Care UK Community Partnerships Ltd

Stanecroft

Inspection report

Spook Hill
North Holmwood
Dorking
Surrey
RH5 4EG

Tel: 01306876567
Website: www.careuk.com

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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?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 25 September 2018 and was unannounced.

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

Stanecroft is owned and operated by Care UK Community Partnerships Ltd. It provides accommodation and nursing care for up to 50 older people, who may also be living with dementia. There were 45 people living in the service at the time of our visit. A further two people lived at Stanecroft, but were in hospital on the inspection date. The service is arranged into five individual units. The service also has an onsite day service which is accessed by some of the people who live at Stanecroft, in addition to being open to the wider community.

The service 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 last carried out a comprehensive inspection of this service on 23 August 2017 when we rated the service as Requires Improvement and made two recommendations about how the service could make improvements to the leadership and training of staff.

At this inspection, we found that the provider had allocated a regional support team to assist the registered manager in moving the service forwards. Through this process, the provider had maintained a strong oversight of the service in addition to mentoring the management support team. This has led to a much more open culture and a greater sense of personalisation across the service. The next step is for these new ways of working to be embedded and for the registered manager to take the service forward in a proactive way.

There were sufficient staff to safely support people. Appropriate checks were undertaken to ensure only suitable staff were employed and new staff completed a programme of induction. All staff accessed mandatory training and specialist training was ongoing.

People were safeguarded from the risk of abuse and staff understood their roles and responsibilities in protecting them from avoidable harm. Staff had a better understanding of people's capacity and legal rights and took positive steps to gain valid consent.

People's needs were appropriately assessed and care was planned in a person-centred way. Support was

delivered in response to people's changing needs. Advanced care planning enabled people's end of life wishes to be known and respected.

People were supported to maintain adequate levels of nutrition and hydration and told us they liked the food provided.

Medicines were managed safely and people received their medicines as prescribed. Staff now worked in partnership to ensure people received holistic personal and health care support.

The service was clean and there were systems in place to appropriately manage infection control. There was an ongoing programme to improve the design and layout of the service to effectively support people living with dementia.

People received support from staff that were kind and compassionate towards them. People were involved in making decisions about their care and staff had a good knowledge of people's individuality and preferences.

People had greater opportunities to participate in activities of interest and staff engaged with people in a way that was meaningful to them. There were better systems in place to ensure that people were listened to and concerns were addressed in a way that improved the quality of care.

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 safeguarded from the risk of abuse and staff understood their roles and responsibilities in protecting them from avoidable harm.

The service was clean and there were systems in place to appropriately manage infection control.

There were sufficient staff in place to support people safely. Appropriate checks were undertaken to ensure only suitable staff were employed.

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

Management and staff were beginning to implement a culture of reflective practice.

Is the service effective?

Good

The service was effective.

Staff received ongoing mandatory and specialist training to enable them to support people effectively.

People were supported to maintain adequate levels of nutrition and hydration.

People's needs and choices were assessed. Staff now worked in partnership to ensure people received holistic personal and health care support.

Staff had a better understanding of people's capacity and legal rights and took positive steps to gain valid consent.

There was an ongoing programme to improve the design and layout of the service to effectively support people living with dementia.

Is the service caring?

Good

The service was caring.

People received support from staff that were kind and compassionate towards them.

People were involved in making decisions about their care and staff had a good knowledge of people's individuality and preferences.

Care was provided in a way that protected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People experienced a personalised approach to care and staff were responsive to their changing needs.

People had greater opportunities to participate in activities of interest and staff engaged with people in a way that was meaningful to them.

End of life care enabled people's final wishes to be respected.

There were better systems in place to ensure that people were listened to and concerns were addressed in a way that improved the quality of care.

Is the service well-led?

Requires Improvement

The service was not wholly well-led.

The provider had a clear vision and strategy for delivering high quality care. Significant regional support had been allocated to the service to monitor and mentor the management team.

The culture was becoming more open and staff and management teams were working better in partnership to improve the quality of support provided.

There were increased opportunities for people and their representatives to be consulted and involved in the running of the service.

New ways of working and learning from events now needed to be embedded and taken forward to create a service that proactively moved forward.

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 inspection was carried out 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 25 September 2018 and was unannounced. 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. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us 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 eight people who lived at the home, four relatives and two other health care professionals that were visiting the service. We also spoke with ten staff, including the registered manager. 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 reviewed a variety of documents which included the care plans for six people, four staff files, medicines records and other documentation relevant to the management of the service such as audits, meeting minutes, surveys and action plans.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Stanecroft. For example, one person said, "Staff do their best to make you feel comfortable within your surroundings. I have never felt insecure or threatened." Likewise, another person commented, "I feel safe; the people here make me feel safe." People's representatives echoed these comments and said they felt their loved ones were safe living at the service. For example, one relative told us, "She is safe here because there is 24-hour care. When she has a medical problem, the doctor is called. Someone notices if she doesn't turn up for a meal." Similarly, another family member informed us, "I have felt that he has been very safe here. So much so that I was able to go and enjoy a holiday without worrying about him."

Staff understood their roles and responsibilities in protecting people from harm. Staff completed regular safeguarding training and were knowledgeable about what do if they thought someone had been abused. One staff member told us, "If I needed to raise a concern I'd go to my manager, a team leader, social services or CQC." The registered manager had a good understanding of their safeguarding responsibilities and made appropriate safeguarding referrals as required and co-operated fully with safeguarding investigations and the local authority when previous concerns had been identified. There were no ongoing safeguarding investigations at the time of this inspection.

Individual risks to people were identified and managed safely. For example, where people had been identified as being at high risk of falls, preventative measures had been implemented. A relative told us, "Mum has a mattress at the side of her bed in case she falls out of bed." Staff knew which people were at risk of dehydration or weight loss and recorded the amounts these people ate and drank. Likewise, staff knew the risks for those people who were less mobile and took steps to reduce the likelihood of pressure damage. Appropriate pressure relieving equipment was in place for those who needed it and staff ensured those people at risk were supported to change their positions regularly to reduce the risk of developing pressure wounds.

Environmental risks had been considered and mitigated. Regular audits and checks took place to ensure the environment and equipment remained safe and fit for purpose. There was a business continuity plan in place which outlined how people would be supported if the service needed to be evacuated. There was an emergency 'grab box' which contained people's personal emergency evacuation plans (PEEPs) and other guidance that staff would need in the event of an emergency.

The service was clean and staff observed good hygiene measures. We saw staff regularly washing their hands between tasks and ensuring appropriate personal protective equipment, such as gloves and wipes were used as required. Sluice rooms were kept locked and found to be clean, with no significant odours. People and relatives confirmed that staff kept bedrooms and communal areas clean and tidy. Regular monitoring checks were carried out and the most recent audit carried out by the registered manager demonstrated that any necessary improvements were identified and actioned.

There were sufficient staff in place to support people safely. People told us that whilst staff were sometimes

busy, there were enough staff on duty to keep them safe. For example, one person informed us, "I feel far safer here than I was at home, mainly because there are enough staff to watch you all the time and if you have any problems you can go to them." Similarly, another person said, "The fact there are staff around even at night makes me feel safe."

The registered manager informed us that there were 12 care staff during the day and six care staff at night. Management, housekeeping and catering staff were in addition to this number. Two dedicated lifestyle co-ordinators also led a programme of activities for people to participate in. The rotas and our conversations with staff reflected these levels.

We observed that people were appropriately supported and received the care they needed in a timely way. With the exception of a specific staff deployment issue on one unit which is highlighted under the Effective domain, staff told us that current levels enabled them to do their job and spend time supporting people in the way they wished.

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 use care and support services. There were also copies of other relevant documentation, including employment history, relevant references, medical fitness and proof that people had the right to work in the UK.

Medicines were managed safely and people received their medicines as prescribed. Medicines were administered by senior staff who had completed competency based training in the safe handling of medicines. Staff supported people to take their medicines in a way that followed their individual needs and best practice guidelines. Staff did not sign medication administration records (MAR charts) until medicines had been taken by the person.

Medicines records contained photographs of people and listed their allergies. Protocols were in place to support the administration of 'as needed' (or PRN) medicines. Medicines were regularly audited to ensure any discrepancies were identified and rectified swiftly. We completed a random stock check of medicines and found those items matched the records in place.

Medicines were delivered and disposed of by an external provider and stored safely within the service. Medicine trolleys were well organised and kept locked when unattended. The temperatures of the medicines' room and fridge were checked and recorded daily to ensure medicines were stored in accordance with the manufacturer's instructions.

A culture of reflective learning was growing which enabled lessons to be learned when things went wrong. Accidents and incidents were scrutinised after occurrence to identify causes and actions to prevent re-occurrence. For example, monthly falls audits looked at people, locations and times of falls to ensure reasons were fully explored and action taken to ensure future risks were minimised.

Good

Is the service effective?

Our findings

Our last inspection identified that staff did not always have access to appropriate training and support to deliver their roles effectively and we recommended further improvements in this area. Since that inspection, the registered manager has taken a more structured approach to the training and induction of staff and we noticed that overall staff were more confident and competent in their roles.

People told us that staff supported them well. For example, one person said, "The staff are excellent, very good. If I wanted help they would give it. They do a good job." Similarly, another person commented, "The staff are perfect. I can't find any fault with them. I am very happy here."

During our inspection, we observed that on one unit, there were a number of people with highly complex and competing needs. There were two staff allocated to this unit, one of which was highly experienced and the other, a new member of staff. The deployment of staff in this way, made it very difficult for the staff on this unit to deliver consistently effective support. A relative also told us that they had noticed some some variance in the skills of staff. As such, they said, "There are some truly outstanding staff who provide great support. There are others though and they are in the minority, but they just don't seem to get dementia care." We raised this issue with the registered manager who agreed to look more closely at the skills and experience of staff when allocating staff to work on the units each day. We could also see that specialist training was ongoing and therefore we will follow this up at our next inspection.

New staff undertook a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to to deliver caring, compassionate and quality care. New staff shadowed more experienced staff to get to know people and their role and told us that time was set aside for them to complete their learning. Staff told us that they received ongoing training in areas such as safeguarding, moving and handling, infection control and fire safety.

People were supported to maintain adequate levels of nutrition and hydration and were positive about the meals they received. One person told us, "The food is pretty good. We get a good choice of things and plenty of it. I saw a carer take something back the other day because it wasn't hot enough and I saw that it was changed, not just heated up." Likewise, another person commented, "The food is very good, and you get enough."

The registered manager informed us that staff had recently completed training in 'dining with dignity' and we saw that elements of this learning was now reflected in their practice. For example, tables were now laid out with menus and condiments. Where people were unable to make a verbal selection from the menu, staff visually presented the meals available. The registered manager had also ordered baskets to enable people to be able to help themselves to snacks throughout the day and these arrived during the course of the inspection. At lunchtime we noticed that portions were very large and we overheard comments from people such as, "There's too much, I don't want it" and "Having so much food puts me off." Whilst people said the food was nice and were happy to eat following staff reassurance that they didn't have to eat it all, we

noticed a lot of surplus food being returned to the kitchen. We raised this with the registered manager who agreed to speak with the chef about portion sizes and offering second helpings rather than one large plate of food.

Staff had a good knowledge of people's dietary needs and preferences and where people required support with eating and drinking, this was provided appropriately and discreetly. People's weights were regularly monitored and appropriate action taken according to any significant weight loss or gain. The chef regularly spoke with people and staff to get feedback about the meals and how they could be improved. They told us, "We have one person whose taste has been affected by their illness, but I know they really like spicy food. I make them a separate hot curry or meatballs that have been rolled in chilli powder."

There were a large number of people who required specialist meals because of food allergies or choking risks. The kitchen assistants were not always regular staff and as such this created both pressure on the chef and risks to people. For example, we observed one member of agency staff almost give a person a standard meal, when they required a soft diet. The chef intervened and the person received the right food, but this was highlighted to the registered manager who agreed further support and training needed to be provided to kitchen staff.

People's needs and choices were assessed to ensure support was delivered in a way that achieved effective outcomes. Care plans had been formulated on the basis of the assessment information which outlines their needs and preferences. Information gathered about people's wishes around daily routines, mealtimes and interests were used to deliver personalised care.

Staff had a better understanding of people's mental capacity to make decisions and took steps to protect people's legal rights. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment 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 that appropriate applications had been to the local authority where people had been judged as being deprived of their liberty. The registered manager maintained a tracker of these applications and the outcomes. Staff spoken with were clear about people's individual levels of capacity and able to describe how this may fluctuate and the steps they took to deliver support in the least restrictive way. We observed staff seeking permission and consent from people prior to providing their support.

Staff now worked better in partnership with each other and external other healthcare professionals to ensure people received holistic personal and health support. One staff member told us, "Its improved a lot; everyone is supporting each other now." We joined the daily heads of department meeting and observed good communication between staff across the units throughout the day. Care plans recorded involvement from other professionals including, doctors, district nurses, dentists and opticians. Where specialist advice had been given, such as from the speech and language therapist or doctor community mental health team, this had been incorporated into people's care plans that staff then followed.

People were observed to be at ease in their environment and moved freely around the service. Reminiscence and sensory equipment had been added to communal areas since the last inspection which provided people with the opportunity to spend time engaging with areas and items that were meaningful to

them. The design and adaptation of the service was continuing to be developed to more effectively support people living with dementia. Bathrooms and toilets throughout the service were coloured which made them easier for people to recognise.

Good

Is the service caring?

Our findings

The atmosphere within the service was relaxed and friendly. People spoke positively about their relationships with staff and told us that they were treated with kindness. One person commented, "The staff are very good. It is a nice place to live we all seem to mix in very well. If you couldn't settle here, you couldn't settle anywhere." Similarly, another person told us, "We are very well looked after. I can't fault the place." Relatives were equally positive in their feedback of the care their loved ones received. One relative informed us, "The staff offer real physical affirmation; lots of hugging and holding hands. They genuinely care."

We noticed lots of positive and meaningful engagement between staff and people. One person had been unwell earlier in the week and we noticed numerous staff ask how she was feeling. One staff member went and gave the person a hug, to which they responded; "I love you." The staff member replied, "And I love you too." Similarly, during an activity session, we overheard a person tell a staff member they were too old to dance. The staff member immediately answered, "You're never too old" and went and played the person's favourite song. Staff routinely crouched to people's eye level to talk with them and listened with empathy and patience. We observed that if people became anxious, staff immediately noticed and went and sat next to them and engaged them in a reassuring conversation.

Friends and families were welcomed into the service and relatives confirmed that there were no restrictions on their visiting. People had been supported to personalise their rooms in ways that were meaningful to them.

People were involved in making decisions about their care and encouraged to be as independent as possible. One person told us, "You are allowed freedom, they don't tell you what to do all the time." Similarly, another person informed us, "I prefer to stay in bed in the mornings and they [the staff] don't have a problem with that." Speaking with staff about the same person, we were told, "They are much more comfortable being in bed in the morning, so we let them tell us when they want to get up."

Staff had a good knowledge of people's individuality and preferences and care plans provided the information to support people in a personalised way. For example, we read in one person's records, '[person's name] can at times show signs of frustrated behaviour towards staff and other service users. It is important to remember that [person] is struggling to make sense of their current reality and living in a care home with lots of strangers doesn't make sense to them." In discussion with a staff member about this person they told us, "The person can get very unsettled, but if you quietly whisper a few key words in their ear, then they relax and let you help them."

People were supported to follow their own religious or spiritual beliefs. One person told us, "You don't get forced to go to any unknown religious service. You have your own religion and can stick with it." We noticed that care records made reference to people's religions and what this meant in respect of their care.

Care was provided in a way that protected people's privacy and dignity. One person told us, "Staff respect my likes and dislikes. My privacy is respected more than when I was at home. They always knock on the door

before they come in." Personal care was provided discreetly and sensitively. Staff were observed knocking on people's doors before entering their rooms and ensuring doors were closed when care was being given. Lots of people were seen to visit the hairdresser who was working in the service during the inspection. After which we overheard staff chatting with them about their new hairstyles and complimenting people on their appearance.

People were encouraged to be involved in the running of the service. In addition to speaking with staff and management, there were monthly residents' meetings where people could discuss activities, food and what they would like to change about the service. From the meeting minutes we could see that people's feedback had been listened to and acted on. For example, one person had requested a trip to a local museum which had recently taken place and others had requested a sundial for the garden and a bar area within the service. Both of which were in the process of being arranged.

Good

Is the service responsive?

Our findings

People told us that staff knew them well and that they were cared for in the way they wanted. For example, one person said, "I am able to have a bath every morning, with help, then I get dressed for breakfast." Similarly, another person commented, "I like to get up between 8:30am and 8:45am and then I choose what I'm going to have for breakfast." During the inspection we observed people being supported with their daily routines in a way which reflected their needs and preferences.

Each person had a plan of care which provided information about their support needs. Care plans were holistic and contained information about how people's physical, social and emotional needs were to be met. Staff also maintained comprehensive daily records about people's care, including how they were and the things they talked about. We could see that where relevant, this daily information had been used to update care plans regarding people's preferences, activities and daily routines. Staff were familiar with people's needs and their descriptions of people's care reflected the information recorded.

Staff were responsive to people's changing needs and care records identified the support required to ensure appropriate delivery of care. For example, one person's needs had changed significantly since they moved to Stanecroft. The person's relative told us, "We had two care reviews in a short space of time and they were proactive in requesting the specialist help [person's name] needed.

End of life care enabled people's final wishes to be respected and allowed people to pass with dignity and peace. Staff had sensitively spent time talking with people and their families about their wishes for end of life care. Where people were either unable or had chosen not to participate in these conversations, staff had recorded other relevant information about the person's beliefs and wishes to assist advance care planning. The registered manager had signed Stanecroft as a participant of 'John's Campaign' – a project to encourage greater family involvement in end of life care, including offering the facility for family members to stay overnight with people in receipt of palliative care.

People had greater opportunities to participate in activities of interest and staff engaged with people in a way that was meaningful to them. Staff were continuing to work hard to develop the programme of activities available to people and it was clear from feedback, that these efforts were being well received. For example, one person told us, "'I like the activities. The art class is my favourite. Occasionally we go out on outings too." Similarly, another person said, "There are lots of things to do."

The lifestyle co-ordinators had worked hard to develop links with the local community and as such had set up a pen pal scheme with a local school. Swimming and yoga classes had also been a huge success, with one staff member telling us, "[person's name] who is 96 years old just got her 25m badge."

There was a vibrant music and movement class taking place during the inspection which the people participating in were clearly enjoying. Staff were observed to be offering encouragement at an appropriate level. Some people chose not to join in the group sessions and we noticed that staff were now more creative in the way they engaged with them. For example, we saw a staff member encourage two people to do a

jigsaw puzzle. Each person had their own puzzle that was matched to their ability level, but by placing them side by side enabled the people to feel connected to one another. Staff also informed us that activity staff were trialling staying later one evening a week to provide more one-to-one activities such as reading, pamper sessions or just engaging in meaningful conversation.

There were better systems in place to ensure that people were listened to and concerns were addressed in a way that improved the quality of care. One person told us, "If you ask the manager something she will answer you. You don't have to wait a week." Similarly, another informed us, "Any issues I've had have been resolved."

Complaint records were now well documented and showed that issues that had been responded to appropriately and in a timely way.

Requires Improvement

Is the service well-led?

Our findings

Our last inspection of 23 August 2017 identified that the service was still working to implement its own action plan of improvement and we recommended that this continue to focus on team building and staff morale. At this inspection we found that a lot of progress had been made in this area and that the staff and management team were working much more effectively in partnership together.

Since the last inspection, the provider had maintained significant regional support to the service and management team at Stanecroft. The oversight and monitoring on behalf of the provider had been robust and clear in its vision for delivering consistently high quality care. Whilst this had been effective, the internal management of the service had, in some areas continued to be reactive in its approach. For example, a provider audit in July 2018 had highlighted that toilets were not always maintained in a hygienic state. In response, the registered manager stated she had introduced an hourly check on communal toilets. During the inspection this did not happen and a toilet was left soiled until we brought this to the registered manager's attention. It was clear that the action plan was not followed by the staff team as a whole.

Whilst there was a lot of positive feedback about the registered manager, there were also some comments that issues were not always dealt with as seriously and proactively as they should be. For example, one staff member told us, "A bit more control needs to be in order. The manager is very concerned with the standards like she should be. However, where there are slight slips, things should be followed up more vigorously." In relation to some of the issues raised, it was clear that action had been taken, but this had not been effectively communicated. For example, a relative had raised a concern about some loose paving slabs outside, but felt that nothing had been done. The registered manager was able to demonstrate that she had actually addressed the matter, but acknowledged that she had not communicated this to the relative, nor recorded the issue as a concern.

As highlighted under the Effective domain, staff were not always appropriately deployed across the service. The registered manager was again responsive to this, but it was not something she had previously taken into consideration. We also observed that care staff were cutting people's nails with scissors. The provider's policy stated that scissors should not be used and that care staff should only cut finger nails with a pair of suitable clippers. Neither the registered manager nor staff were aware of this policy. Appropriate action was taken once highlighted.

The management team have a plan in place to address all outstanding issues against their action plan and we will follow this up at our next inspection.

The registered manager had a good understanding of their legal responsibilities as a registered person. For example, sending in notifications to the CQC when certain accidents or incidents took place and making safeguarding referrals where necessary. Feedback from other professionals highlighted that the service was continually improving and had positively embraced partnership working and developing community networks.

The culture of the service was now more open and focused on developing personalised support that placed people at the centre. Staff were better supported and regular individual and group staff meetings had both improved communication and enabled staff to feel involved in the running of the service.