can say what they do or do not want."

Staff had received training about the Mental Capacity Act 2005 (MCA). The 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.

Staff spoken with were aware of the need to assess people's capacity to make specific decisions. Where appropriate they had involved family and professional representatives to ensure decisions made were in people's best interests. Care plans contained assessments of people's capacity to make certain decisions and where necessary, a best interest meeting was held with appropriate people involved in their care and decision making. One relative explained how they had been involved in a discussion about the Acoustic monitoring system the service used to monitor people at night. They said they had had a "frank" discussion with the staff and had agreed the use of the system to safeguard their relative at night.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS applications had been made when necessary and the registered manager had followed up decisions with the local authority. When a DoLS application was accepted the registered manager completed the

necessary notification to CQC.

All areas of the home were well lit and there was signage to enable people to find their way around. Toilet and bathroom doors were clearly labelled to enable people to find the right rooms. The use of different colours in toilets enabled people to maintain their independence. This showed the service considered current guidelines when providing an environment that could enable people living with dementia to maintain more independence leading to a more fulfilled life.

Good

Is the service caring?

Our findings

People were cared for by kind and caring staff. Throughout the day we saw staff spoke to people respectfully and showed kindness and patience when supporting them. Staff supported people to move around the home, they did not rush people and offered encouragement and reassurance where appropriate.

During the inspection many positive comments were made regarding the attitude of the care staff from both people using the service and their relatives. One person told us, "Nothing is too much problem for them [the staff]." Another person said, "The staff are kind, caring and very nice," Whilst a third person told us, "The care staff are kind and considerate nothing is too much trouble," One visiting relative told us, "Staff are lovely in so many ways." Another relative said "Everything is good here from the bottom right up to the top, everyone is so caring and kind to both residents and visitors."

The regular staff team knew people well and treated them as individuals. Some people preferred to remain in their rooms to watch TV or read a book/magazine. Staff respected their preferences and we saw staff checking they were safe and comfortable throughout the day.

The registered manager was in the process of building up a strong staff team at Stockmoor Lodge. The use of regular agency staff and the original staff team from the old service, some of whom had worked for the service for some years, enabled people to build relationships and friendships with staff and other people who lived at the home. Staff knew people well and throughout the day we heard friendly chatter between people and staff.

People's privacy and dignity were respected and their independence was promoted where possible. One person told us how kind staff were when they helped them with personal care. They said, "They [the staff] are really good they always make sure the door is shut and they make me feel comfortable when they are helping me to wash and get dressed." We observed staff knocked on doors and asked if it was "Ok," to enter the room.

People were able to choose who supported them with personal care. One person said they had chosen to have a female member of staff to help them with their personal care and this was always respected. Care plans also reflected people's preference for care worker.

Each person who lived at the home had a single room which they were able to personalise according to their tastes and preferences. Some people had bought their own furniture with them which made their rooms very homely. People were able to see personal and professional visitors in their personal rooms or in communal areas.

People told us they felt involved in decisions about the care they received. One person told us, "I have only been here a short while but they went through everything with me." They added, "Nothing was rushed they wanted me to feel at home here." A relative explained "[Person's name] has capacity to make decisions on the care, but also has poor short term memory so I have been asked to review the care plan." Another

relative said "[Person's name] lacks capacity I have been involved in the review of the care plan." We observed one person received a visit from the community physiotherapist. They were totally involved in the discussion about their care and the plans for future rehabilitation.

People's cultural and religious beliefs were respected. One person liked to attend church regularly. The registered manager had arranged for the person to go to church when they wanted to. As they had moved further away from their regular church the person had said they would attend the services held in the home. However when they wanted to attend church a taxi was arranged for them. The registered manager had formed links with the local church and they were in the process of setting up Alpha sessions in the home. "Alpha is a series of interactive sessions that freely explore the basics of the Christian faith". One person told us they were looking forward to the Alpha sessions starting. The registered manager was also aware of how they could access community links for people with other religious or cultural needs.

Requires Improvement

Is the service responsive?

Our findings

Staff were responsive to people's needs and wishes. They had a very clear understanding of people's needs and how to meet them. However care plans were not always used consistently to ensure information and guidance to meet people's needs was readily available. For example, we found for one person with specific healthcare needs some basic information was not recorded in the actual care plan. We had to look through the entire electronic care planning system used by the organisation to find the information required. We found that all this information had been recorded in a risk assessment. The risk assessment contained plenty of information and actually read more like a care plan. This meant staff using the system would not know where the information was stored without looking through everything.

We also found that one person requiring information on how to prevent pressure ulcers developing did not have a risk assessment or guidance for staff to follow. Whilst another care plan said there was an action plan we were unable to find it. Another example was for one person whose care plan said they had, "No difficulty communicating." When we spoke with this person they did have difficulty communicating and found it difficult to hold a conversation. This showed the person's care plan had not been updated to reflect recent changes in their needs. Another person's care plan clearly said, "Does not drink alcohol." In their eating and drink care plan it stated, "I like to have a pint when I go out…" Again this gave staff contradictory information to work with.

Looking through the care plan system it was hard to see trends or appointments. For example for one person who experienced urinary tract infections [UTI's] it was difficult to identify when they had last had a UTI. For another person it was difficult to see when and how often the podiatrist had visited them. Whilst most staff knew people well there were new staff and agency staff who weren't as familiar with people's need. This meant there was a potential risk people would not receive the care and support they needed consistently.

Before people moved to the home they were visited by a member of the management team to assess and discuss their needs, preferences and aspirations. This helped to determine whether the home was able to meet people's needs and expectations. People and their representatives were encouraged to visit the home before making a decision to move there.

Some people were able to tell us they had been asked about their wishes when they first came to live at the home. One person said, "They [the staff] were very thorough. We discussed what I needed and what I liked and didn't like. No concerns from that approach for me. The cook also visited me to talk about the food I like and don't like. Very good service I thought." A relative said, "We were both involved from start to finish."

People could be confident that at the end of their lives they would be treated with compassion and any discomfort would be effectively managed. People were supported to make choices about the care they received at the end of their life. The staff worked closely with local healthcare professionals to ensure people's comfort and dignity at the end of their lives was maintained. The registered manager explained that they were in the processes of being re-accredited for the Gold Standard Framework (GSF) and they

continued to work to the principles and guidelines. The GSF is a comprehensive quality assurance system which enables care homes to provide quality care to people nearing the end of their lives. Care plans contained information about the care the person would, and would not, like to receive at the end of their lives, including under what circumstances they wished to be admitted to hospital and whether they should be resuscitated. The registered manager and community nursing staff ensured appropriate medicines were available to people nearing the end of their life to manage their pain and promote their dignity.

We saw there was a plan for activities in the home and people were encouraged to attend. However the numbers of people living in the home had increased and activities staff were sometimes unable to get round to seeing everybody who choose not to attend the planned activity events. Activities took place in the activities room and in each unit. This meant that some people could not attend as activities staff sometimes relied on care staff to bring the person to the activities room. On the first day of the inspection we observed a local choir visit, people were escorted to the activities room for the choir session however they were not involved in the choice of music. A lot of people attended on the day and the room became overcrowded and hot. We discussed this with the registered manager who agreed care staff had tried to show the inspection team that activities did take place. We discussed with the registered manager the number of staff available to ensure everyone in the home had access to activities. They explained the activities provision was constantly under review to accommodate people's interests and the number of people wishing to take part.

The activities plan for the week was displayed around the home and made available to people in their rooms. Regular events included a toddler group which people said they really enjoyed. A carer and baby group, a visit from the local school and seasonally appropriate activities. The registered manager explained how they were planning a Royal Wedding Party and they were looking at themed days. The registered manager had built up strong relationships with the local community and was looking at other ways of involving the home in the local community. For example one idea put forward was to use an area of the home as a polling station on election days, however they were still looking at the logistics around ensuring security for people living in the home.

During the morning of the first day of the inspection we overheard two gentlemen discuss the Cheltenham races. Later that day we saw staff had arranged it so they could sit together in front of a large screen TV. We saw they were enjoying the races and discussing who they might bet on.

The housekeeper also leads on the activities provided within the home. They organise garden club supporting people to grow flowers and vegetables. The maintenance person had also introduced a men's club, although this was just getting organised.

Some people we spoke with said they preferred not to attend organised activities but liked to occupy their own time. The activities organiser explained how they planned to find ways of introducing people to more activities without them feeling they had to attend.

The home had a complaints procedure which was prominently displayed and was routinely given to people when they moved in. We looked at the complaints procedure and found it was written in large print so people with a visual impairment would be able to access the policy.

People and visitors said they would be comfortable to make a complaint if they were unhappy with any aspect of their care. Most people said they would speak to the registered manager or the deputy. One person said, "You see the manager around every day. If I had anything to complain about I would talk to her." Another person said, "My personal choices are always met, I only do what I want to do. If I needed to complain about anything I know they would be listened to." A relative told us, "I can't fault this place."

Another relative said "You can raise anything and they will give you time to explain how you feel." However one relative said they had raised concerns but did not feel they had been addressed.

We discussed with the staff how they promoted communication and information sharing in line with the Accessible Information Standard. The Accessible Information Standard aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. Staff told us they used a variety of ways to communicate information depending on the person. We observed staff described the meal available for one person with sight difficulties. Another person was shown the different options. A staff member explained they had pictures but they felt seeing and being able to smell the options was a better way of offering people choice at mealtimes. Other information could also be provided in either; easy read versions, large print or verbally recorded. At the time of the inspection everybody's first language was English, however translations of documents could be obtained for people whose first language was not English.

Good

Is the service well-led?

Our findings

People benefitted from a service that was well led. The registered manager had a clear understanding of the management of the home and how to lead staff by example. They had high standards that they aspired to and progress in developing the new home could be seen. They and the provider were committed to continuously improving the service. This was apparent when they spoke about future plans for the service in the local community.

There was a registered manager in post. 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.

People told us they felt the home was well led. One person told us, "The manager leads the home well; they come around to see me." Another person said, "The manager is always around, you can speak to them at any time." A relative told us, "The manager has an open door policy; you can just pop in for a chat." Another relative said, "The manager is very approachable they will sort any issues out straight away."

The systems in place were being used effectively to identify and drive improvements in the home. Issues raised had been managed through training for staff and team managers. For example staff attitudes had been discussed within the management team. Training and support for managers had been put in place so they felt more able to support staff. Regular engagement was introduced with staff so they felt they could discuss how they felt with the management team about changes in place. This meant they felt more inclusive in decisions being made about the running of the new home. When issues had been raised about medication management, all senior staff were booked in for training and booklets were issued to staff to identify areas where there was a lack of knowledge. This also lead to joint working with specialist nurses in end of life care and medication and the specialist Parkinson's nurse. This meant that people were supported by staff with up to date information. However this information was not always consistently recorded in the care planning system. The registered manager agreed to look at ways of ensuring information was recorded in a consistent place so all staff could access it easily.

The registered manager had recorded actions taken as, "You said, We did." We saw outcomes for issues that had been raised clearly displayed on a noticeboard. For example, people had said they did not get ice cream often enough. The registered manager looked into this and as a consequence fridges were provided in the units furthest from the kitchen. This meant people could have the choice of ice cream at mealtimes. Another example stated, kitchen staff said their hours did not meet the needs of their role. They tried a revised working time for three weeks and all kitchen staff agreed it had improved the service they were able to deliver.

There were effective quality assurance systems operated by the registered manager and the provider. These included regular audits, themed conversations with people and telephone surveys.

They completed audits of topics including medicine administration, night care and care plan reviews. In addition, they completed weekly and daily checks, such as reviewing nutrition, hydration and re-positioning charts, and ensured medical equipment was fully functioning.

We saw that where shortfalls in the service had been identified action had been taken to improve practice. For example, the registered manager was ensuring they used regular agency staff. This meant people no longer received care from staff that they did not know or did not know their care needs. The registered manager had also identified some shortfalls with the care planning system and had raised this with staff. This meant people were supported by a service that learnt from their mistakes and continuously worked to improve.

The registered manager also worked closely with other healthcare organisations. For example following a safeguarding issue the registered manager and provider had introduced further training in meeting the nutritional needs of people using the service. This lead to staff having the correct information to support people at risk of malnutrition.

The registered manager told us about how they were building relationships with the community. The area the new home was in was also was a new build area with a school and local surgery. The registered manager had formed links with a local choir, the toddler group the school and church. They were looking at other ways of including the community in the daily activities of the home. A recent tea and cakes event had been well attended and people said they had enjoyed it.

The registered manager and provider promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. A copy of the homes policy and procedure for the Duty of Candour was available for people, staff and visitors to read. This demonstrated the organisations approach to being open and transparent.

The registered manager and provider had looked at innovative ways to improve the experience for people living in Stockmoor Lodge. They had introduced an Acoustic monitoring system. This enabled people who had consented to its use to have an undisturbed night's sleep. Staff could monitor them without entering the bedroom several times through the night. They had also looked at up to date technology and the use of Skype, computers and Ipads to improve people's access to information and maintaining contact with family and friends. The registered manager told us how the home had recently adopted a non-uniform approach for care staff. This was in line with current best practice guidelines for working with people living with dementia. They said the initiative had been very well supported and although some relatives and professionals had had reservations about how they would identify staff they now said it promoted a more homely feel. At the time of the inspection the qualified staff were also moving towards a non -uniform approach in the home.

Following a management meeting the home had agreed to sign up as Antibiotic Guardians. Antibiotic Guardian is a campaign led by Public Health England (PHE), which urges members of the public and healthcare professionals to take action in helping to slow antibiotic resistance through over use. The registered manager said this had been well accepted by their GP surgery.

The registered manager and provider listened to the views of people and staff. There were regular meetings with people living in the home and relatives so they could have a say in the day to day running and any improvements they identified. For example at one meeting we saw people had discussed the acoustic monitoring system and how it benefitted people. They had also had a presentation from a Dementia Friend.

Dementia Friends is a programme run by the Alzheimer's Society to "change people's perception of Dementia." The registered manager said relatives had liked the presentation as it helped them understand their loved one. The registered manager also explained how they had involved people in the recruitment process for new staff. They explained they had asked people for their opinions and had taken on-board their thoughts and observations. People had also been asked to contribute to questions asked at interviews if they were unable to attend personally.

Staff confirmed that a system of one to one supervision meant they could discuss training needs and any issues regarding the care and support they provided or the running of the home. This also gave the registered manager the opportunity to share best practice training and guidelines with staff either on a personal basis or in group supervision.

All accidents and incidents which occurred in the home were recorded and analysed and action taken to learn from them. This demonstrated the home had a culture of continuous improvement in the quality of care provided.

The management team attended local provider groups which enabled them to keep up to date with local initiatives and share good practice with their own staff and other providers. The management team also kept their skills and knowledge up to date, though research and training, and through manager meetings within the organisation when they could share what went well and what they did about things that did not go so well.

The registered provider ensured the home was run in line with current legislation and good practice guidelines. There were up to date policies that were available to all staff to make sure they had the information they required to provide safe and effective care.

The provider had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities.