Care Quality Commission

Bupa Care Homes (CFHCare) Limited

Stonedale Lodge Residential and Nursing Home

Inspection report

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Croxteth
Liverpool
Merseyside
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Date of inspection visit:
03 February 2016
04 February 2016
05 February 2016

Date of publication:
16 March 2016

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

Situated in the Croxteth area of Liverpool, Stonedale Lodge Residential and Nursing Home offers personal and nursing care for one hundred and eighty people. The provider is BUPA Care Homes (CFC Care) Ltd. Accommodation is provided on six units, each with 30 beds. Dalton and Anderton units provide personal care for people living with dementia, Clifton unit provides nursing care for people living with dementia, Blundell and Townley provide general nursing care and Sherburne unit provides general personal care.

This unannounced inspection of Stonedale Lodge Residential and Nursing Home took place over three days from 3 – 5 February 2016. At the time of our inspection 117 people were living in the home.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the previous inspection 9-12 June 2015 the provider was found to be inadequate and the service was placed in 'special measures' by CQC. We found breaches of regulations in all key questions we inspect (safe, effective, caring responsive and well led).

The purpose of 'special measures' is to:

Ensure that providers found to be providing inadequate care significantly improve.

Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in 'special measures' are inspected within six months of the publication of the inspection report.

At this inspection we found improvements had been made. This meant the service was no longer rated inadequate and could be removed from 'special measures' by the Care Quality Commission (CQC).

Following the inspection in June 2015 we also issued an urgent statutory notice requiring the provider not to admit any further people to Stonedale Lodge Residential and Nursing Home. In light of the improvements we found at the February 2016 inspection we have now lifted this statutory notice which prevented people being admitted to the service.

The breaches of regulations we identified in June 2015 were now met. We have revised the rating for the home following our inspection though the service cannot be rated as 'good'. To improve the rating to 'good' would require a longer term track record of consistent good practice.

Following the last inspection staffing numbers were found to be adequate so that people were supported safely; thus promoting better consistency of care and improving staff morale Our observations and feedback from people who were living at the home and relatives indicated people were now supported by sufficient numbers of staff to provide safe care and support in accordance with individual need.

The staff we spoke with were aware of what constituted abuse and how to report an alleged incident. The registered manager demonstrated they were keen to liaise and work with the local authority safeguarding team and agreed protocols had been followed in terms of reporting and ensuring any lessons had been learnt and effective action had been taken.

We found that the home was operating in accordance with the principles of the Mental Capacity Act 2005 (MCA). Although care practices were consistent and this indicated staff were generally following good practice we found some hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used.

We made a recommendation in the report regarding this.

Staff involved people in discussions about their care and encouraged them to make decisions.

We observed staff gaining people's consent before supporting them with care and daily tasks. People's consent, or relatives if required, was not always documented in the care files we saw to evidence their inclusion. This had been picked up in recent managerial audit and the registered manager discussed ways this would be implemented.

People living at the home were protected against the risks associated with the safe management of medicines. Staff received medicine training and their competencies were checked to ensure they were able to administer medicines safely.

Recruitment procedures were robust so that staff were suitable to work with vulnerable people.

Arrangements were in place for checking the environment to ensure it was safe. A series of health and safety audits were completed on a regular basis.

On the inspection we visited all of the units in the home and found them to be clean. Staff were seen to adhere to basic infection control practice when attending to people and serving meals.

Staff told us they were supported through induction, regular on-going training, supervision and appraisal. A training plan was in place to support staff learning. Staff clearly knew their roles and what was expected of them. Formal qualifications in care were on-going for the staff along with more specific clinical training for senior and nursing staff.

People's nutritional needs were monitored by the staff. Menus were available and people's dietary requirements and preferences were taken into account. We received mainly positive feedback about the quality and choice of meals from people we spoke with.

Our observations showed good adherence to ensuring people's rights were respected and people were cared for in polite and dignified way. Dignity champions were appointed on the units to oversee these standards and implement 'best practice'.

Health checks were undertaken on a regular basis and staff were vigilant in monitoring people's general health. People were able to see external health care professionals to help monitor and maintain their health and welfare. Risks to people's safety were also recorded and measures were in place to keep people safe.

The staff interacted well with people and demonstrated a good knowledge of people's individual care, their needs, choices and preferences. During the course of our visit we saw that staff were caring towards people and they treated people with compassion, warmth and respect.

A process was in place for managing complaints and the home's complaints procedure so that people had access to this information.

Staff were aware of the whistle blowing policy and they told us they would use it if required. Staff said they were able to speak with the registered manager if they had a concern.

Arrangements were in place to seek the opinions of people and their relatives, so they could provide feedback about the home. This was carried out by satisfaction surveys, day to day contact and formal meetings.

Staff told us the overall management of the home had improved greatly since the last inspection. Staff told us they felt supported and that the culture of the home was now open and positive and this was due to the staff working as a strong team under the leadership of the registered manager.

Systems, processes and audits were in place to assure the service provision and drive forward improvements. The registered manager and management team had expanded these to capture a full picture of the home and to meet the challenges the service faced in 'moving forward'. It was evident that the introduction of these more robust measures had helped to promote effective and safe standards of care and improve staff morale. We found the overall leadership to have greatly improved under the new registered manager.

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 safe.

On this inspection the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have revised the rating from 'inadequate' to 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' however would require a longer term track record of consistent good practice.

People we spoke and relatives told us they thought the home was safe.

There were sufficient numbers of staff on duty to help ensure people were cared for in a safe manner.

Staff recruitment procedures were robust to ensure staff were suitable to work with vulnerable people.

People living at the home were protected against the risks associated with the use and management of medicines.

Staff were aware of what constituted abuse and told us they would report an alleged incident.

Risk assessments were in place to support people and to protect them from unnecessary harm.

Standards for monitoring the control of infection were in place. We found the home to be clean at the time of the inspection.

Is the service effective?

Requires Improvement

The service was effective.

On this inspection the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have not revised the rating from 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' would require a longer term track record of consistent good practice. We have also

made a recommendation around the MCA and therefore the rating cannot be 'good'.

Staff followed the principles of the Mental Capacity Act (2005) for people who lacked capacity to make their own decisions. Staff were generally following good practice around this though there were some hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used.

People had access to external health care professionals to monitor their health and wellbeing.

People's health care needs were monitored effectively to ensure their care needs were met.

People's nutritional needs were monitored by the staff. Menus were available and people's dietary requirements and preferences were taken into account.

Staff told us they were supported through induction, regular on-going training, supervision and appraisal.

Is the service caring?

Good

The service was caring.

We have revised this rating from 'requires improvement' to 'good' based on the improvements made.

We observed good interactions between staff and people they supported. Staff support was given in a respectful and caring manner.

Staff demonstrated a good knowledge of people's individual care, their needs, choices and preferences. This helped to ensure people's comfort and wellbeing.

People and relatives we spoke with told us the staff consulted them about their care and decisions around daily living.

People's dignity was observed to be promoted in a number of ways during the inspection. Dignity champions were appointed to monitor standards of privacy and respect afforded to people living in the home.

Is the service responsive?

Requires Improvement

The service was responsive.

On this inspection the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have revised the rating from 'inadequate' to 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' however would require a longer term track record of consistent good practice.

Staff we spoke with had a good understanding of people's needs and how people wished to be supported.

We saw care was personalised, taking into account how people wished to be supported to meet their individual needs.

Care documentation was updated to reflect any change in care or treatment to ensure accuracy of the information held.

A process was in place for managing complaints. People told us they would speak with the registered manager and/or unit managers if they had a concern.

Arrangements were in place to seek the opinions of people and their relatives, so they could share their views and provide feedback about the home.

Is the service well-led?

Requires Improvement

The service was well led.

On this inspection the changes being made evidenced the service was actively addressing the concerns we found at the last inspection. We have revised the rating from 'inadequate' to 'requires improvement' for this key question based on improvements made. To improve the rating to 'good' however would require a longer term track record of consistent good practice.

The home had a registered manager in post. We received positive feedback from the staff, people who lived at the home, relatives and health professionals about the leadership and overall management of the service following the appointment of a new registered manager.

Quality assurance systems and audits were in place to monitor performance and to drive continuous improvement.

The culture of the home was open and transparent and staff told us staff morale had improved.

Staff were aware of the home's whistle blowing policy and said they would not hesitate to use it.

Care Quality Commission

Stonedale Lodge Residential and Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This unannounced inspection took place from 3 – 5 February 2016. The inspection team consisted of two adult social care inspectors, a pharmacist inspector, a specialist advisor in older people/ dementia care and a pharmacist specialist advisor. A specialist advisor is a person who has experience and expertise in health and social care.

Before our inspection we reviewed the information we held about the home. We looked at the notifications the CQC had received about the service and we contacted the commissioners of the service to obtain their views.

During the inspection we visited all six of the units (houses) that make up Stonedale Lodge Residential and Nursing Home. These included three units supporting people living with dementia. Some of the people living at in these houses had difficultly expressing themselves verbally. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We were able to speak with fourteen people in total who were living on the units in the home. We spoke with seven visiting family members.

As part of the inspection we also spoke with three health professionals who were able to give some feedback about the service. We liaised and spoke with a local safeguarding team who had been involved with the

service over the last six months.

We spoke with members of the management team (registered manager, area manager, quality assurance manager, clinical services manager, clinical care manager and training manager), 30 staff (including care staff, trained nurses and unit managers) and ancillary staff (head chef, 'hostesses', laundry assistants, housekeepers and activities co-ordinators/hobby therapists and maintenance person).

We looked at the care records for 19 people who lived at the home, two staff personnel files, medicine charts and other records relevant to the quality monitoring of the service. We undertook general observations, looked round the home, including some people's bedrooms, bathrooms, the communal rooms and external grounds.

Requires Improvement

Is the service safe?

Our findings

We inspected the home in June 2015 and a number of breaches of regulation were identified that led to the key question, 'Is the service safe?' being rated as 'Inadequate'. This comprehensive inspection took into account the action the provider had taken to address the breaches in regulations.

In June 2015 the following breaches were identified:

People were not protected against the risks associated with the management of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. There were not enough staff on duty at all times to help ensure people were cared for in a safe manner. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found the home had made a number of improvements including daily audit checks of the Medication Administration Record Sheets (MARS) and regular medication audits. The audits were concise and had clear action plans and there were clear signs of on-going improvement. We found there were sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the care needs of people living at the home. The requirements had been met.

At this inspection we checked the medicines and records for 27 people across the six units. We found the majority of people's records had photographs and their allergies had been recorded. This reduces the risk of medicines being given to the wrong person or to someone with an allergy, and is in line with current guidance.

We checked the quantities and stocks of medicines for several service users on all six units, and found the stock balances to be correct, with the exception of one. The medicines were stored in a dedicated clean and tidy medicines room that was air conditioned to keep the medicines at the correct temperature. The home had a clear ordering and checking process to ensure the correct medicine was being delivered into the home. The levels of stock were not excessive and were well maintained.

At the previous inspection food supplements were not always given as prescribed. We looked at three people who were on food and fluid balance charts. All three people had their weights checked regularly, and the dietician was actively involved with their care. We looked at one person's record who had been discharged from hospital, which had conflicting information on what medicines the person should have been taking. The home had already identified the issue and had contacted the hospital to obtain clarification.

Unit managers told us the registered manager had introduced ring fenced time for administering morning medication and that during this time phones were managed by reception/admin staff to avoid interruptions. They told us this was a really good initiative and avoided medication rounds being rushed and minimised risk of any errors. Phone calls were put through to the units in the event of an emergency.

Medicine champions were appointed on the units and they worked closely with the unit managers to oversee the safe management of medicines. This included the completion of medicine audits and overseeing medicine training for staff and checking staff competency to ensure their medicine practice was safe.

We spoke with people living at the home and their visitors. We received positive comments to the effect that staffing was consistent and people's care needs were being met. A relative commented, ''As far as I'm concerned there is always enough staff around. (Family member) is very settled and is relaxed here so we know she's being well cared for.'' A person living at the home commented, ''Its smashing. (Staff) are great – they are here soon as I press the bell.'' All of the people we spoke with echoed these comments. We asked people who lived at the home if they felt safely cared for with the numbers of staff available. People's response was positive regarding this.

We spent time in the lounge and dining area on all of the units. We saw staff constantly present to support people. We saw people receiving support to mobilise (for example) and staff were not hurried and took their time to ensure people's safety and wellbeing. We made detailed observations on Clifton Unit which admitted people living with dementia. We saw that people had very changeable and challenging care needs; they were well supported by staff. This included good support from a 'hostess' who assisted with people's dietary needs and an activities coordinator who visited the unit up to three times weekly.

We visited all of the six units in the home. We saw there each unit had a unit manager to monitor and manage staffing on a daily basis. The unit managers received support from the registered manager, a quality manager and a clinical care and clinical service manager.

We saw that a management assessment tool was in use to help ensure staffing numbers were sufficient to meet people's care needs. We spoke with staff on each unit who told us that things had improved and staffing was more consistent. Staff told us they worked well as a team and felt better supported by the management team who were now more 'visible' and visited the units daily. For example one staff member said, ''There's definitely been a change for the better. Nursing staff are more settled and (registered manager) is very approachable and takes action to sort things out.'' Another staff member commented, ''There's more structure and leadership. (Registered manager) is over all the time and knows what's going on. Staff morale is much better.''

Some staff expressed some misgivings regarding the future of the staffing arrangements once the home admitted more people. A staff member told us, ''It's OK now but we worry about the future. If we admit a lot of (people) we might not get more staff.'' We spoke about this with the registered manager who said there would be a planned admission process in the future (once able to admit) and this would be at a pace that suited the over needs of people living at the home and staff. Prior to the inspection we had concerns raised about a lack of staff on Clifton Unit. We looked at duty rotas for all six units in the home and saw that staffing numbers had been consistently maintained. Unit managers told us they have 'protected time' for admin/reviewing care-plans and for supervision with staff. Some training dates were highlighted on the duty rota to allow planning to cover for staff training.

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at two staff files and asked the manager for copies of appropriate applications, references and necessary checks that had been carried out. We saw these checks had been made so that staff employed were 'fit' to work with vulnerable people. We looked at the recruitment policy and discussed what processes would be employed if a potential staff member was an ex offender. The manager explained how any risks would be assessed and was able to show us an example involving a

thorough local assessment by the registered manager as well as a review by a senior Human Resource (HR) manager to authorise any decisions made.

We found staff were able to assess and manage risks so that people could be as independent as possible. People we spoke with who lived and visited the home told us that safety was not an issue. One person said, "I can ring the bell and I know staff will come quickly." Another person said, "I feel safe here and I can always talk to the staff." We spoke with relatives and visitors to the home. A visitor said, "My (relative) has been in hospital and other care homes before here. I had concerns with all of them but I am more than happy with care here. The manager and staff organised everything so well. I can go home now and know (relative) is safe.''

The care files we looked at showed how risks to people's safety were assessed and how this information was used to record a plan of care. Risks assessments identified possible risks and the level of support required to help protect people from unnecessary hazards, thus ensuring people's safety and promoting independence where possible. We saw this in areas such as, falls, nutrition, mobility and pressure relief.

We saw a good example of staff managing risks to help maintaining a person's safety and independence on all units. On Clifton Unit we observed a person to be restless and agitated at times and wanting to 'get out for a walk'. We saw staff take time to organise this which helped to relaxed and deescalate any agitation.

At the time of our inspection the registered manager advised us there were no people living in the home with a pressure ulcer. Risk management included checks of people's skin and care records evidenced any deterioration or concerns about people's pressure areas that would require more in depth monitoring.

Incidents that affected people's safety were documented and audited (checked) to identify trends, patterns or themes. Any actions or recommendations made had been taken in a timely manner to reduce the risk of re-occurrence and help ensure people's on-going safety and wellbeing.

The staff we spoke with clearly described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. Training records confirmed staff had undertaken safeguarding training. All of the staff we spoke with were clear about the need to report through any concerns they had. We saw there was a clear line of accountability regarding the reporting of any allegations.

There had been a number of safeguarding incidents that had occurred since the last inspection. We were told by the local authority safeguarding team that there had been effective reporting of these by the home and there had been appropriate liaison with professionals regarding any investigations. The registered manager demonstrated they were keen to liaise and work with the local authority safeguarding team and agreed protocols had been followed in terms of reporting and ensuring any lessons had been learnt and effective action had been taken.

Arrangements were in place for checking the environment to ensure it was safe. For example, a series of health and safety audits were completed on a regular basis where obvious hazards were identified. We met with the maintenance manager for the home, who showed us well maintained and clear records outlining the continual assessment and monitoring of the environment of the home. There were clear lines of reporting to the registered manager and also health and safety managers higher up the organisation.

We checked some specific maintenance and safety records. A detailed fire risk assessment had been carried out and updated at intervals. Personal evacuation plans (PEEP's) were available for the people resident in

the home and clearly displayed on each unit. These were updated regularly. We spot checked other safety certificates for electrical safety, gas safety, fire, legionella, maintenance of equipment, risk of scalding from hot water temperatures and infection control. These were up to date evidencing good monitoring and safety in the home.

On the inspection we visited all of the units in the home and found them to be clean. Staff were seen to adhere to basic infection control practice when attending to people and serving meals. We saw there were hand wash facilities available in all bathrooms and toilets including liquid soap and paper towels for use. We spoke with some of the housekeepers who were able to tell us about what to do in case of an infectious outbreak. A relative told us the home was clean.

Housekeepers were present on all units seven days a week. We saw up to date daily cleaning records which were completed once bedrooms and bathrooms, for example were cleaned. The management team completed infection control audits, as part of monitoring safe standards in control of infection.

Requires Improvement

Is the service effective?

Our findings

We inspected the home in June 2015 and a breach of regulation was identified that led to the key question, 'Is the service effective?' being rated as 'Requires Improvement'.

This comprehensive inspection took into account the action the provider had taken to address the breaches in regulation. In June 2015 the following breach was identified:

People's health care needs were not consistently monitored effectively which potentially placed people at risk of poor care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found improvements had been made and this breach was now met. People's health care needs were now being monitored effectively and planned to meet their individual needs. The requirements had been met.

We looked in detail at the care received by some of the people living Stonedale Lodge Residential and Nursing Home. We found the review and carrying out of people's health care needs was now consistent and effective. Health checks were undertaken on a regular basis and staff were vigilant in monitoring people's general health. Previous failings had been mainly on one unit. We found this unit more settled with staff who knew people's health care needs and liaised effectively with external professionals who were providing also providing support.

We spoke with visiting health care professionals who told us things had improved from our previous inspection. One professional said, ''There has been a palpable improvement. The managers are in better touch with the units and link in well. (People) are much better monitored and the nurses follow things up.''

There was clearly a 'joined up' approach to care between the units and the registered manager with evidence in the registered manager's office of care planning and monitoring. The registered manager showed us an anonymised clinical monitoring board which was updated at least weekly and daily if required. This had a number of key indicators regarding people's health care. This meant the registered manager was aware of statistics around wound care, modified diets, people receiving input from district nurses and medication issues. They were therefore able to monitor these more effectively.

We found good examples on all of the units of care being carried out effectively for people needing support with their health care needs. For example, we found food diaries were in place for people who had lost weight or were at risk of becoming nutritionally compromised. Fluid diaries were also maintained if required. These were unto date for the people we reviewed although we commented to the registered manager that some had not been signed off by the nurse in charge on a daily basis which was the home's policy. The registered manager said they would reinforce this. Some people were weighed weekly and others monthly in line with their individual circumstances / risks.

The incidence of wound care in the home was low. We did, however, review one person who had a minor wound and found this was being well monitored and reviewed. There were notes to say the visiting community matron was involved and supported decisions around wound care.

A number of people were nursed in bed due to their frailty and condition. People had equipment in place such as, pressure relieving mattresses and specialist nursing beds to help protect their skin and ensure their comfort. People appeared comfortable and settled. Staff attended to people's needs in a timely manner and staff completed daily notes regarding the care provision in accordance with people's plan of care.

We saw that there was a clear referral criterion to the community matron and on all units good liaison with community health professionals. For example, on Townley Unit we reviewed two people's care and saw input from health care professionals and there were regular reviews of care for a person with a chest condition and, on Clifton Unit, for people living with dementia. Another example was on Blundell where we saw good liaison with health professionals around supporting a person with their nutrition.

The community matron visited the home on a regular (almost daily) basis and liaised with staff with respect to people health care needs. There were entries in care files to evidence regular reviews and input by other health care professional such as, the GP, district nurses, swallowing and language therapy team (SALT) and dieticians. On one of the units a GP was visiting to assess a person and the community matron was seen on all of the units over the inspection. Staff requested a visit from the community matron for one person who they were concerned about. This request was actioned promptly by the staff to ensure the person received the support needed.

People living at the home and visitors we spoke with said that staff liaised well with health care professionals who acted to support people. One person said, "The staff are great. They really keep an eye on me. The doctor is coming today to see me as I've been not well.'' Feedback from relatives was also good and they told us they thought the standard of health care support was consistent and of a good standard.

We looked at the training and support in place for staff. The training manager told us about the induction programme for new staff. This was covered over an initial four to five day programme covering subjects such as; role of the care worker, equality and diversity, dementia awareness, medicines, and health and safety issues. New staff had support from a 'buddy', a more experience member of the staff team, during the induction period. Staff we spoke with said they had attended induction and that it prepared them for their role. Extra training was included for nursing staff and senior carers, as part of their extended role.

The training manager told us about the staff training and how this was implemented over the units. We saw a copy of the staff training matrix which identified and plotted training for staff in 'mandatory' subjects such as, health and safety, medication, safeguarding, infection control and fire awareness. Staff received dementia training and dementia coaches were appointed; they had specific dementia training that they had been able to share with other staff.

Staff told us they had regular support sessions with their line managers such as, supervision sessions and staff meetings. We found these were not consistent on all units however. For example, on one unit we spoke with the unit manager who was fairly new to the post. They told us that staff supervisions were a priority that needed to be addressed and they were making this an aim over the coming months. Unit managers told us they now had better protected time for their management role. The registered manager told us 77% of staff were up to date with their formal supervision at this time.

The registered manager told us that some staff had a qualification in care such as QCF (Qualifications and

Certificates Framework) and this was confirmed by records we saw where 45% of staff had a qualification. The registered manager acknowledged this figure had not improved since our last inspection but there would be a drive to get more staff trained with a formal qualification. Staff spoken with said they felt supported by the training provided.

We looked to see if the service was working within the legal framework of the Mental Capacity Act (2005) [MCA]. 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.

We saw examples where people had been supported and included to make key decisions regarding their care. Where people had lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. We saw this followed good practice in line with the MCA Code of Practice. For example on one unit we saw a well-documented and thought out decision for a person who required regular antibiotic therapy to treat a recurring and persistent medical condition. We spoke with the relative who told us, ''It's taken two years of on-going discussion at other care homes regarding this issue. Here it has been sorted out very quickly and the staff have been really supportive in this. They have formulated and plan with the GP and myself involved; excellent really.''

We had some discussion with staff on Clifton Unit, which specialises in nursing people with dementia, re their understanding of the MCA. We found the unit manager had a good understanding of the principals concerned. We were shown some assessment around individual decisions regarding admission to the home and involvement in the care planning which were now standard for all people admitted.

Although care practices were consistent and indicated staff were generally following good practice we found some hesitancy around fully understanding the use of the 'two stage mental capacity assessment' and when this should be used. For example we saw the standard assessment to assess capacity also included an outcome of 'variable'. This was confusing as, for one person we saw, the test clearly indicated they did not have capacity to decide on involvement in the care plan (at that time) but the outcome was judge as 'variable'. In this case the unit manager told us the person's mental state fluctuated. In this case the indication was for another, separate, test of the person's mental capacity at a later date.

The form also included a section called 'capacity decisions over care planning process' and this covered sections on all the activities of daily living in the care plan. This was completed for one person we reviewed but again, was confusing as the 'evidence' section did not contain any evidence of the two stage mental capacity test having been carried out for these 'decisions'. In other, more specific examples, where a mental capacity test would have been evidence of good practice – for example the use of bedrails which can be interpreted as a restrictive practice – we did not find any evidence of consent or individual mental capacity test for this decision. We discussed these findings with the quality assurance manager and the registered manager who said they would take on board our comments and review this.

We would recommend the current assessments around mental capacity are better evidenced regarding specific decisions and follow the guidance in the Mental Capacity Act Code of Practice.

Staff were able to talk about aspects of the workings of the MCA and discuss other examples of its use and how someone is deprived of their liberty. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application

procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The MCA DoLS requires providers to submit applications to a 'Supervisory Body' for authority to do so. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We found that related assessments and decisions had been properly taken and where authorisations had been authorised the provider was complying with the conditions applied to the authorisation.

We found the registered manager and senior staff had been trained and prepared in understanding the requirements of the MCA in general and (where relevant) in the specific requirements of the DoLS.

We looked at decisions which had been made regarding DNACPR (do not attempt cardio pulmonary resuscitation). These are decisions initiated by medical staff [GP in this instance]. The two DNACPR forms we reviewed had not been fully completed and did not display any evidence of whether the person involved had been consulted or whether they had capacity to make the decision . The unit manager said they would address this with visiting GP's to help ensure DNACPR forms followed clear and best practice. We did see that both had a 'future decision' form completed as part of a 'best interest' discussion with a family member by nursing staff. This included notes on the mental capacity of the person at that time and their inability to be involved in the decision.

We observed the lunch time meal on five units. The main meal was served at tea time with a lighter meal at lunch time. We saw people being served drinks and snacks during the day. There was a choice of cold drinks, tea and coffee and smoothies (fresh fruit drinks).

Dining room tables were attractively laid for lunch and if people were not able to sit at the table or if they preferred to have a tray then this was provided. Meals were served on time and the portion size was appropriate. Staff provided assistance with meals in accordance with people's individual need. This support was given in a discreet and patient manner; staff had time to socialise with people over lunch and people appeared to enjoy their meal.

We discussed with staff and the people living at the home if they enjoyed the food and if meal times were organised. We recorded mixed opinions but generally people told us the meals were good, well presented and served on time. People's comments included, "Food not always good but we do have choices. If I don't want the main meal, I can have sandwiches as an alternative", "I like the meals, the choice is fine and we get plenty to eat."

The menu was displayed for people to see and this showed people were offered a choice of hot and cold meals during the day. Pictorial menus were also available to help people choose. We saw a BUPA principal menu file in the main kitchen with evidence of suggested meals/menu choices. People were consulted about the menu choices in advance and regional favourite meals were prepared. Snack 'night bite' boxes were kept on the units.

A 'hostess' was available on the nursing units to provide extra support with meals. The 'hostess' along with staff were spoke with were knowledgeable regarding peoples' preferred foods and dietary requirements. This included the use of thickening agents and fortified drinks which people had prescribed. A breakfast club had been introduced on one unit where staff came in earlier on shift. This was to support people who liked to have their breakfast early.

People's dietary requirements, preferences and choices were recorded in their plan of care and staff also had access to information cards about the quantities of thickening agents to be applied to drinks. Records

of these were also kept in the main kitchen so that the catering staff were aware of people's nutritional requirements.

Aids and adaptations were available to promote a dementia friendly environment. For example, well lit areas, signs at eye level for key areas such as, toilets and bathrooms, plenty of seating areas and avoidance of reflective floors.

Good

Is the service caring?

Our findings

We inspected the home in June 2015 and noted at this inspection that on two units staff used some inappropriate language when talking about people. For example, using the term 'done' when referring to having supported a person with personal care. At this inspection we found staff language was respectful; this was confirmed by our observations, people living at the home and relatives we spoke with.

People we spoke with who lived at the home told us the staff were polite, caring and kind and were happy living in the home. One person said, "All the staff are very kind and I only have to ask and help is on its way. They do listen to me." Another person reported they felt well looked after and had their dignity respected as staff knocked on their door and sometimes got asked his views regarding the home. They said visitors were able to visit when they wanted and they had choice regarding where to spend time during the day. A person told said, (staff member) is very helpful and explains things if you are not sure". Relatives told us they had confidence in the staff and that they were both caring and committed to care.

A number of staff had been appointed the role of dignity champion to help monitor standards of respect, privacy and adherence to people's rights. People's dignity was observed to be promoted in a number of ways. For instance, staff were observed to knock on bedroom doors seeking permission before entering, personal care was provided with the bedroom door closed, people's preferred term of address was respected and visits by health care professionals were carried out in private. This we observed when a person required medical treatment.

Our observations showed positive engagement between staff and the people they supported. The staff interacted well and demonstrated a good knowledge of people's individual care, their needs, choices and preferences. When supporting people staff were patient and compassionate in their approach, providing plenty of reassurance and ensuring people's comfort before leaving them to assist someone else.

Staff involved people in discussions about their care and encouraged them to make decisions. Throughout the inspection we observed staff taking time to explain to people what they were doing and making sure people happy for them to proceed.

Staff were able to answer queries relating to people's care and support. For instance, staff were aware of people who had suffered a recent fall or needed support with meals. They told us the current staffing levels had enabled them to 'really get to know the people they looked after'. A staff member told us, "We work in their (people's) home; we try and do everything for them (people)."

Staff advised us of the key worker role. This role assisted staff to get to know people well, acting as a co-ordinator for clothing, and completing daily checks of bedrooms to ensure they were kept clean and tidy. Some concerns came to light when talking to staff about the management of the laundry and that at times clothing was mislaid The staff told us they felt the home would benefit from having a member of staff dedicated to taking clothing to individuals rooms to make sure all appropriately placed and minimise things getting lost. We spoke with the registered manager about the laundry and they advised they would look into

this.

There were a number of friends and relatives visiting during the inspection and there were no restrictions on visiting times, encouraging relationships to be maintained. It was evident the staff knew families well and visitors were warmly welcomed. A relative told us they were always made welcome by the staff.

For people who had no family or friends to represent them contact details for a local advocacy service were available. People could access this service if they wished to do so with or without staff support.

Requires Improvement

Is the service responsive?

Our findings

We inspected the home in June 2015 and a breach of regulation was identified that led to the key question, 'Is the service responsive?' being rated as 'Inadequate'.

This comprehensive inspection took into account the action the provider had taken to address the breaches in regulation. In June 2015 the following breach was identified:

We found some people's care planning had not changed as their needs had changed. People's care was not planned with respect to people's individual care needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found improvements had been made and this breach was now met. People's care needs were recorded in a plan of care that described what staff needed to do to make sure people received personalised care. The requirement had been met.

We looked at how people were involved with their care planning and saw some evidence that people's plan of care had been discussed with them and/or their relative though this varied on the units though this was not always evidenced in the care files we saw. The registered manager said they were looking at different ways of evidencing this as this had been picked up on a recent audit.

People told us the staff always talked with them about their care and that they were advised of any changes. Staff told us they made sure people's views were listened to and respected when making decisions about their care and involvement in day to day tasks. We saw an example of this for a person who had made their own key decisions about their diet. Relatives told us they were included in their family's care.

Our observations showed staff had a good knowledge about people's care needs and they responded promptly when people needed assistance. We saw this in practice, for example staff support with personal care, meals, and transfer with the use of a hoist.

We looked at the care records for 19 people who lived at the home. We found that care plans were individualised as they recorded people's preferences, choices and reflected their current care and associated risks. We saw this in many areas. For example, people who were at risk of falls, who needed support with eating and drinking, presented with behaviours that might challenge or to be living with dementia. The care plans we saw were well developed and gave detailed information for the staff regarding the care provision including how people wished to be supported. These were related to people's current care needs and used to help monitor their health and wellbeing. Staff were aware of the importance of these and told us how they would report any change in a person's condition.

Care plans viewed included details of a person's life history. People's preferences were reflected throughout the care files seen in areas such as, preferred gender of carer, where to spend the day, social activities, who is important to the person, type of preferred bedding, daily routine of when to get up and retire at night,

night time support (bedroom light on or off), choice of meals and drinks. We saw people's preferences were respected. For instance, some people did not wish to sit at a dining room table at lunch time. This wish was respected and they were provided with a tray for their meal.

Staff completed daily records and these gave an over view of the care and also any change in a person's condition or change to their treatment plan. Staff told us they received a handover of people's care needs.

The care files contained a 'my day, my life, my portrait' which gave a summary of people's care and health and wellbeing. This was to provide an over view of a person's care should they need hospital admission.

We asked about social activities for people and how people spent their day. An activities coordinator was present on the units during our inspection and the registered manager informed us three activity sessions a week were arranged for each unit. We noted good interaction between the activities coordinators and people taking part in the social events. This included singing, arts and crafts, cake icing and reminiscence sessions. Time was also spent with people on a one to one basis. Staff said they would benefit from more dementia friendly equipment to assist with meaningful activities though they knew the registered manager was addressing this. A person who lived at the home said, "Always plenty to do, love karaoke and it's usually on a few times per week."

Staff told us they spent time getting to know people and to find out their interests. For one person we saw a social activity was based around aspects of their past employment and staff told us how much the person engaged through these sessions.

The provider maintained a record of compliments, concerns and complaints. Any issues raised had been dealt with in accordance with the home's complaints procedure. We looked at a staffing complaint which had been raised with us and saw the actions taken by the registered manager. Staff told us they know who to report any concerns and mishaps to and that they felt comfortable to do so.

The complaints procedure was displayed for people to refer to should they need this information. A relative told us they could go to the manager of the unit where there family member was accommodated or to the registered manager if they had a problem and it would be dealt with immediately.

Arrangements for feedback about the service included satisfaction surveys for people who lived at the home.

Requires Improvement

Is the service well-led?

Our findings

We inspected the home in June 2015 and a number of breaches of regulation were identified that led to the key question, 'Is the service well led?' being rated as 'Inadequate'. This comprehensive inspection took into account the action the provider had taken to address the breaches in regulation. The provider sent us a service improvement plan and further updated plans were sent to us to help evidence the improvements being made.

In June 2015 the following breach was identified:

Systems to get feedback from people so that the service could be developed with respect to their needs and wishes needed developing to provide feedback more effectively. There were areas of care management that needed to be improved and these had not always been identified by existing audits and systems in the home. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found improvements had been made in the way the home operated and was managed. More effective feedback was now sought from people who lived at the home and their relatives regarding how the service was operating. This requirement had been met.

A new registered manager was appointed for the service following the inspection in June 2015. The registered manager has held previous management positions with the organisation. A relative told us they had ''100% trust'' in the registered manager.

Quality assurance systems and processes, including the completion of audits had been developed and implemented. These were now more robust to help assure the delivery of a safe effective and well managed service. We found the breaches in respect of care, staffing, medicines and management of the home had been met.

We reviewed some of the current quality assurance systems in place to monitor performance and to drive continuous improvement. The registered manager was able to evidence a series of quality assurance processes and audits carried out internally and externally from visiting senior members within the organisation. The systems, processes and audits had been expanded to capture a full picture of the home and to meet the challenges the service faced in 'moving forward'. It was evident that the introduction of these more robust measures had helped to promote effective and safe standards of care and improve staff morale. Staff had a good knowledge of the current auditing systems and how these fed into the overall analysis of how the home was operating. A staff member said, "The audits are key to moving forward and the results are shared with all the staff." We saw boards on the units which provided recent audit scores for infection control and medicines.

We saw a number of audits and clinical risk reviews in areas such as, care needs and associated risks, infection control, medicines, nutrition/weight loss, wound care, medicines and falls. Findings from the audits and clinical risk reviews were discussed at clinical risk meetings with the heads of each unit; we saw

any required actions were completed within 24 hours. These findings were fed into a more formal review which was completed by the quality manager. This review had four key themes- 'quality of care, quality of life, quality of leadership and management and quality of the environment'. The latest review was signed off in January 2016 with a score of 83% and included monitoring of wound management, nutrition, medication, GP reviews, bedrails, DoL referrals, care reviews, accidents and incidents, infection control, resident involvement, complaints/concerns, environment and resident involvement. The registered manager told us the review helped them to focus on areas of improvement, for example, more resident involvement around care planning which they will be addressing.

The registered manager had introduced a clinical indicator board. This provided an anonymised over view of people's clinical care and dependencies based on the audits and staff's professional judgement. Staff told us this was valuable tool which provided an accurate over view of people's current health and wellbeing, thus providing a valuable an aid to ensuring people received safe, effective care based around individual need.

In November 2015 people who lived at the service were given the opportunity to complete satisfaction surveys in the home; 60 were given out and 23 returned. The surveys covered areas such as, food, staff support, bedroom, communal space, housekeeping and changes to improve resident life at the home. The feedback was positive and any suggestions, for example, menu changes, had been taken on board by the registered manager to improve people's meal experience. The registered manager told us relative surveys would be sent out later this year.

Resident/relative meetings were taking place on the units and minutes seen showed a range of topics discussed including how the home was now operating.

Through their day to day management the registered manager undertakes a morning 'walk round' on the units to meet with the staff, visiting health professionals and people living at the home. This we observed during our inspection and confirmed through staff discussions. The registered manager told us the visual checks were an important part of monitoring standards and improving the service provision. We saw an example of where these checks had been carried out to help assure the meal experience. This resulted in two sittings over lunch so that staff had the time to assist people with their meals without being rushed.

Staff told us the overall management of the home had improved greatly. They told us they were feeling more positive with the introduction of a new home manager who they said 'has turned the home around', they were aware of the work to be done and the importance of good practice and maintaining standards on a long term basis.

They told us they felt supported and that the culture of the home was now open and positive and that this was due to the staff working as a team under the leadership of the registered manager. Staff said the registered manager provided excellent support along with other members of the management team. Their comments included, "Very good manager, things are so much better now", "(Registered manager) works so hard and is always available to chat to and along with the unit managers", "Everyone works as a team", "The home is 100% better", "Really proud to work here" and (Registered manager) is brilliant, turned the home round". Staff told us the registered manager arranged a 'weekly drop in' sessions for staff to speak with them in private.

Staff knew their roles and what was expected of them and staff interviewed told us how the registered manager was keen to develop their professional expertise and knowledge base through on-going training and development. Staff meetings were held to share information about the service and for staff to raise any

issues. Staff told us these were arranged on a regular basis and we saw minutes of meetings held. A member of the management team told us about the weekly heads of department meeting and their views were sought as to 'how things were' and to look at how the service was operating.

Staff were aware of the whistle blowing policy and they told us they would use it if required. Staff said they were able to speak with the registered manager if they had a concern.

External monitoring included an environmental health inspection in August 2015. The home scored four stars based on how hygienic and well-managed food preparation areas were on the premises (the highest score being five). Recommendations within the report had been actioned in a timely manner. In 2015 a local community health team visited the home to report on infection control. We looked at one report from October 2015 and saw a score of 94% was awarded for one unit.

An infection control lead was appointed in the home to monitor standards of cleanliness. Cleaning rotas and infection control audits were completed however that registered manager told us future plans for the home include the implementation of a more in depth cleanliness audit which has recently been successfully piloted on one unit.

We talked with the registered manager regarding the on-going development of the service. They told us about some quality improvement initiatives and new approaches. This included extending 'hostess' hours on one of the units, starting up a residents' committee, sending out relative satisfaction surveys, identifying staff champions for falls and dementia and delivering more bespoke training for staff including a formal qualification in end of life care. This showed the registered manager's commitment to drive forward improvement so as to provide high quality care and improve people's experience of living in a care home.

The manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the home in accordance with our statutory notifications. This included the DoLS authorisations which we had not been notified of at the last inspection.

From April 2015 it is a legal requirement for all services who have been awarded a rating to display this. The rating from the last inspection for Stonedale Lodge Residential and Nursing Home was displayed for people to know how the home was performing.

The new registered manager and the changes being made would suggest the service was actively addressing the concerns we found at the last inspection. We have revised the rating for this key question to 'requires improvement'. To improve the rating to 'good' would require a longer term track record of consistent good practice.