

Care UK Community Partnerships Ltd

Stanecroft

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Stanecroft is a care home providing accommodation and personal care for up to 50 older people, who may also be living with dementia. There were 42 people living in the service at the time of our visit. A further three people lived at Stanecroft, but in hospital on the inspection date.

The inspection took place on 23 August 2017 and was unannounced.

The home had a registered manager. 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. The registered manager was present during the inspection.

We carried out an unannounced comprehensive inspection of this service on 21 October 2016 when we rated the service as Good. Earlier this year, we received some concerns about the service and these have been investigated through a large scale enquiry with our partner agencies.

On 26 April 2017, in response to the concerns raised, we undertook an unannounced focused inspection early in the morning. At that time we found that some people were lying in soiled bed clothes and linen. We also identified that records about the care people provided at night were not always an accurate reflection of the support they had actually received. On the basis of our findings, we issued a Warning Notice against the provider and registered manager that required them to improve the way records were maintained.

We have been in continuous contact with the provider since our focused inspection and they have been providing us with regular updates against their action plan. This inspection was carried out to follow-up on the Warning Notice and ensure that the information we had been given by the provider was an accurate reflection of people's experiences of the service.

We arrived at this inspection at 5:45am and on this occasion found that most people were comfortably in their beds. It was clear that people had received appropriate care during the night and that the records completed by the night staff reflected the care that had actually been given. Our interviews with staff highlighted that they now understood the importance of the records they kept and that there were improved systems in place to enable them to do their jobs properly. As a result, the requirements outlined in the Warning Notice had been met.

Since our last inspection the provider had allocated additional resources to strengthen the management and leadership of the service. The feedback from everyone we spoke with confirmed that the individuals brought in to support Stanecroft had been positive in moving the service forward. Whilst the culture of the service was becoming more open, there was still more work to do in this area. Factions across the staffing and management team continued to impact on the way services were delivered.

Ongoing monitoring both internal and external to the service had led to improvements and an action plan for the way forward. Internal management now needed to start being more proactive in the way it assessed its own quality of services.

There were systems in place to train staff, but staffing shortage and other priorities meant that people did not always benefit from the support of familiar staff who knew their needs well. Delays in key training, such as moving and handling being completed caused staff to have to leave working on their units to support other parts of the service.

We have made two recommendations which highlight how the provider could make further improvements to the management of the service and the training of staff.

People were safeguarded from the risk of harm, because staff now understood their roles and responsibilities and knew where to go if they had concerns. Better systems had been introduced to assess and manage the risks to people.

The provider had maintained safe staffing levels through the provision of agency staff. Appropriate checks were undertaken to ensure only suitable staff were employed.

People's legal rights were better protected and staff ensured that they gained consent before delivering care. Where people lacked capacity to make decisions for themselves, there were processes in place to support people in line with their best interests. Whilst not all staff fully understands the principles of the Mental Capacity Act, there was a general awareness for people to be offered choice and for support to be delivered in the least restrictive way.

Medicines were managed safely and people received their medicines as prescribed. Staff worked in partnership with other healthcare professionals to ensure people's health needs were met. People received more personalised support and had opportunities to spend their time doing things that were meaningful to them.

People had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet. Where people had specialist dietary needs, these were known and respected. Assistance at meal times was provided with dignity by staff who knew people's preferences and responded to their choices.

The atmosphere in the service was relaxed and friendly and people had positive relationships with the staff who supported them. People were treated with kindness and in a way that respected their privacy and dignity.

People and their representatives were actively involved in making decisions and choices about their care. Both people and their relatives said they felt confident about expressing their views. The provider took appropriate steps to ensure that any concerns or issues raised were listened to, treated seriously and resolved in a timely way.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were protected from the risk of abuse because staff understood their roles and responsibilities in safeguarding them.

The service had systems in place to appropriately assess and manage risks to people.

Staffing levels were sufficient to meet people's assessed needs safely. Appropriate recruitment checks were carried out to ensure suitable new staff were employed.

Medicines were managed safely and people received their medicines as prescribed.

Is the service effective?

Requires Improvement ●

The service was not always effective.

There were systems to train staff, but changes to the staffing team meant that people were not always supported by staff who were fully trained and familiar to them. Staff did not always feel fully supported in their roles.

Staff understanding of the Mental Capacity Act was varied, but overall care was now provided in a less restrictive way.

People had choice and control over their meals and were effectively supported to maintain a healthy and balanced diet.

Partnership with other healthcare professionals had improved. People were better supported to access the other healthcare services they required.

Is the service caring?

Good ●

The service was caring.

The atmosphere in the service was relaxed and friendly and most staff took appropriate steps to support people with their emotional and spiritual needs.

People had warm and caring relationships with the staff who supported them.

People were involved in making decisions about their care and staff better understood the importance of respecting people's choices and individual preferences.

Staff respected people's privacy and took appropriate steps to ensure their dignity was promoted.

Is the service responsive?

Good ●

The service was responsive.

People experienced a more personalised approach to care and staff had a better understanding about their needs as a whole. Developments to care plans were ongoing.

The development of meaningful activities was continuing to improve and people were able to spend their time doing things they enjoyed.

There were better systems in place to ensure that when people raised issues that they were listened to and their concerns addressed.

Is the service well-led?

Requires Improvement ●

The service was not wholly well-led.

The provider had allocated additional resources to strengthen the management and leadership of the service.

The culture was becoming more open, but greater work was needed to ensure all staff felt supported and valued in their roles.

There were better systems in place to monitor and improve the quality of services provided.

Stanecroft

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 was a re-inspection of this service to check whether the provider was now 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 an updated rating for the service under the Care Act 2014.

This inspection took place on 23 August 2017 and was unannounced. The inspection commenced at 5:45am. This was because we had previous concerns about the care provided at night. The inspection team consisted of three inspectors and an expert by experience. An expert by experience is someone who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, we reviewed records held by CQC which included notifications, complaints and safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. The provider submitted a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of our inspection we spoke with 16 people who lived at the service, 4 visitors, 14 staff and the registered manager. In the planning of this inspection, we gathered feedback from a number of other health and social care professionals who have been working with the service and encouraging improvement.

We observed interactions between people and staff throughout the day and joined people across the service at lunchtime to gain a view of the dining experience. We also sat with staff during one of their handover meetings to observe how information was communicated throughout the team.

We reviewed a variety of documents which included the care records for 15 people, three staff files, medicines records and other documentation relevant to the management of the home.

Is the service safe?

Our findings

People told us that they felt safe living at Stanecroft. For example, one person said, "I do feel safe. They make sure I can do things and I'm not in a rush." Similarly, another person commented, "Nothing to worry about here, they keep us safe and sound." Relatives also expressed that they felt their loved ones were safe at the service. As such, one family member told us, "He is kept very safe. They keep an eye on him which is the level of care he needs"

People were protected from the risk of abuse. People told us that staff were kind to them and that staff treated them well. People repeatedly commented that they had "No worries" and also expressed that "Our things are safe."

People benefitted from the support of staff understood their roles and responsibilities in safeguarding them. Staff received training in safeguarding and demonstrated that they knew what to do if they thought someone was at risk of abuse. We saw in staff meeting minutes that staff regularly talked about safeguarding. During the inspection we sat in on a staff handover meeting in which staff discussed any safeguarding issues relevant to the units they worked on. All staff confirmed that they felt able to share any concerns they may have. Staff also expressed that they would report abuse to outside agencies if necessary and knew where to find the contact details for these. The registered manager was aware of her responsibility to report safeguarding matters to both the local authority and CQC and had ensured that such referrals were made in a timely way.

Individual risks to people were appropriately identified and managed. Care records documented the risks that had been assessed in respect of areas such as skin care, dehydration and malnutrition. Where a risk had been identified there was a clear plan in place to manage it. Staff on duty knew the risks associated with the people they supported and followed the guidelines in place to manage the risks. For example, one person was at risk of choking and had been assessed as requiring their drinks to be thickened. There was clear care plan in place for this, of which all staff supporting this person were aware. Likewise, a relative told us, "I don't need to worry; they keep an eye on her. She does like to wander around but they make sure they know where she is."

There were systems in place to manage the risk of falls. Over recent months a high number of falls had occurred within the service. In response, a new 'Falls Champion' role had been introduced. Staff explained that a member of staff from each unit was designated this role at every shift changeover. The allocated Falls Champion was then responsible for monitoring the whereabouts of those people at risk of falls. Internal audit records for the last two months showed that since the introduction of this role, the number of falls occurring had significantly decreased across the service.

Environmental risks had been considered and mitigated. Each person had a Personal Emergency Evacuation Plan (PEEP) that provided guidance to staff in the event of an emergency situation. These were accessible to staff and the necessary equipment to aid evacuation was readily available throughout the service. The management team had a good oversight over accidents and incidents within the service.

Records contained information about how the incident occurred, witnesses to it and action taken and referrals made as a result of it.

The local fire service had recently visited the service and made some recommendations and the health and safety lead for the provider was in the service on the inspection day, checking that compliance had been achieved.

Staffing levels were sufficient to meet people's assessed needs safely. People and relatives highlighted that whilst there were busy times during the day, that overall staffing levels were sufficient to meet people's needs. People told us that they received care when they needed it and that staff came if they called for them. For example, one person said, "There is always someone popping in to check on me, they are very good and if I need something you don't wait too long for them to come back." Likewise a family member confirmed, "She is taken notice of when she calls or asks, they are busy but she doesn't seem to wait too long and never says she waits for care at night either." Similarly, another relative commented, "There are usually staff coming and going and they are always checking on her. I don't hear bells going often and I come in the evening too. There is always someone around to assist her."

People received appropriate support in a timely way. Staff and management told us that current minimum staffing levels were set at ten care staff and two team leaders during the day and five care staff and one team leader at night. Domestic, catering, management and activity staff were in addition to this number. Whilst, there were significant care staffing vacancies, a review of rotas found these levels to have been consistently met with the use of agency staff covering the gaps. Staff told us that they mostly had sufficient time to do the work expected of them. Staff did however also express that the number of new staff or temporary staff on duty could sometimes be a challenge, in terms of all staff on duty having the necessary skills to support people effectively.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This demonstrated that steps had been undertaken to help ensure staff were safe to work with people who used care and support services. There were also copies of other relevant documentation, including employment history and professional and character references in staff files to show that staff were suitable to work in the service. The provider had systems in place to ensure that DBS and training checks were undertaken on all staff supplied by external agencies.

People received their medicines as prescribed and in a person centred way. For example, one person told us, "[They] bring me my medication when I need it. It is always on time. I don't like taking tablets much and they never rush me." Similarly, another person commented, "Your pills are always at the same times each day, and if there are any changes and you need something different they talk to you about it and explain what the doctor said in simple terms."

There were systems in place to manage medicines safely. Staff who administered medicines had received training and followed guidance from the Royal Pharmaceutical Society. For example, medicines were dispensed and administered to people on an individual basis and they did not sign Medication Administration Records (MAR charts) until medicines had been taken by the person. Staff washed their hands in between each person they administered medicines to.

Appropriate records were maintained in respect of medicines. There were no gaps in the MAR charts for the current period. A team leader audited medicines on a daily basis and ensured any follow-up action was taken. It was however identified that when care staff administered topical medicines such as creams during personal care, this was not recorded within the MAR charts. This was brought to the attention of the registered manager who agreed to address the issue straight away.

Each person taking 'as needed' medicines, such as medicines for anxiety, pain or to aid sleep, had an individual protocol held with MAR charts. This described the reason for the medicines use, the maximum dose, minimum time between doses and possible side effects. For example, one person was prescribed a glycerol spray for Angina. There was a protocol in place which advised staff of the symptoms that would mean this should be administered.

All medicines were delivered and disposed of by an external provider. Medicines were stored safely. There were lockable rooms for the storage of medicines. Medicines trolleys were locked when left unattended. Medicines that required refrigeration were stored in fridges, which were not used for any other purpose. The temperature of the fridges and the rooms in which they were housed were monitored daily to ensure the safety of medicines. The medicines trolley was organised and creams had opening dates on them.

Is the service effective?

Our findings

People told us that staff were good and supported them well. For example, one person said, "They are very efficient and make me feel looked after" and another commented, "They are very good at looking after us all the same, busy but know what they are doing to keep us well."

Due to the high number of agency staff that had been used to cover staff vacancies, some relatives made comments about the number of different staff that supported their loved ones and how this was sometimes unsettling for them.

The changes to the staffing team meant that people were not always supported by staff who were fully trained and familiar to them. Staff competencies were varied and where possible rotas were based on ensuring more experienced staff were allocated to each unit in order to coach other staff. It was however identified that this had not always been possible and the units were sometimes covered by staff who were either very new, temporary or who had not completed the required training to deliver their roles fully. Staff reflected that this sometimes impacted on the way care was delivered. For example, one staff member said that there is, "A lot of swapping around if people need to be hoisted and the staff you are working with aren't trained in moving and handling." Likewise, another member of staff told us, "Sometimes new staff have to work with agency staff and that can be really difficult, because it means that neither staff member knows the people very well."

There were systems to train staff, but learning was not consistently reflected in the way they worked. The provider, Care UK had a corporate training programme that offered a range of relevant training courses. The registered manager maintained a matrix of both practical and e-learning that staff had completed. Not all training had been completed in line with the provider's policy and in some cases staff had completed the training, but the learning was not always displayed in their practice. For example, some staff did not always follow appropriate infection control standards. In one case, we saw a staff member leave a person's bedroom where they were providing personal care and walk into the communal area still wearing the same gloves. Similarly, whilst the majority of staff had completed training in the Mental Capacity Act, the provider's own audits had identified this was not an area in which staff felt competent.

The provider had an induction programme for new staff which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. From discussion with staff and management however, it was identified that this programme was not always being delivered as intended. For example, new staff had sometimes been signed off without completing their own reflections on their learning. New staff had also not always completed their induction in accordance with the timescales set down.

The provider's own governance audits had highlighted that training was an area for improvement and steps had been planned to address the above areas. For example, additional face to face training in the Mental Capacity Act had been scheduled and a team leader had been allocated dedicated time to complete observations on new staff.

It is therefore recommended that the provider continue to ensure that all staff receive the required training and support to deliver their roles effectively.

Staff had received recent supervision and appraisal sessions with their line manager. We saw from the minutes that these sessions had more recently been used to discuss practice issues and identify areas for staff development. Staff views about the support they received was variable and whilst it was evident that some improvements had been made, the support to staff was not fully embedded within the culture of the service.

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. 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).

People told us that staff involved them in making decisions about their care and support and we observed that people now had greater freedom and choice over how they spent their time. For example, the coaching sessions that staff had received around person centred care had led to support being provided in a less task orientated way.

The registered manager had taken appropriate steps to manage restrictions on people's freedom. DoLS applications had been submitted to the authorising authority where appropriate. Two people required their medicines to be administered covertly and there was documentation demonstrating the best interests process that had been completed in respect of this.

Staff understood the importance of gaining consent from people, but some were not familiar with the principles of the MCA or who was subject to a DoLS authorisation. The management team were aware that staff knowledge was varied and additional learning was booked to improve this.

People had choice over their meals and were effectively supported to maintain a healthy and balanced diet. One person told us, "It is very nice, a choice of things and smaller things if I don't fancy a big meal." Another person commented, "It is very good. I tell them things I don't like and they will offer me something else."

Lunchtime was a social occasion which brought people together. People could choose where to take their meals. Those wishing to eat in the communal dining area were joined by staff eating their own meals. Staff reported that this initiative had been successful in breaking down barriers and promoting conversation.

People who needed assistance to eat and drink received appropriate support. One relative told us, "He doesn't eat much and they encourage him in a nice way." This was reflected in our observations of the support people received at mealtimes. For example, we saw staff showing people the choices available and offering to cut their food for them.

Portion sizes varied which indicated that people's appetites were known and staff made appropriate enquiries where people did not eat their meal. One person did not want to eat their meal, when staff asked if they fancied anything they said, "Yoghurt" and this was immediately provided to them.

The chef maintained a list of people's dietary requirements from allergies to likes/dislikes and food

consistency. Kitchen staff also joined care staff in staff meetings which were held three times a week to ensure they were kept up to date about any changes. Where there were concerns about the food or fluid intake for a person, we saw that this was being recorded and monitored alongside the person's weight.

People were supported to maintain good health and access external healthcare support as necessary. People told us that staff arranged for them to see professionals such as the doctor, dentist or optician as necessary. For example, one person told us, "I can see anyone I ask for and usually they come a day or so later." Similarly, a relative informed us, "They call me if they need to call the doctor. They know the residents well here and listen to them when they say they feel ill."

Partnership working with other healthcare professionals had improved. Care records showed that people had been appropriately referred to other health services including; district nurses, speech and language therapist and the community mental health team. We saw that where specialist advice had been given about how to support people, this had been included in their care plan and staff were aware of the advice.

Is the service caring?

Our findings

People described staff as "Kind" and "Caring." One person told us, "I think they are brilliant here. The ones you see all the time are fantastic and the new ones are very nice and everyone is friendly." Similarly, another person expressed, "They are lovely and look after me." Relatives also talked about the compassionate way in which support was delivered. One family member said, "They are fantastic and so kind." Likewise another relative reflected, "They are very nice and also they support me too and give me the time with him I need in private too."

The atmosphere was homely and friendly with a lot of laughter shared between people and staff. We noticed that staff were creative in the way they engaged with people. For example, we saw a member of staff walking around the service with two people, singing and chatting as they went. We noticed the smiles and laughter from these people who clearly really valued this interaction.

Staff were tactile and caring in the way they supported people. We saw member of staff discreetly talking to a person about needing the toilet. They then encouraged the person to walk slowly to the bathroom. We noticed the staff member held the person's hand and guided them carefully with their arm across the person's back, chatting to them throughout.

Care was provided in a way that promoted people's privacy. People told us that staff were good at respecting their private space. For example, one person commented, "They always knock or call out when they come in my room." Similarly, another person said, "If I am using the bathroom or toilet they knock or they wait outside. They call to see if I'm okay and I reply and that is reassuring for us all." Relatives also commented how staff respected their family time. As such, one family member told us, "They are very respectful of family and give us time to be together whenever we like."

Support was provided in a way that upheld people's dignity. People presented as being clean and well cared for. Family members were keen to express this was always their experience. For example, one relative told us, "She is always clean and nicely dressed and I think she is helped to wash daily and bathed once or twice a week. She is happy with that as am I." Likewise, another family member commented, "The ladies' hair is always nicely combed and everyone is nicely dressed here."

People were actively involved in making decisions about their care and staff understood the importance of respecting people's choices and allowing them to live their lives as they wished. One person told us, "Staff are lovely and listen to you all the time. I feel like they want to listen to me." Another person commented, "They know me well and how I like things done." People talked to us about how staff made enquiries about how they preferred to receive support. We saw how people and their loved ones had been involved in creating 'Life Stories' which provided key information about people's lives so staff could tailor their support accordingly. One relative reflected, "They treat her like a person and not just another one to care for."

People's religious, cultural and spiritual needs were known and respected. Staff knew about people's beliefs and ensured these were reflected in the support provided. For example, a staff member highlighted to us

how important one person's religion was to them and as such staff ensured they spent time sitting with them and reading the parish booklet from their local church.

End of life care was planned in partnership with people. Care records contained information about people's wishes for how they wished to be cared for at the end of their lives. Relatives also confirmed that staff had sensitively discussed these choices with them when care reviews were held. There was a system in place to ensure people's choices about resuscitation were known and respected.

Is the service responsive?

Our findings

People experienced a personalised approach to care and staff had an understanding about their needs as a whole. When we arrived at the service at 5:45am, most people were asleep in their beds. Those people that did get up around 6am had expressed a positive choice to do so. Staff told us that there had recently been a lot of discussions about how to create a more personalised service and it was evident that this area had greatly improved.

Developments to care plans were ongoing and people were more involved in the planning of their care. One person told us, "I know I can add things to my plan when I want to and chat with them about how I want to be looked after." Likewise, a relative commented, "They have been very good at sitting with us as a family and discussing all her care. It's all explained in easy terms and all our thoughts are listened to."

Each person had a plan of care that outlined their individual needs and preferences. Prior to moving into the service, a needs assessment was completed. Assessment information was then used to formulate a plan of care that provided information to guide staff. Due to the high number of new and temporary staff working within the service, a new summary care plan had recently been introduced. This made key information about people's care needs available to staff in an accessible and easy to read way.

People's care was planned to their individual needs. Discussions with staff highlighted that they had a good understanding of people and how their needs and interests affected their support needs. For example, the care records for one person read, '[person's name] has dementia and needs to be prompted to attend activities. Able to attend group sessions if informed they are taking place.' This person told us that they enjoyed attending group activities and we observed ourselves that this was the case. Likewise, it was recorded in the person's sleeping plan that they liked to go to bed at 9:30pm and the daily records reflected that this was their usual time of going to bed.

Staff were responsive to people's changing needs. We saw that care plans and risk assessments were reviewed at regular intervals and more frequently if something occurred. For example, following a period of ill health additional support had been provided to a person when mobilising. Similarly, another person had been assessed as being at high risk of developing pressure wounds and as such they were supported to be repositioned throughout the night.

People were able to spend their time doing things they enjoyed. The service had always had a range of organised group activities each day which people could access. These included visiting entertainment, games and cooking and continued to be enjoyed. One relative commented, "There is a lot going on. He went to the seaside the other day. They give you photos and write down things he likes doing. He has freedom to choose."

Since our last inspection, staff had also improved social opportunities for people who did not wish to participate in structured activities. We saw staff spending time doing jigsaws with people, chatting or reading to them. Consequently, activities had become more personal and better suited to people's

individual choices. One person told us, "I feel I can be like I was at home. If I don't want to spend time with anyone I stay in my room or find a quiet spot to sit and have a read." Similarly, another person said, "I like to sit in the garden and have a cup of tea and I like to go to the garden centre."

There were systems in place to ensure that when people raised issues that they were listened to and their concerns addressed. People were given information about how to make a complaint and there was evidence that when they did, their concerns were listened to and investigated. The complaints procedure was readily available and people and representatives told us that they felt comfortable to raise any issues with either staff or the management team.

Is the service well-led?

Our findings

Our last inspection of April 2017 identified that records did not always provide an accurate and contemporaneous account of the care people received. In particular, we identified that some night staff were completing records before care had actually been delivered. Due to the seriousness of these concerns, we issued a Warning Notice which required improvements to be made swiftly. Following the last inspection, the provider had been in continuous contact with us and submitted a detailed action plan which they regularly updated.

When we arrived at this inspection we looked at all the night records across the service. We found that significant improvements had been made and that staff were now accurately reporting on the care they provided. As such, the Warning Notice has now been complied with.

The service had benefitted from additional management support. Following the concerns raised at our last inspection and during the wider investigations with our partner agencies, the provider had allocated experienced support managers to work alongside the registered manager. In addition a member of staff from one of the provider sister services had been transferred to work at Stanecroft. The feedback from everyone we spoke with highlighted that this additional support had been positive in making improvements.

The culture of the service was more positive than had been identified at our last inspection, but improvements were still necessary. There were still factions within the staff team and some staff expressed that positive changes were attributable to the external input into the service and therefore would not be sustained once this was removed.

The provider's action plan identified that team building workshops were planned and that further work is needed to improve the support and morale of staff.

It is therefore recommended that the provider continue with these plans to address and improve the culture between management and staff at Stanecroft.

Communication across the service had improved. Since our last inspection, the systems in place for staff to communicate with each other had been reviewed. As a result, in addition to the shift handover sessions which occurred between team leaders each day, a new '11 at 11' meeting had been introduced three times each week. The purpose of this meeting was for staff across the service to take 11 minutes out of their day at 11am on a Monday, Wednesday and Friday to share their issues and concerns with other members of the staff team. We attended one of these meetings and found it to be an effective way of ensuring staff and management were kept update.

Practice issues were being better discussed and addressed. Our last inspection highlighted that staff had various concerns about each other's practices, but were not confident that these issues were being dealt with. At this inspection we found that supervision and appraisal systems were starting to address these

areas and setting objectives for improvement. Challenge was also becoming more open. Team leaders had received coaching in how to constructively challenge their staff and were feeling more confident in managing concerns as they arose. For example, one team leader told us, "It is important that team leaders are visible and correcting practice issues as they arise." The feedback from staff was that they welcomed this direct approach and wanted to see more open leadership across the service.

Quality monitoring across the service had improved. In addition to the action plan prepared to demonstrate ongoing improvement to the external agencies, a range of regular audits and checks had been undertaken to monitor progress. For example, as a result of the previous concerns raised about the quality of care at night, representatives from the management team had undertaken seven unannounced monitoring visits at night. These were detailed and looked at the tasks staff had completed and checked records such as observation and repositioning charts.

Areas of improvement were being identified and addressed. Each month the registered manager completed a themed audit each month. It was evident that where actions had been set as a result of these audits, the appropriate follow-up had taken place. For example, in May the audit on Activity Based Care highlighted that there was a lack of information in people's Life Stories and this had since been addressed. Similarly, PRN protocols were updated following a Medicine Audit. We did however notice that a gas inspection in 2016 had highlighted that work needed to be completed and whilst it was safe, no date for this work to be completed had been scheduled. This was highlighted to the registered manager who agreed to action this straight away.

People and relatives told us that they felt better engaged with, and that they were now being listened to. In the past they had not always seen changes made as a result of their feedback. Feedback also highlighted that sometimes change took time to be effective. For example, one family member told us, "There are regular meetings for relatives and you can make suggestions. You do see them actioned sometimes but it can take a while to make changes."

Incident and accident reports were completed as necessary and the management team appropriately reported all notifiable incidents to the CQC in accordance with the Health and Social Care Act and without delay.

The provider had implemented a Duty of Candour policy. Duty of candour forms part of a new regulation which came into force in April 2015. It states that providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the patient or service user in relation to the incident. The provider had demonstrated the principles of this regulation by sharing openly the concerns of the last inspection with people and relatives of the service.