Bupa Care Homes Limited

Stonedale Lodge Care Home

Inspection report

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16 March 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Situated in the Croxteth area of Liverpool, Stonedale Lodge Care Home offers personal and nursing care for 180 people. There has been a recent change of legal entity and the provider is now registered as Bupa Care Homes Limited. The service is called Stonedale Lodge Care Home.

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 Care Home took place over three days from 14-16 March 2017. At the time of our inspection 142 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 last inspection in February 2016 we found previous breaches of regulation had been met. Although improvements had been made we had not rated the service as 'good' at that inspection as we needed evidence of longer term consistency in respect of maintaining improvements within the service. At this inspection we found these improvements had been maintained and developed further.

People living at the home and relatives told us they felt staff delivered safe care.

The environment and equipment was subject to checks and service contracts to ensure the safety of people living at the home.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported. An adult safeguarding policy and the local authority's safeguarding procedure was available for staff to refer to.

Staff we spoke with told us they always asked for people's consent before providing care and we observed this during the visit.

Care plans provided information to inform staff about people's care needs and risks to people's health and wellbeing had been assessed to ensure their safety.

People and relatives were included in planning care and involved in care reviews. This could be recorded in more detail to show their involvement.

People at the home were supported by the staff and external health care professionals to maintain their health and wellbeing.

The home adhered to the principles of the Mental Capacity Act (2005). Applications to deprive people of their liberty under the Mental Capacity Act (2005) had been submitted to the local authority.

The staff in the home knew the people they were supporting and the care they needed. Staff approach was kind and supportive and people's individual needs and preferences were respected by staff.

Staff files showed appropriate recruitment checks had been made so that staff employed were 'fit' to work with vulnerable people.

Staff received training in key areas and more 'specific' training to ensure they had the skills and knowledge to care for people safely. There was an induction programme with mentorship for new staff.

Staff told us they received a good level of support from the management team. This included supervision meetings and appraisals.

We observed there was enough staff to carry out care in a timely manner. We saw staff were attentive to the needs of people and no one appeared to wait for assistance.

Activities co-ordinators provided a varied programme of social activities in accordance with people's needs and wishes. Staff were aware of the importance of providing stimulation for people with dementia to keep people engaged and motivated.

People told us they enjoyed the meals and the menus provided a good choice of well balanced meals. People's nutritional needs were assessed and catered for. We observed lunch and this was a sociable occasion for people.

People and relatives were invited to give feedback about the home through meetings, surveys and daily discussions with the staff.

We observed relatives visiting during the inspection and people told us there were no restrictions on visiting encouraging relationships to be maintained.

A complaints' procedure was available and people living at the home and relatives were aware of how to raise a concern/complaint

The manager was aware of their responsibility to notify us, the Care Quality Commission (CQC), of any notifiable incidents in the home.

The culture within the service was and open and transparent. Staff and people said the home was 'well run' and the registered manager was supportive and approachable.

There was a good management structure in the home with effective quality assurance processes and systems to monitor standards and to support future improvements within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Suitable systems and processes were in place to ensure the premises and equipment were maintained and safe to use.

People were protected against the risks associated with medicines because the provider's arrangements to manage medicines were consistently followed.

People's care needs had been risk assessed to ensure their well-being and safety.

Staff had been checked when they were recruited to ensure they were suitable to work with vulnerable adults.

The staff we spoke with described how they would recognise abuse and the action they would take to ensure actual or potential harm was reported.

There were sufficient numbers of staff on duty to support people in a safe consistent way.

The home was clean and we there were systems in place to manage the control of infection.

Is the service effective?

Good

The service was effective.

Staff sought consent from people before providing support. Staff had an understanding of mental capacity and how this applied to people who lived at the home.

Staff were supported through induction, appraisal and the home's training programme to carry out their role effectively.

People's nutritional needs were assessed according to dietary preference and need. People told us they liked the food and were able to choose what they wanted to eat from a varied menu.

People had a plan of care which provided detail about their care

needs. People told us the staff had a good understanding of their care needs.

People had access to external health professionals to maintain their health.

Is the service caring?

Good

The service was caring.

People living at the home were relaxed and settled. We observed positive interactions between people living at the home and staff.

People at the home told us they were listened to and their views taken into account when deciding how to spend their day.

People told us staff were polite. We observed the staff to be caring, polite and sensitive to people's needs.

People we spoke with and relatives told us the staff involved them with the plan of care and care reviews conducted.

Is the service responsive?

Good

The service was responsive.

A varied programme of recreational activities was available for people living at the home to participate in.

Care was planned with regard to people's individual preferences and wishes.

A process for managing complaints was in place. People and relatives we spoke with knew how to make a complaint and felt confident in doing so.

Is the service well-led?

Good

The service was well led.

The service had a manager who was registered with the Care Quality Commission. The registered manager was long standing and was supported by a strong committed management team.

Staff said they felt supported by the registered manager and that the management of the home was good.

There was a positive and caring culture in the home and people

and relatives reported favourably regarding the service provision.

There were a series of ongoing audits and quality checks to ensure standards were being maintained and further developed.

Staff were aware of the whistle blowing policy and were confident in its use.

The Care Quality Commission had been notified of reportable incidents in the home.

Stonedale Lodge Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 14–16 March 2017. The inspection team consisted of three adult social care inspectors, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service

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

During the inspection we visited five of the six units (houses) that make up Stonedale Lodge Care Home. This included three units supporting people living with dementia. Some of the people living on the units had difficulty 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 nine people in total who were living on the units in the home. We spoke with 10 visiting family members/visitors. During the inspection we also spoke with a health professional who visited the home to see us.

We spoke with members of the management team (registered manager, area manager, clinical services manager, care services manager and area training manager), 20 staff (including care staff, trained nurses, unit managers and ancillary staff (head chef, 'hostesses', housekeepers, activities co-ordinators and maintenance person). We also spoke with a visiting health professional to ascertain their views about the

home.

We looked at the care records for 12 people who lived at the home, five staff personnel files, medicine charts and other records relevant to the quality monitoring of the service. We undertook general observations, looked around the home, including some people's bedrooms, bathrooms, the living areas and external grounds.

Good

Is the service safe?

Our findings

We asked people living at the home and their relatives if they felt the service offered a safe service. People's comments included, "Yes, I do, look, they are here all the time, I need help and they come to me", "The carers keep me safe, and they use a wheelchair if I'm very unsteady (instead of a walker). If ever you're frightened in the toilet or bathroom, you've got a buzzer to press" and "They (staff) are not there to lift but to make sure you're as safe as you can be. They (staff) watch you (when moving) to make sure you're safe. The security keeps us safe too and I'm happy around everyone – not frightened at all."

We spoke with relatives/visitors and they reported, "Yes the care is safe, the care is 'sound', "Care is fine. We've no complaints at all – we feel (relative) is very safe here" and "(relative) had a couple of falls but there are measures in place now and they've not had a fall for ages", "I'm quite happy to leave (relative) in capable hands. Because of (relative's) condition, they get frightened at times; staff speak to (relative) to reassure them."

There was universal agreement that people felt confidence in the ability of the staff to support them. A relative confirmed the staffing levels seemed 'okay' and there were always staff around in the dining area and lounge. Another relative expressed the view that the home was lovely and "I don't worry about (relative) as much as I have done in the past." A relative described an occasion when staff had responded very quickly to a potential risk to their loved one.

We asked people to tell us what they thought about staffing levels and whether there were ever times when these changed, such weekends or nights. We received positive comments about the consistency of staff numbers. People said, "Yes (enough staff) and it's never any different", "There's always somebody around" and "It's all right most of the time". Relatives were also positive about staffing numbers.

People told us staff answered any calls for assistance promptly and they had a call bell in their room. People said, "As soon as you ring, they're (staff) there" and "There's a special button. Staff are pretty good – you don't expect them to be immediate."

We visited all units and found staffing numbers stable at the time of our visit. When we looked at the duty rotas for each unit we saw that the provider's designated numbers of staff were being met. Staff morale was found to be positive with staff reporting there was enough staff to carry out care. If agency staff were used then the management team where possible asked for the same agency staff to help ensure continuity of care.

Observations of routine care on all units evidenced a good ratio of staff. Staffing rotas showed this had been consistent over a number of months. We observed there were enough staff to carry out care in a timely manner. We saw staff were attentive to people's daily personal care needs. For example, we observed people living with dementia were attended to quickly when they became agitated or wanted assistance and received routine care in a timely manner. A staff member said, "We have enough staff to help the residents."

We looked at how staff were recruited and the processes to ensure staff were suitable to work with vulnerable people. We looked at five staff files and asked the registered 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. All files were presented in an organised manner.

We looked at the administration of medicines at the service. We found daily audits and weekly checks of the Medication Administration Record Sheets (MARS) and regular medication audits were still ongoing since the inspection in February 2016. The audits were concise and had clear action plans and there were clear signs of ongoing improvement. People and relatives/visitors we spoke with were happy about how their medicines were managed by the staff.

At this inspection, we checked the medicines and records for 11 people across three of the six units, which included Blundell Unit, Anderton Unit and Clifton Unit. We spoke with four members of staff including the registered manager and three unit managers regarding the administration of medicines. We found 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.

Medicines were stored in a dedicated clean and tidy medicines room that was air-conditioned to keep them 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 this inspection, we looked at one person who could be given their medicine in a covert (hidden) manner if the person refused to take them. A best interest meeting had been recorded in the person's care plan and the person's doctor and pharmacist had been contacted for advice. Although the care plan said what type of liquids a medicine could be crushed in, the care plan did not set out how individual medicines should be administered. The registered manager told us that further advice would be taken.

We looked at how clinical care was managed so that people were supported to minimise risk. We found key areas of clinical care were being monitored well with good assessment processes and clear care plans in place.

For example, one person who was at risk of developing pressure ulcers had been assessed appropriately and had a clear plan with specified use of specialist equipment such as a pressure relieve mattress. Pressure ulcers are caused by 'sustained pressure being placed on a particular part of the body'. We found this area of care continued to be managed appropriately. The person had 'blisters' recorded and the wound care plan was clearly written, easy to follow and looked to be appropriate for the documented wounds.

Another person had an ongoing medical condition which meant they presented with a risk of falls. We saw they had been appropriately assessed and measures put in place such as a referral to the falls team and staff observation so that further risk could be reduced. Two people we reviewed had ongoing medical conditions that, if not monitored well, could present with serious clinical risk such as risk of choking and urinary tract infection. We found measures in place helped to minimise these risks and were clear and easy for staff to follow. Staff spoken with were aware of how they needed to carry out care in line with the assessed risks.

Risk assessments had been carried out to assess the use of bedrails to help ensure people were safe. Dietary needs and nutritional requirements had also been recorded and assessed routinely using an appropriate assessment tool (Malnutrition Universal Screening Tool – MUST). Weight charts seen had been completed

on a monthly basis or more frequently if required.

We found staff had good knowledge of the whereabouts of first aid equipment for use on an emergency. We saw that staff were aware of the arrangements for first aid and there were notices on each unit as to the whereabouts of first aid boxes and suction machines. We saw these were regularly checked by the clinical service managers.

Staff told us for people at risk of falls, their safety was paramount. We made observations which helped confirm how staff kept people safe. We observed an incident when a person suffered a fall whilst moving independently in the lounge. Two staff members responded immediately and a third carer joined them shortly. This person was both checked for injury and reassured; within five minutes staff had taken the person's blood pressure and then supported them in walking to the medical room for further checks. Staff took immediate action to ensure the person's health and wellbeing.

Lunch was well managed on the units and staff were present to support people with their meals; no one was left waiting for assistance over the lunch time period. The staffing ratio also meant that staff had some time to socialise with people which people told us they appreciated.

Staff who we spoke with had a good understanding of how to maintain people's safety and were aware of safeguarding and whistleblowing policies as well as being familiar with the process of elevating any concerns to senior care staff and/or management. All staff we spoke with about this were confident they could report any concerns, they would be listened to and appropriate action taken. A staff member said, "I would speak up if I thought something was wrong, I would not hesitate." The majority of staff had completed safeguarding training (91.3% completion rate) across Stonedale Lodge Care Home.

We had been notified about a number of safeguarding incidents that had occurred since the last inspection. These were incidents or examples of care were people could be at risk of abuse and neglect and required investigation. Most of these notifications were for incidents of minor altercations between people who had been agitated because of their clinical condition. These had been reviewed with the safeguarding team (from social services) who reported staff had acted appropriately to reduce future risk. We had received outcome reports from the safeguarding team prior to our inspection regarding incidents such as medication errors, unexplained bruising and people experiencing falls. Any recommendations made had been acted on by the service. This approach helped ensure people were kept safe and their rights upheld. We saw that the local contact numbers for the safeguarding team were available along with the home's safeguarding policy.

We checked some specific maintenance and safety records. We looked at fire safety maintenance records and these were up to date. Personal emergency evacuation plans (PEEPs) were available for the people living in the home. These were displayed at the entry to each unit and were checked on a regular basis and maintained for easy reference. PEEPs documented a person's level of mobility and factors which needed to be considered such as horizontal/vertical method of evacuation. Fire safety standards were monitored and managed safely. The fire log book evidenced how frequently audits took place and what areas were focused on throughout the care home. We carried out a spot check of a number of safety certificates for fire safety, gas safety, electrical safety, legionella risk and safety checks for the temperature of the hot water. Equipment such as, bed rails, wheelchairs, hoists, mattresses and other equipment were also routinely maintained. These checks evidenced good monitoring of environmental safety in the home.

All units were secure and access could only be gained by inputting the correct code into the key pad at the entrance, the code to exit the unit being different. There was also a signing in book for visitors to the unit and it was observed that relatives signed in and also knew the code to access the unit. The code was

changed regularly to ensure people's safety.

The control of infection appeared to well managed across Stonedale Lodge Care Home. The environment was clean, hygienic and well maintained with visible signage up around the units in relation to hand washing. Soap and hand wash were available and staff wore personal protective equipment, such as gloves and aprons.

Visitors and people we spoke with on the inspection told us they had no concerns about the cleanliness of the home. The management team completed infection control audits, as part of monitoring safe standards in the control of infection and there had been liaison with external environmental health professionals, such as, Liverpool Community Health (LCH - infection control team) in order to learn and share best practice. People we spoke with told us their bedrooms were cleaned every day and that they were happy with the overall cleanliness at Stonedale Lodge Care Home.

Housekeepers were present on the units. We spoke with a housekeeper who was very knowledgeable regarding their role and had a good background knowledge regarding the cleaning solutions they used, any risks to people as well as the protocol if there was an infectious outbreak. We saw that cleaning solutions were safely stored.

Good

Is the service effective?

Our findings

We asked people to tell us if they received the care and support they needed and had access to a GP and other health professionals. Everyone we spoke with told us they were happy with the care delivered by staff and that staff called the doctor quickly if unwell. People expressed confidence that staff would make an appointment for them if needed. People said, "Yes, the doctor comes over quickly, you maybe wait half an hour", "I'm waiting to see one now, perhaps early this afternoon because I've got what looks like a slight chest infection. It has been arranged for the local doctor to come." Relatives told us, "The doctor comes out, yes. We met the new GP recently, in a discussion about DNR and (relative) stated their own views" and "No worries on that front the doctor is always called and we are told why.".

A person told us about specialist support they had received from an occupational therapist to assess their standing and another person told us how the staff checked on their health by taking their blood pressure. People we spoke with told us they felt staff had the knowledge and skills to support them with their care.

We looked to see if the service was working within the legal framework of the 2005 Mental Capacity Act (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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found staff had an understanding of the principles involved and the records we saw documented examples where people who lacked capacity had had 'best interest' decisions made.

We saw examples where people had been supported to make key decisions regarding their care. Where people may have lacked capacity to make decisions we saw that decisions had been made in their 'best interest'. For example, staff explained about one person who had bedrails in place to ensure their safety was maintained. The person lacked the capacity to consent to this and there was a statement in the assessment which told us why they lacked the mental capacity for this decision; in this example the person could 'not retain the information'. We discussed how the use of the [new] 'two stage assessment tool for simple decisions' introduced by the provider could be used in these instances as a more thorough assessment of capacity to consent to these key decisions. We saw entries in the person's care notes such as 'consent gained' whilst carrying out a wound dressing. This showed staff understood that the person could consent to some areas of care and this was consistently checked. This followed the principles of the MCA.

In another example we saw the two stage assessment tool had been used for a person who was being monitored by the use of a room sensor. The assessment clearly showed why the person did not have the capacity to be involved in this decision and why staff were acting in the person's best interest to maintain their safety.

We saw one person had supporting documentation in their care notes around a relative having a lasting

Power of Attorney (LPA) to show they could make decisions for the person.

Staff spoken with had all undergone training in the MCA. We saw the training information and this was easy to understand and covered the principles of the MCA.

We looked at 'do not attempt cardio pulmonary resuscitation' (DNACPR) for five people on three units. These were completed appropriately and decisions made in people's best interests were supported by additional support plans and assessments.

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). We found this was being monitored well. For example, we saw a care plan for one person who was on a DoLS authorisation and this was clear and was being regularly reviewed; there were dates recorded when the authorisation was up for review and staff had alerted the local authority regarding the need for this.

Staff training appeared to be well managed across Stonedale Lodge Care Home. An area training manager explained how training was monitored and delivered across the different BUPA services, for new starters as well as those who needed refresher training. A team of 15 trainers delivered induction packages, as well as other training courses, which needed to be delivered in relation to the service and staff needs. The staff induction included shadowing more experienced staff and completion of a probationary period. The registered manager informed us that the standards implicit in the 'Care Certificate' were embedded in the induction package and we saw this was stated on the induction package (booklet).

All new employees where required to complete a mandatory five day induction programme. This meant that staff would not only complete mandatory training required to fulfil specific roles but also promoted the completion of the care certificate standards. The induction/care certificate portfolio covered a number of areas, for example, privacy and dignity, dementia and cognitive awareness, wound management, health and safety, nutrition, infection prevention and control, safeguarding, equality and diversity, prevention and management of falls and communication.

Training compliance reports and staff training status reports were completed by the training manager and highlighted when refreshers were required for staff. Training was delivered according to a training plan that has been developed in order to reflect mandatory and statutory training requirements. This was led by an allocated regional/area trainer. Specialist training included, nurse accountability, skin integrity and catheterisation, for example. Nursing staff told us they had received good wound training and felt competent to identify and care for people with pressure ulcers. Staff told us when people developed wounds the service had strong links with the community matron for advice and support. This was seen when reviewing care files.

We spoke with a number of staff cross the course of the inspection who all expressed their approval of the training offered by BUPA as well as their induction packages. One staff member we spoke with explained that they had just returned to work and were completing a five day induction in order to re-fresh their skills, knowledge and abilities. They spoke positively about the induction. Another staff member said the training was 'really good' and if there was ever any specific training staff wanted to access they could just request this with management and it would be arranged. The home's training statistics were high for courses completed however, the number was found to be lower for first aid. Although there were first aiders appointed on the units, the registered manager agreed to arrange first aid training for staff who had yet to completed this.

Care staff were also encouraged to gain qualifications in care such as, QCF (Qualifications and Certificates Framework). We saw 60% of staff had completed their NVQ / Diploma in level 2, 3 or 4. Staff attainment of these qualifications shows good evidence of staff having a sound knowledge base for care.

We were told about the training for staff around people living with dementia. This had been developed with input from Bradford University and was being rolled out to all staff. One of the clinical service managers had been identified as a 'Person First Coach' and had attended a training course to be responsible for implementing this.

Supervision meetings and staff appraisals were held. A staff member told us they met on a regular basis to discuss their training needs and 'how they were getting on with their work'. All staff we spoke with said they felt supported by the management.

People had a plan of care to identify care needs. A nursing care plan provides direction on the type of care an individual may need following their needs assessment. Care planning is important to help ensure people get the care they need when they are at a care home. An initial care needs assessment had been completed and people's plan of care contained information and guidance for staff on people's health and social care needs, for example, safety, moving around, skin care, eating and drinking, mental health and well-being and breathing. Information was also recorded around preferred routine, choices, daily records of the care given by the staff and input from external health and social care professionals to oversee people's health and wellbeing.

Medical conditions that required clinical intervention were recorded and treatment plans were followed by the staff. We saw this for a person who was receiving treatment for a wound and for another person who had a urinary catheter fitted because of an ongoing medical issue. Another person who had a long term medical care need was being regularly reviewed by the GP with other health care professionals involvement.

Additional care plans were put in place should a person require more in depth support from the staff to help monitor their condition. We saw this for a person who needed support with their eating and drinking and the provision of thickened fluids to reduce the risk of choking.

We discussed with people what they thought about the food, if they had a choice and had enough to eat. People's responses were mixed, though the majority of answers were broadly positive. All said that people were given some choice and that there was enough to eat. Their comments included, "It's very, very good. Anything I want, I ask the kitchen", "and It's good enough – hospital food, you know", "It's very good on the whole. I haven't said anything but I wish the food could be served a bit hotter" and "I really enjoy the food." Relatives were positive about the meal choices.

There were menu boards on each unit near to the kitchen areas however people did not refer to using these. People described being offered choices by staff members verbally each day, from the list/menu. People with special diets had their needs catered for. A person said, "They (staff) come round and tell you, on the day before. I'm diabetic and they look after what I can and can't eat."

During lunch staff asked people what they would like to eat by showing them the choice of two plated meals. A person told us they liked this as they could see what the meal looked like and if they 'fancied it', so much better and nicer than just being told.

We observed lunch being served. On the units dining tables were laid with care, including cloths, flowers, napkins and full sets of cutlery before the meal. People were invited in turn to sit at one of the tables but

could also choose to stay in an armchair and use a side table to eat at. People were given a hot drink whilst waiting to be served their meal, which was a light lunch of soup and sandwiches or quiche (main meals are in the evening). One person was helped to add a small amount of brandy to their cup of tea which they wanted; everyone was offered their choice of meal and some people who had changed their mind were offered an alternative. For people who needed support the staff were attentive to their needs, no one was rushed.

We met with the chef who described how they used their experience and knowledge around people nutritional needs to make decisions about menus. Such modifications were based on people's preferences and on ideas gained through discussions with chefs at other homes within the group. The chef was knowledgeable regarding people's individual preferences. There was a flexible approach to people whose preferences meant that they might miss the main evening meal and need to be given something to eat later in the evening, referred to as 'night bites'.

On the units for people living with dementia we made some observations of good attention to design to assist people's orientation. Staff explained this was an ongoing project. The corridors had a selection of framed prints of old Liverpool and movie stars from the past. There were memory boxes on the wall next to each respective bedroom door and staff explained these provided cues for conversation with people as well as aiding people to orientate them to their bedroom. There were also 'destination points' with themed displays of interest.

We discussed progress on the units for people living with dementia with an admiral nurse (nurse specialising in dementia care) employed by the provider. The admiral nurse had carried out a number of audits covering aspects of dementia care including the environment. The audits covered both the general experience of people with dementia, the environment they were living in and the dining room experience. The audits had been carried out eight months ago and all of the recommendations made (such as attention to memory boxes) had been actioned.

Good

Is the service caring?

Our findings

People living in the home and relatives told us the staff were very kind and polite. A relative said, "The staff are always polite, they know (relative) so well and they are so attentive to (relative), can't fault them (staff)." Likewise another relative on one of the units told us, "This unit is excellent. Big improvement in (relative); more alert and sleeping better. Staff really seem to care." A person living at the home commented on how the staff always knocked on their door before entering and staff had asked if they would prefer to have a female carer to help them wash and dress. They told us they were pleased the staff had asked them about this as it showed a mark of respect for an elderly person.

People said they felt comfortable talking with the staff. Their comments included, "Yes, they (staff) communicate with you – very good to you", "I've never given it a thought; the staff have a serious job to do – old people, sick people – and they really earn their living", "Oh yes – they're (staff) very easy to speak to, no problem at all" and "The staff are very friendly and very obliging."

Relatives were complimentary regarding the standard of care. They described the staff as attentive and very caring. Relative comments included, "My (relative) is very happy at the home" and "I'm amazed that they (staff) are able to get (relative) up and out of bed; (relative) is like a different woman being here. It's lovely and I don't worry about (relative) as much as I have done in the past."

We observed the staff throughout the day and saw good communication and interactions between the staff and people they supported. Staff had good understanding and knowledge of how people wished to be supported, taking into consideration their medical condition and personal choices and preferences. For example, time of getting up in the morning or retiring at night, preferred meals, choice of clothing and hobbies and interests. A staff member said, "We know the residents so well and they are like our family." We saw staff were familiar with people living at the care home and were kind and caring in their approach.

We heard staff talking with the people they were supporting. Their address included, "(Person) would you like some breakfast, I've got some lovely porridge which you like here for you", "Morning lovely, how are you this morning? Would you like me to get you anything, some breakfast, a cup of tea?", "I've got a nice cup of tea here for you (person), you want me to make you some toast to go with it?" and "Ooooh don't your nails look lovely (person), they really suit you."

People appeared very comfortable and content in the presence of the staff. There was a relaxed atmosphere on the units with plenty of chatter and laughter. This we noted especially when people were joining in with various social activities, for example, 'knit and natter' on one of the dementia units. The activities co-ordinator was very patient in their approach taking time to help people with their knitting, choosing different colours and providing encouragement.

When the staff supported people with daily tasks this was carried out in a patient and supportive manner. Staff support was given at a pace to suit each individual. When staff assisted people to move using the hoist, they ensured people's dignity was not compromised in anyway. A blanket was placed over their knees and

their clothing adjusted so as to ensure their dignity during the transfer. For people being nursed in bed, they appeared comfortable and staff completed regular checks to ensure their comfort and well-being throughout the day.

We saw relatives were involved in people's plan of care and care reviews. For people who had no family member or friends to represent them, contact details of a local advocacy service were available. People could access this service if they wished to do so with or without staff support. These details were clearly displayed and staff knew how to contact the service if a person requested this. Three advocates were currently supporting people at the time of our inspection.

We saw visitors popping in at various times of the day. Relatives told us they could visit any time. A relative said "The staff are so welcoming, they all go out of their way to make you feel welcome, it was like that when I first came here to look around."

Staff were aware of how respect and follow people's choices and wishes for end of life care and when to implement advance care planning to record their anticipated care needs and wishes. This we saw when reviewing people's care files.

Good

Is the service responsive?

Our findings

People told us the staff talked to them about their care, their health needs and that they were informed if there was a change of medicine. They went on to tell us that the staff knew them very well. Their comments included, "The staff just know" and "Yes, they know what I like and this includes a cup of tea when I wake up at night, I only have to ask."

People told us they could request painkillers when they needed them and staff were quick to respond. Two people said they had painkillers as part of their routine medication but could ask for me if they were in a lot of pain and were given this if staff felt it to be safe and appropriate. With regards to meeting people's health needs a person said, "I know why I am here and the staff look after me very well medically." A relative said, "I have seen the care plan. Recently had a concern about (relative's) chest and I was kept fully updated" and "They (staff) always address any concerns and are very reassuring."

We looked at how people were involved with their care planning. We saw evidence that people's plan of care had been discussed with them and/or their relative though the way this involvement was recorded was not consistent across all the units. We discussed with the registered manager the need to record this information in more detail however it was evident that discussions with people and relatives were held by the staff around 'key care' decisions. We saw for one person a 'choices and decisions over care' care plan. This provided detailed information about the request for the person's sons to be involved in the decisions and choices of all aspects of their relative's daily living. We saw in some instances people had signed their care plan though this evidence was not always as strong in all of the care files we looked at.

The care files we reviewed had been updated to reflect people's current care needs. Staff we spoke with told us they were informed of any changes within the home, including changes in people's care needs through daily handovers between staff and through viewing people's care files. We saw completed care records for monitoring people's food and fluid intake and change of position to ensure their comfort.

The care files contained a 'my day, my life, my portrait' about what a normal day looked like for people to help staff take into account their care needs. Detailed information was recorded around people's likes and preferences, choices so that staff knew how to provide care in accordance with people's wishes and needs. A staff member said, We get to know people so well, they are like family."

For people who experienced changes in behaviour a behavioural assessment tool was implemented. This tool along with a plan of care identified triggers and the level of support needed to manage people's anxieties and behaviours. For one person who did not like noise we saw good information on how to manage this. For example, offering the person a quieter room to sit in as well as engaging the person in conversation to try and divert their attentions away from the noise levels.

During the inspection we noted that people could stay in their room or sat where they wished in the lounges and dining areas. Some people liked to sit next to each other at lunch time and we saw staff responding appropriately to this request.

People generally said they felt sufficiently occupied in the day. People's comments included, "We have bingo, cards. I'm not fussy about those really and I don't like reading, but my room - it's like a little home. I've got everything I need; TV, radio, CD player and fridge, so I can please myself", "I like to have a chat with the staff and the make time for me", I'm not a bingo fan and I can't recall any concerts/singing but there's always television to fall back on", "They (staff) do have social activities. They've had bingo – I haven't been but I will do. I think there was something earlier on – a group of singers in" and "There seems to be things on, not sure but I do join in."

There appeared to be a variety of different social activities taking place throughout the week. There were four activities co-ordinators in post with a fifth soon to be joining the home. Different activities included: 'knit and natter', tea dancing, 'social club', bingo, karaoke as well as other activities taking place when there was specific celebrations such as birthdays, St Patricks Day, Valentine's Day and Christmas. There was a visible activities board displayed on each unit so people living at the care home knew what activity had been arranged for that day.

We spoke at length with an activities co-ordinator who had attended a number of courses to inform their job role, including dementia training. They told us that when a person was admitted to the home a 'map of life 'was completed to ascertain individual interests and hobbies and to provide a point of discussion in any one-to-one time between the person and activities co-ordinator. Activities co-ordinators kept records of participation in every person's care file and we saw examples of these

We asked people how they provided feedback about the service. People were unsure about this however told us they were happy to approach the staff if they wished to make a suggestion. Relatives were aware of both satisfaction questionnaires and meetings, even if they had not fully participated.

People we spoke with reported they were happy living at the home. People expressed confidence that any concerns raised would be resolved though no one we spoke with had needed to make a complaint. During the inspection staff reported to the maintenance team some equipment that needed repair; this was resolved immediately.

Relatives we spoke with all happy that any concerns were or would be dealt with quickly. Their comments included, "I would speak to (staff) and if they couldn't sort it, it would be sent to admin, I imagine" and "Any time you have a concern, they'll (staff) respond either straight away or will come back and tell you later what they've done."

The home had a complaints' procedure in place. We saw that three complaints had been received since the last inspection in February 2016. These had been investigated and responded to by the registered manager in accordance with the service's complaints' policy.

Quarterly residents' and relatives' meetings took place and minutes seen showed topics discussed, for example, menus and social activities. A more 'regional' based menu had been introduced based on feedback from people who wanted dishes such as, 'scouse' on the menu.

Staff meetings were held for all units and also within the senior management team. Minutes were seen and this included topics such as staff training and development, staffing, concerns, emerging risks and quality assurance. Staff told us they were kept informed of developments within the service.

Good

Is the service well-led?

Our findings

We asked people if they knew who the registered manager and unit manager were and if they felt they were approachable. People said, "You can ask (unit manager) anything; (unit manager) is very approachable", "Very caring attitude", "Yes I know who the manager is and they come round each day", "The bosses come in every now and again. They're all brilliant and they say 'Everything all right? Anything wrong, you come and tell us", "A lady called (registered manager) comes in sometimes. She's very good." All people and relative we spoke with thought the home was well managed.

At the last inspection in February 2016 we found previous breaches of regulation had been met. Although improvements had been made we had not rated the service as 'good' as we needed evidence of longer term consistency in respect of maintaining improvements within the service. At this inspection we found these improvements had been maintained.

Being a large national provider BUPA ensured there were systems in place to monitor the running of the home. We found established and well developed systems of management in all areas. It was evident that the management team worked closely together to assure the quality of the service.

We reviewed some of the 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 developed to capture as full picture of the home as possible. Staff had a good knowledge of the current auditing systems and how these fed into the overall analysis of how the home was operating. Staff said, "We complete checks to ensure the home is running safely, we report on any concerns we find, it all runs very well."

The home had an on-going Home Improvement Plan (HIP). We were shown the improvement plan for February 2017 with completed actions/ongoing. This review covered areas within the environment, 'first impression' audit, staff supervision, care and medicine audits. Actions needed or those completed were recorded and dated.

Clinical risk meetings were held to discuss emerging risks and findings from audits. The registered manager discussed a key management tool used to monitor the service. This was the 'Quality Metrics' report reflected in the companies 'Enhanced Quality Model' which had four key themes- 'quality of care, quality of life, quality of leadership and management and quality of the environment'. We discussed the Quality Metrics and the key indicators within this. These covered pressure ulcers, nutrition (including people weight loss), medication errors, safeguarding referrals, deprivation of liberty referrals, infection rates, care plan auditing, accidents and incidents (current low rate for these) and quality assurance feedback from people living at the home and their relatives.

A clinical indicator matrix was displayed in the registered manager's office and updated each day to provide an anonymised over view of people's clinical and dependencies. The senior management team confirmed

that this was a valuable tool for assessing people's current health needs, well-being and safety. Senior management told us how they focused on a different area of clinical risk each week and how measures put in place had decreased risks. For example, the use of hydration stations (provision of more fluids for people) in successfully reducing the rate of urine infections and graphs used for effective tracking of falls. The metrix report showed a reduction in the falls rate with the use of this tool.

We were shown other examples of good practice. This included the introduction of a 'my thickener protocol and recording form' for recording the use of thickening agents added to drinks. The service has also been asked to take part in conjunction with Public Health England to investigate the burden and transmission of acute gastroenteritis in care homes. This showed the staff were keen to further improve the service for the benefit of people living there.

The clinical service managers and registered manager told us about their daily walk round on all the units to 'check-up' on the meal service, the environment and to meet with staff and people living on the units. The registered manager had introduced a 10 minute morning meeting for the unit managers. Feedback from the three units that we visited was that the meetings were beneficial enabling staff to discuss items such as, emerging clinical risks, concerns/complaints, admissions and staffing. This demonstrated good lines of communication between the staff.

During the inspection we met with an area director for BUPA. We were shown a monthly home review which they completed in February 2017; this included meeting with staff, people living at the home a walk round of the environment and checking on security arrangements, care plan reviews, checks of the kitchen, laundry and general maintenance of the service. The home review recorded a score of 54 (pass being between 51-60) and all actions had been met from the previous audit. The area director visited the home once a month to review the service and the home managers for the local BUPA care homes met each week to share 'best practice' and to discuss changes with the organisation as a whole.

Staff said they could approach the managers and there was a culture of being listened to and responded. Staff told us they were aware of the whistleblowing policy and would feel confident to use it. This helped to promote an 'open' and transparent culture in the home.

We saw that the management team had an 'open door' policy and staff could seek support and advice as and when they needed it. Staff informed us that the management were very visible on the units and had a good understanding of how the units operated. Staff told us the home was managed well and staff worked as a cohesive team. Staff explained that the registered manager was extremely approachable, supportive and offered an effective leadership style. A unit manager said, "It's lovely now, it's definitely come a long way especially on the management side of things." An employee of the month operated within the home which staff appreciated.

We were shown an analysis of the findings from the most recent residents' experience surveys results from December 2016. Eighteen people had responded and the results were positive regarding the service provision. For example, 100% of people felt they were happy and content, listened to by the staff, safe and secure and treated with dignity and respect. Areas for improvement included activities, communal space and food which the registered manager was aware of and a number of changes had already been made.

The registered manager had notified CQC (Care Quality Commission) of events and incidents that occurred in the home in accordance with our statutory notification requirements.

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 Care Home was displayed for people to know how the home was performing.