Care Quality Commission

Stroud Care Services Limited

Stinchcombe Manor

Inspection report

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Stinchcombe
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Date of inspection visit: 20 and 21 May 2015
Date of publication: 23/07/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Stinchcombe Manor is a care home that provides accommodation, nursing and personal care to up to 36 people. At the time of our inspection 29 people were using the service. This included six people who had moved to Stinchcombe Manor on a temporary basis following a fire at another service provided by Stroud Care Services. The provider, Stroud Care Services, took responsibility for the service from the previous provider on 2 April 2015.

This inspection was unannounced and took place on 20 and 21 May 2015.

There was a registered manager in post They were also the owner and registered provider. 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.

Summary of findings

People were not always kept safe. There was no dependency tool in use to determine safe staffing levels. Recruitment checks to ensure staff were qualified to carry out their role were not always in place. Risk assessments were not detailed enough to ensure people were safe.

People were protected from the risks associated with medicines because the provider had clear systems in place. The registered manager and staff team understood their role and responsibilities to keep people safe from harm. Staff knew how to raise any concerns regarding people's safety. The provider had taken steps to ensure the environment and equipment used was safe.

The service did not always provide people with effective care and support. Staff had not received the training required to meet people's needs. People were not protected from the risk of deprivation of their liberty because the provider had not sought authorisation from the appropriate authorities. People's intake of food and drink was not monitored closely. People had access to health care professionals when they needed.

People did not receive a service that was consistently caring. People were not involved in the planning of their care and support. People's independence was not promoted due to the lay out of the service and lack of planning. Staff treated people in a caring manner and ensured their privacy and dignity were maintained.

The service was not always responsive to people's needs. Care plans were not person centred. There was no plan of activities, both within the service or for trips in the community. Care records were not consistently detailed. The service did not always respond appropriately to comments and complaints. However, the provider was introducing a new care planning system which they intended to have in place within six months

The service was not consistently well-led. The provider had taken responsibility for the service on 2 April 2015 and completed a number of quality audits. These had resulted in action plans the provider was in the process of implementing. The management structure of the service was not clearly understood and job descriptions were not clear. The staff were not working effectively as a team and some staff did not have confidence in the new management team.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the training of staff, consent to care and treatment and record keeping.

We have made recommendations to improve the service provided to people in relation to staffing levels, ensuring the environment is dementia friendly and the leadership and management of the service.

You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe.

There was no dependency tool in place to ensure safe staffing levels.

The provider had not ensured qualified nursing staff were registered with the nursing and midwifery council.

Risk assessments did not provide sufficient guidance to keep people safe.

The staff and managers were aware of their responsibilities to keep people safe from harm and knew how to report any concerns.

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

The provider had taken steps to ensure the environment and equipment used was safe.

Is the service effective?

Requires improvement

The service was not always effective.

Staff had not received the training required to meet people's needs.

The service did not always meet the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's fluid and nutritional intake was not closely monitored.

Staff worked with health and social care professionals to access relevant services.

Is the service caring?

Requires improvement

The service people received was not consistently caring.

People's views were not actively sought and they were not involved in making decisions about their care and support.

People's independence was not promoted as a result of the lay out of the building and lack of planning.

Staff treated people in a caring manner and ensured their privacy and dignity were maintained.

Is the service responsive?

Requires improvement

The service was not always responsive to people's needs.

People's care records were not person centred. The provider was in the process of implementing a new care planning system.

Daily recordings of people's wellbeing were not being kept.

Summary of findings

People were not offered regular activities in the home or local community.

The provider did not always respond appropriately to comments and complaints.

Is the service well-led?

Requires improvement

The service was not consistently well-led.

The registered provider had recently taken over the service. There was a core group of existing staff with new staff being introduced. As a result, the team was still developing and the new management structure was not clear to all staff.

Quality audits had been carried out and action plans were being put in place to improve the service. These plans need to be fully implemented.

Stinchcombe Manor

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 inspection took place on 20 and 21 May 2015 and was unannounced. The inspection was carried out by two inspectors as we had received some concerns about the care people were receiving.

This service was registered with the Care Quality Commission on 2 April 2015, when Stroud Care Services took over as the provider. Stinchcombe Manor was previously registered under a different provider. The service was last inspected on 25 September 2014, when we saw the provider at that time, had taken the required action to improve the areas highlighted at our inspection on 15 and 17 April 2014.

Prior to the inspection we looked at the information we had about the service. This information included the statutory notifications that the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. We also looked at quality monitoring information provided by Gloucestershire County Council.

We contacted the three GP surgeries people were registered with, a community nurse who visited regularly and the commissioners of the service. We asked them for some feedback about the service. We were provided with a range of feedback to assist with our inspection.

People were able to talk with us about the service they received. We spoke to ten people. We also spent time observing how people were being looked after.

We spoke with nine staff, including the registered manager, deputy manager, clinical lead, nursing staff, care co-ordinator, care staff and housekeeping staff. We also spoke with three relatives who were visiting people and one relative by telephone.

We looked at the care records of five people living at the service, three staff personnel files, training records for all staff, staff duty rotas and other records relating to the management of the service. We looked at a range of policies and procedures including, safeguarding, whistleblowing, complaints, mental capacity and deprivation of liberty safeguards, recruitment, accidents and incidents and equality and diversity.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe. However, we received mixed feedback about whether there was enough staff. Some people told us there was enough staff and that their call bells were answered quickly. One person said, "I sometimes have to wait but a member of staff will come and explain, they told us this was because the staff were supporting other people". A relative said, "There's not always enough of them". Care staff also gave different responses to the levels of staff. One said, "Yes, we have enough staff to care for people safely most of the time. Another said, "We struggle at times and it will be good when we have more staff".

The registered manager told us they had reviewed staffing levels to ensure there was sufficient staff to care for people safely. They said this was because when they took over the running of the service they were concerned there was not enough staff. In response they had increased the staffing at night. Staff rotas showed there were now three care assistants and a registered nurse working at night. Staffing during the day had also been reviewed and increased from five to seven care assistants and a registered nurse. This was confirmed in the rota. The registered manager said this would increase to eight care assistants and a registered nurse once they had recruited additional staff. At the time of our inspection the required staffing levels were being achieved through staff working additional hours and agency staff being brought in.

We were told recruitment for staff had been ongoing since Stroud Care Services had taken over responsibility for the service. There had been a high staff turnover during the changeover period, with a number of staff leaving at that time. The registered manager told us they had recruited a number of staff including a clinical lead, two registered nurses, care assistants, a cook and two activity co-ordinators. Some staff had taken up their position whilst others were waiting for their references and other documentation to be returned confirming they were suitable to work with vulnerable adults.

The registered manager told us they had reviewed the staffing levels through carrying out observations and talking with staff. There was no staff dependency tool which looked at the needs of the people individually and collectively to ensure there were sufficient staffing in place.

Recruitment records for staff employed at the service did not always contain the relevant checks. Records did include a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. References were also obtained from previous employers prior to staff working with people. However, there was no record of checks to ensure qualified nurses were registered to practice. This is a simple check which can be carried out with the nursing and midwifery council.

People were kept safe by staff who knew about the different types of abuse to look for and what action to take when abuse was suspected. Staff were able to describe the action they would take if they thought people were at risk of abuse, or being abused. They were also able to give us examples of the sort of things that may give rise to a concern of abuse. There was a safeguarding procedure for staff to follow with contact information for the local authority safeguarding team. Staff we spoke with told us they had completed training in keeping people safe. Staff knew about 'whistle blowing' to alert management to poor practice.

Risk assessments were in place. However, these were generic and lacked detail. For example, risk assessments identified the need for staff to be given training but did not identify how to safely provide care and support in a person centred way. One risk assessment to support a person to evacuate the building in the event of a fire stated they used a walking aid, when in fact the person was not mobile. The provider told us they were reviewing all care documentation including risk assessments as part of their action plan. The deputy manager confirmed this was being done as a priority and would be completed within six months.

Medicines were given to people safely and in a timely manner. The clinical lead was in the process of changing the medicine system to a new pharmacist. They had completed an audit on the stock that was held and medicines no longer in use had been returned. The clinical lead had arranged a medicine review meeting with people's GPs so that they could be assured that they were receiving medicines appropriately. This was confirmed in a

Requires improvement

Is the service safe?

telephone conversation with a practice manager of the local surgery who commended the staff on being proactive in organising and liaising with the GP in respect of the care of their patient.

Some people's finances were looked after by the office. We completed a random check on the finances. A member of staff told us that when they took over the running of the business they were unable to find any records of the money held for safe keeping. Checks had been completed on the finances and a new record introduced when the new provider took over the business. The record included money coming into the home and any purchases. This included a receipt. Money held for safe keeping was held in a safe which was accessed by the senior management team. There was no inventory of people's personal belongings on file. This meant people's personal belongings could not be kept safe and secure.

The new provider had taken steps to ensure the environment was safe. This included liaising with the local fire brigade. We were told a fire officer was visiting the service on the 16 June 2015. The provider had completed a visual check on the firefighting equipment and all staff had taken part in a fire drill. Servicing was being arranged with an external contractor to come and check the moving and handling equipment and the lift. A contractor was in the process of completing electrical testing of appliances and checks had been completed on the boiler and gas appliances. A new cooker had been purchased as the original one had been condemned. The provider told us they were planning to replace the boiler.

We saw in the garden a large supply of walking aids and moving and handling equipment. Arrangements had been made with the local supplier to come and collect these. The provider told us the equipment had belonged to a number of people that no longer lived in the home. They had completed a review of all mobility aids and moving and handling equipment in the home to ensure it was appropriate for people and was still required.

We were told all hoists had been checked to ensure they were safe and they were planning to purchase new slings for people. This would mean that people would have their own sling and would reduce the risks of cross infection. Slings are individual lifting aids that fit to hoists to allow people to be moved safely and comfortably. Staff practice had been reviewed to ensure appropriate and suitable moving and handling of people was completed. A member of staff had been trained to provide moving and handling training to staff. The registered manager told us some practices observed when they first started were not appropriate and this had been addressed with the staff involved.

The home was clean and free from odour. Where there was a slight odour steps were taken to reduce this. Housekeeping staff were employed to assist with the cleaning of the home and to complete the laundry. A member of staff told us the new providers had taken steps to improve the cleanliness of the home purchasing new cleaning equipment. They told us "The new provider will replace carpets with suitable flooring where there was a risk of odour due to continence issues".

We recommend that the provider seeks guidance from a reputable source to determine safe staffing levels.

Requires improvement

Is the service effective?

Our findings

People using the service told us about the service they received. They told us their needs were met. One person said, I like it here the grounds are beautiful, I love the view from my window, it is one of the best views I have ever seen". Another person said, "I like my room, I have all I need in here, I don't like going downstairs as it is too far to go to the toilet or there is always a queue, I have my en suite here so I am happy".

Training records showed staff received a range of training to meet people's needs. Newly appointed staff completed induction training. An induction checklist ensured staff had completed the necessary training to care for people safely. One staff member who had recently commenced employment at the service said, "Induction was good, I was introduced to people and feel like part of the family now". Staff said they had received a range of training to meet people's needs. However, qualified nursing staff had not received training updates for some areas of care. For example, nursing staff had responsibility for catheter care and wound care and had not undergone any recent training. Relatives of two people said they were concerned the provider did not have a good understanding of the needs of people with dementia. Health care professionals said they were concerned about the lack of clinical training and knowledge regarding dementia and diabetes amongst staff and managers at the service. Care staff said they felt they needed more training on dementia.

This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager said there was a plan in place for the deputy manager to carry out individual supervisions with each staff member. They said once this had been completed the clinical lead would supervise the nurses and the care co-ordinators the care staff. Supervisions would then be planned to take place every four weeks in line with Stroud Care Services policy. This formed part of the provider's action plan.

People were not always able to make their own choices and decisions about their care. The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Information in people's support plans showed the service had not always assessed people in relation to their mental capacity. Staff told us they had received Mental Capacity Act 2005 (MCA) training and were aware of how this impacted on the support given to people. The service had supported one person through a process of 'best interest' decision making to ensure they received medicines as prescribed.

We looked at whether the service was applying DoLS appropriately. These safeguards protect the rights of adults using services by ensuring that if there were restrictions on their freedom and liberty, these were assessed by professionals who were trained to assess whether the restriction was needed. The clinical lead told us they had completed an application in respect of one person for a Deprivation of Liberty Safeguards (DoLS) since the change of ownership of Stinchcombe Manor. There were two other people that had been subject to a DoLS under the previous management. However they were reviewing everyone in the home to determine if they were at risk of a deprivation of their liberty. This was because there were systems in place that could restrict people's liberty such as locked doors, stair gates and the use of bedrails. Some people were not able to consent to these restrictions. We checked to see if the existing DoLS applications had been authorised. It was noted that these had expired and there was no evidence that these had been resubmitted. The clinical lead was following this up on the day of the visit and confirmed they were waiting for a DoLS assessor to come out and complete the process. This meant that people were being deprived of their liberty without correct authorisation being in place.

This was a breach of Regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had access to drinks in the dining area, squash, water, fresh and dried fruit. People told us the food was good. One person said, "There is only one choice, but it is usually very good, far too much food as the plates are piled up high". Another person told us "The food is alright but I do like certain brands". This person had condiments in their room including sauces, salt and pepper.

We observed people at lunchtime. The food was hot and appeared appetising. Meals were put onto plates in the kitchen and then brought to tables or taken to people's rooms if they were eating there. There was no choice of meals. People did not seem to enjoy the lunchtime experience. There was little conversation and several

Requires improvement

Is the service effective?

people repeatedly left the table and seemed unsure as to whether lunch had finished or not. This was not helped by a long delay for people between courses. A new cook had been appointed and was starting to work on 21 May 2015. We were told a new menu with more choice was to be introduced but this was not available for us to view at the time of our inspection.

People's care records did not contain satisfactory monitoring of their fluid and nutrition intake. A relative told us the home had expressed concerns regarding a person's weight loss. The person's care records showed they had not been weighed since February 2015. The person did not have a risk assessment in place to plan the care and support to help them with this.

People told us they had access to other health professionals and staff would organise health appointments if they were unwell. People were registered with a GP. There were three GP practices that supported the home. The clinical lead was arranging for each person to have a full health review which included a review of their prescribed medicines with their named GP. This would include discussions with family about end of life care where appropriate and any do not attempt resuscitation documentation. This was because there was no evidence that the person or where they lacked capacity their family had been involved in these discussions in the past. A health care professional we talked to was complimentary regarding the clinical lead who had raised issues of concern with them and the GP surgery.

The layout of the building gave the impression of the building being crowded. This was particularly noticeable in the lounge and dining area. The dining area itself did not contain enough tables for people. The provider was redecorating a second lounge. This was a large and attractive room with nice views from the windows. This room had previously not been in use. They said the plan was for this room to become the main lounge to provide people with more communal space. The provider was planning to extend the dining area and have a canteen style kitchen so people could see what was being cooked.

We recommend the provider seeks advice from a reputable source to provide a dementia friendly environment.

Requires improvement

Is the service caring?

Our findings

People told us the staff were caring and friendly. One person said, "It's ok here, the staff are friendly, I like to stay in my room but the staff will pop in for a chat and make sure I am ok". Another person said, "I prefer my own company they make sure I have my paper, I have no grumbles it is alright". Relatives said, "The staff are caring" and, "I am happy with the quality of care".

We observed staff treating people in a caring manner. However, at our visit we saw some people were still in bed at eleven o'clock in the morning and had not received personal care. Staff said this was because they had not had time to provide care. One person who was in bed was offered a drink and staff checked if they were comfortable. The staff member recognised the person was a little cold and rearranged their bedding to ensure they remained warm. Later in the morning we saw the person was still in bed but their hair had been brushed, bedding changed and they were wearing their glasses. The person seemed alert and was listening to music. Another person was assisted by a member of housekeeping staff. This staff member had noticed the person's bedding was not covering them. They put a sheet on the bed to maintain their dignity, noticed their bedding was stained and replaced it with clean bedding. They said, "Care is everyone's business; we have a duty of care to ensure people are comfortable, if it is was my mum I would want the best".

Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. We saw a number of positive interactions and saw how these contributed towards people's wellbeing. For example, a nurse administering medicines to people did so in a kind and caring manner. The registered nurse helped a person who had complex needs, they did not rush the person, giving them their tablets slowly, offering drinks in between each tablet and encouraging the person throughout the time they were helping them. They also spoke to the person warmly about how they were feeling. The person responded positively and seemed to enjoy the conversation.

Staff knocked on people's doors and either waited to be invited in, or if the person was not able to answer, paused for a few moments before entering. We saw people's bedroom doors and doors to bathrooms and toilets were closed when people were receiving care. Some people shared rooms. Privacy screens were available and used in shared rooms. The provider said they were reviewing the provision of double rooms and considering a long term plan to move to single bedrooms all with en suite facilities. Bedroom doors could not be locked from the outside. This meant people could lock their doors when in their rooms but not when they left them. The provider said they were replacing all bedroom doors for ones that were more secure and more personalised.

People's care plans did not consistently demonstrate they had been involved in planning their care and support. People we spoke with did not feel they had been involved in deciding how they should be cared for.

The service had operated a keyworker system, where a staff member was identified as having key responsibility for ensuring a person's needs were met. Staff told us this system had allowed them to get to know the person they were keyworker for well and ensure the needs of the person were met. Staff said this system had been put on hold when the new providers had taken over responsibility for the service. The registered manager said they were reviewing the keyworker system and would reintroduce it once the new staff had started.

People's independence was not promoted. There were few individual plans or risk assessments aimed at encouraging people to develop or maintain their independence. The lay out of the building prevented people moving around freely. There was a lockable door leading from the lounge into the lobby area and a lock on the front door. People needed to find a staff member and ask them to unlock the door if they wished to go outside. One person said, "It's not a problem as such but it is a nuisance". A relative said, "I find it a nuisance, I can't get out unless I can find a member of staff". The registered manager said they were reviewing these arrangements.

Requires improvement

Is the service responsive?

Our findings

Staff told us that until recently there were no daily records in place. These had been introduced by the provider. However, these notes still lacked detail. They recorded that people had received personal care but gave no information on people's well-being. For example, one person who had fallen resulting in an injury was found to have no information recorded on the day of the fall. A second example concerned a person with diabetes and there being no record of blood sugar checks or of the kitchen staff being aware of the person's dietary needs. A third example, involved a person who had moved to the service a few days before our visit. This person's records contained information on a wound they had but no information on how they had settled into the service. The clinical lead had identified these shortcomings. However, they and other staff remained concerned about the quality of record keeping regarding people's health and well-being.

This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People gave mixed feedback on whether the service responded to their individual needs. One person said, "It's Ok, I get what I need". Relatives said, "Some things have improved recently, such as people eating at the dining tables rather than in the lounge" and, "People rarely have to wait long before their needs are met". The registered manager said that individual call bells were not accessible when they took responsibility for the service. They said they immediately rectified this and ensured they were available to people. Call bells were available to people and within their reach. Call bells were responded to promptly by staff.

People's care records were not person centred. There was no information about people's interests, hobbies or life before they moved to Stinchcombe Manor. The provider told us they were introducing a new electronic care planning system. We were told all care plans would be updated on to the new system within six months. The lack of personalised care plans and the high turnover of staff following the change of provider, meant people were at risk of receiving care that was not person centred or given by staff who knew them well.

There was no plan of activities in place. People told us they would like more activities both in the service and trips to places of interest. One person said, "We have done strictly chair dancing, planting seeds and wartime records are often played". Relatives said they would like to see more activities for people. One relative said, "I think they are trying to offer more activities but it could still be better". A new activities co-ordinator had recently been employed. On the first day of our inspection we saw they were involved with activities with a small group of people. These activities included completing jigsaw puzzles and talking about hobbies and interests. . Activities people had engaged in were not consistently recorded in their care plans or daily records. The lack of activities requires improvement to ensure people receive an appropriate level of stimulation and the risk of social isolation is minimised.

Records of complaints were not kept at the service. People we spoke to knew how to complain. They knew a new provider had taken responsibility for the service. The provider said they were going to put information on how to complain in people's rooms and in a new updated service user guide. A recent complaint regarding the service had been made. We spoke to the complainant and registered manager and the deputy regarding this complaint. The complainant felt the issues they had raised had eventually been listened to and partially addressed. However, they felt the provider had initially not been receptive to their complaint. The registered manager and deputy felt they had responded to the complaint. This requires improvement as it is important for people to be able to raise comments and complaints and for these to be listened to and changes made where required.

The provider was in the process of assessing people's need for continence aids. This was being done in partnership with an external continence advisor. The registered manager said when they had taken responsibility for the service many people were using continence aids who, they felt, could be more independent. Staff we spoke with expressed some concern around the availability of continence aids. One staff member said this had created such a problem they were leaving. Another said, "I know they are addressing the lack of continence aids". Relatives also expressed this concern. This showed the provider had not clearly communicated their intentions or plan for addressing this area.

Requires improvement

Is the service responsive?

We visited one person in their room and noted the room was very cold. Care staff told us this was because the person wanted their room at that temperature. The person confirmed this. This showed the provider took people's preferences into account.

Requires improvement

Is the service well-led?

Our findings

People told us they were aware of the change of provider. They said the new provider had meet with them about the change. One person said, "The new provider came to visit and spoke to people in their rooms about what it was like to live here and any improvements they'd like to see". Another person who was temporarily living at Stinchcombe Manor following a fire at their home said they had been kept informed about plans for them to return home. Relatives said, "We were introduced to the new manager" and, "The new providers have talked to me about their plans". We saw the provider had written to people and relatives explaining they were taking responsibility for the service.

During the 6 weeks the provider had been responsible for the service they had made some change. These included an increase of staffing levels, the appointment of a clinical lead nurse, some alterations to the building and environment and reviewing the health care needs of people. These changes had resulted in improvements to the service provided to people. The provider had further plans to improve the service, including making the service more appropriate for people with dementia by introducing memory boxes and altering the colour schemes.

Following taking responsibility for the service on 2 April 2015, the provider arranged for quality audits to be completed. As a result, the clinical lead had drawn up a clinical action plan and an independent assessor had drawn up a quality improvement plan. The provider met with Gloucestershire County Council's quality team on 23 April 2015 and agreed to keep them informed of progress on achieving the actions and targets identified. These plans contain many actions and targets. Some had been achieved, others were longer term so had not yet been achieved. The registered manager said they were in the process of sending out questionnaires to gain the views of people, their relatives and other professionals. They said the findings of these questionnaires will also be incorporated into the action plans to improve the service. We felt these plans need to be closely monitored and remain a priority for the management team.

Staff gave mixed messages regarding the new provider and management. We were told, "We had a wonderful group of staff before, they really cared. The new managers are not friendly or approachable. Things seem money and not care orientated now". However, we were also told, "I have worked for the provider for a while, (Person's name) does everything by the book, but will say it as it is" and, "Things are more relaxed now, it's more like people's home". We spoke to the registered manager and deputy about this. They felt there was a clear division between the staff who worked at the service before they took responsibility and newer staff.

The management structure of the service involved the registered manager, overseeing a deputy manager who then managed a care co-ordinator and the clinical lead. The care co-ordinator was responsible for the care staff, with the clinical lead being responsible for the nursing staff. Feedback from staff and health care professionals showed they were not comfortable with this arrangement and felt senior staff did not always operate effectively as a team. Job descriptions for these roles were not clear.

Staff meetings were held, with one taking place on the second day of our inspection. Again mixed messages were received from staff regarding these meetings. Some staff told us they found these meetings helpful. Other staff said they did not find them useful and did not feel listened to.

The registered manager, deputy manager and clinical lead knew when notification forms had to be submitted to CQC. These notifications inform CQC of events happening in the service. CQC had received appropriately notifications made by the service.

The policies and procedures held at the service included documents relevant for Stinchcombe Manor that were created by the previous provider along with documents created by Stroud Care Services. This could result in confusion for staff. The registered manager said they were aware of this and intended to review and update all policies and procedures at the service.

We recommend that the provider clarifies the management structure to ensure the service is well-led.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use services were not being cared for by staff who had received the training required to meet their needs. Regulation 18 (2) (a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People were not protected from the risk of deprivation of their liberty without the correct authorisation being in place. Regulation 11 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People were not protected from the risk of their care and support needs not being met as a result of inadequate record keeping. Regulation 17 (2) (c).