Stroud Care Property Limited

Stinchcombe Manor

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Stinchcombe Manor is a residential care home providing care for up to 36 older people living with dementia and/or mental health needs. At the time of our inspection 22 people were living at the service. Stinchcombe Manor provides support to people who can often become anxious and distressed, which may result in behaviours others find challenging.

Stinchcombe Manor is a large adapted home with a number of communal areas people can access, including a lounge, dining room and garden.

People's experience of using this service and what we found
People did not receive a safe service as risks to them had not always been safely managed and monitored. The accidents and incidents people experienced were not routinely reviewed to ensure any new or escalating risks to them were identified and acted upon in a timely way to protect them from further harm. As a result, people had not always benefitted from the advice and support provided by external health and social care professionals to ensure their needs were met safely and effectively. People's risk assessments and support plans did not always contain important guidance for staff in how to support them safely. This meant people were at risk of harm as they did not always receive the support needed to keep them safe.

While the provider had been working to improve the systems in place to monitor and improve the service for people, the shortfalls we found at the service had not been identified by their systems. The provider had not identified that their safety incident monitoring system was not effective.

The registered manager had not always followed processes and guidance in place to protect people from the risks of COVID-19. The registered manager and provider had not notified CQC and other agencies of incidents as required. Where areas for improvement had been identified by the provider, effective and timely action to manage risks and improve the service had not always been taken.

We saw staff interacting kindly with people and relatives were positive about the care staff's approach to their relatives. The provider told us how they were working to build a staff team with the right values.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 3 October 2019).

Why we inspected
We received concerns in relation to risk management and the potential impact on people and staff. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report. The provider took immediate action to mitigate fire and choking risks to people. The provider sent us an action plan detailing actions they had taken, and further actions planned, in response to our feedback. It was too soon to say if these actions will be effective in mitigating risks to people.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Stinchcombe Manor on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

At this inspection we have identified breaches in relation to safe care and treatment, governance, safeguarding and failure to notify CQC of specific incidents.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Stinchcombe Manor

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Stinchcombe Manor 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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. 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. We took this into account when we inspected the service and made the judgements in this

report. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service but they were unable to give us feedback about their experience of the care they received. We were unable to use the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This was because one person using the service was anxious about our presence which, had this continued, could have put people and staff at risk of harm. We spoke with ten members of staff including the registered manager/nominated individual, quality and training manager, care manager, two care coordinators, two care workers, two domestic staff and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with two visiting health care professionals.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision and reviewed a selection of management and quality assurance records.

After the inspection
We continued to seek clarification from the provider to validate the evidence found. We looked at training data and quality assurance records. A variety of records relating to the management of the service, including policies and procedures were reviewed. We spoke with six people's relatives. We received feedback from the fire service, community nursing team and frailty lead attached to the service. We attended safeguarding multi-professional information sharing meetings on 3 and 17 August 2021, where we received feedback about the service from safeguarding, three commissioning authorities and the police.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- The registered manager did not effectively manage safety incidents. This meant when safety incidents occurred; such as choking or falls; action was not always taken to address risks. One person had choked three times and staff had to perform first aid. Another person had hit their head following a fall out of their wheelchair. Medical advice had not been sought following these incidents. People remained at risk of harm as clear risk management plans with advice from healthcare professionals had not been put in place to ensure these incidents did not happen again.
- Systems in place for staff and management to report, review and investigate safety incidents, and act to prevent them re-occurring were not effective. During this inspection we identified risks, issues and concerns relating to safety incidents that had either not been reported or had not been adequately acted upon regarding people's falls, seizures and behaviours that may challenge others.
- Universally recognised screening tools were not always used to reliably assess people's risk of weight loss. Where people had been identified as having lost weight, plans had not been put in place in a timely manner and they continued to lose weight, which placed their health at risk.
- Where risk management plans were in place, but managers were aware these plans could not be implemented, they had not put alternative measures in place to keep people safe. Some people at risk of falls did not have working/reliable pressure mats, the provider was awaiting delivery of new mats. Pressure mats are used to alert staff when a person gets out of bed or stands from a chair, so the person can be supported to move safely. People's risk assessments and support plans had not been updated to ensure mitigation of falls risk assessments would remain sufficient.
- One person required emergency seizure medication but only two staff members (including the registered manager) were trained in administering this medicine. Staff would therefore need to call emergency services if a person was to experience a prolonged seizure. This risk response had not been discussed with the GP to ensure it would be appropriate. We found this person's seizure care plan also did not have enough detail to ensure staff would know how to identify a prolonged seizure. Staff told us they would take action after two minutes. However, one person had a seizure that lasted five to seven minutes and the incident record showed emergency care had not been sought. While there had been no impact on the person, this placed them at risk of their seizures not being managed safely.
- The provider had identified problems with the closure mechanism on some fire doors. They had been unsuccessful, despite trying to, in resolving this through the service contract they had in place. There was no risk assessment/s in place in relation to these faults, addressing what the potential risk may be and the action taken to reduce potential risk to people whilst these remained faulty. There had also been no review of personal emergency evacuation plans for the people who may be affected by the faulty fire doors, to ensure they still received the support they needed in the event of a fire.
- During the inspection managers informed us that the affected fire doors always remained closed so

people would be provided with some protection in the event of a fire. Following our visit to the care home managers told us that relevant risk assessments would be completed, and people's personal emergency evacuation plans would be reviewed to ensure people continued to receive the support they needed in the event of a fire.

People's risk had not always been assessed and plans were not in place to keep people safe. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Although staff had been trained and assessed as competent to undertake medicines tasks before administrating medicines for people, we found safe medicine practice was not always followed.
● Some medicines had enhanced storage and recording requirements. These medicines had not been stored or recorded in accordance with legal requirements which increased the risk of misuse.
● Medicines were not always stored at the required temperature as action taken to reduce the temperature in the medicines room was not always effective.

The unsafe storage and recording of some medicines was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's medicine administration records showed they had received their medicines as prescribed.
● The service was working with the dispensary team at the GP's surgery to ensure medicines were supplied in the quantities prescribed.

Preventing and controlling infection

● The service had not experienced a COVID-19 outbreak. Staff did not always wear face masks due to some people becoming agitated and lashing out when seeing staff in masks. In April 2021 the local Infection Prevention and Control team visited the service to provide guidance and advice on the process that needed to follow, to agree this exception from guidelines with the local Health Protection Team.
● At this inspection, we found this exception had still not been completed and the service's decision not to wear masks still required appropriate scrutiny and agreement of the risks related to not using masks.
● The provider's COVID-19 risk assessment did not reflect what was happening in the service; there was no reference to staff not wearing masks and how the risk of the potential spread of infection was to be mitigated.
● PCR (Polymerase Chain Reaction) tests had been carried out and monitored as required. However, no record or oversight of staff LFT (rapid lateral flow) testing had been maintained. The process in place was for staff to carry out LFT testing and log their results at home. No checks were made by the provider to ensure staff were completing LFT testing as per national guidance, to prevent the spread of COVID-19.
● The provider had a contingency plan in place to ensure infection outbreaks could be prevented or managed effectively. However, staff spoken with stated they have not received any training or been part of any discussions on how a COVID-19 outbreak would be managed.
● The provider had processes in place preventing visitors from catching and spreading infections. However, these processes had not always been followed and the process in relation to visiting professionals was inconsistent with national guidance prevent the spread of COVID-19.
● The registered manager ensured people received a negative PCR test result before admitting them to the service. While people were encouraged to self-isolate on arrival, self-isolation had not been maintained at mealtimes which meant the risk of spread of infection remained.

Failure to prevent the spread of infections was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had acted to promote safety through the layout and hygiene practices of the premises. However, we saw this was difficult to maintain due to the needs of the service user group and the nature of the building.

We have signposted the provider to resources to develop their approach.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from abuse from other people living in the service.
● Records showed that one person made frequent threats of violence or was physically aggressive to others in the home. We saw four people had received incidents of physical aggression that could, or had, led to injury. There was no risk assessment or management strategy for these people's risk of abuse and there was no evidence that the effect on their wellbeing had been assessed.
● We saw these incidents had not been reported to the adults safeguarding team to ensure other professionals were involved in maintaining people's safety. We raised safeguarding alerts in respect of people following this inspection, due to our concerns about their immediate safety.

The failure to safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● Staff were recruited safely. Pre-employment checks had been undertaken to ensure staff were suitable for their role. We received positive feedback from relatives about care staff.
● Relatives were positive about staffing levels but two concerns had been raised to CQC since June 2021. The provider told us what action they were taking to address recent staffing issues, exacerbated by staff holidays and the national shortage of care staff.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● We found four breaches of regulation. These failings demonstrated there were a lack of effective systems in place to assess, monitor and improve the service. The systems that were in place had failed to identify or act upon risks in order to provide a safe service to people. This meant that people would have continued to be exposed to the risk of harm.

● There was no effective system for monitoring trends in accidents and incidents. This was needed to ensure risk relating to individuals and the service as a whole would be identified, so action could be taken to mitigate risk and improve the service. We found 79 completed safety incident records for the three months before the inspection. None of the incident records we checked had been investigated or reviewed by managers. Lessons learned had not been identified and shared with the whole team; placing people at risk of harm. While the provider had identified and acted upon the need for improvement to the quality of incident reporting, they had failed to identify that their system for reviewing safety incidents was not effective.

● The provider's medicines audit had not been effective in identifying the concerns we found in relation to the storage and recording of controlled drugs and use of an emergency medicine for seizures. A fan was used to reduce the temperature in the medicines room. However, the provider had not monitored the effectiveness of this action and failed to act when the temperature remained too high to ensure medicines would remain clinically effective.

● Infection control monitoring was carried out through the provider's maintenance audit and an environmental tool for cleaning schedules. These systems were not sufficiently comprehensive to ensure the registered manager would be able to identify whether good infection control practices were being followed. Hence, shortfalls that could increase COVID-19 risks had not been identified.

● A monthly care manager's audit was introduced by the provider in May 2021. While this audit checked risk assessments and support plans were reviewed regularly, the accuracy and quality of the records was not monitored. We found the provider had not identified significant gaps in people's risk assessments and support plans that could place them at risk of harm. Similarly, there were no checks in place to ensure people received the care planned for them, including but not limited to management of nutrition and pressure area care.

● An effective system was not in place to ensure the provider's policies and standard operating procedures continued to reflect current best practice. We found shortfalls in the service's policies in relation to choking, falls and risks associated with anti-coagulant (blood thinning) medicines, that had not been identified and remedied by the provider. This placed people at risk of not receiving care in accordance with national good

practice guidelines.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Working in partnership with others

● There was no effective system for monitoring incidents, including those arising from challenging behaviours, to determine whether they required notification to commissioners, the local safeguarding team or CQC. Safety incidents had not been monitored to ensure input from health and social care professionals was sought in a timely manner. The provider could therefore not ensure an open and transparent culture was maintained that involved the health and social care system in ensuring people's safety.

All of the above demonstrates the failure to operate effective systems to assess, monitor and improve the service which was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Providers are required to act in an open and transparent way when people come to harm and to notify CQC of significant events without delay. The provider had failed to notify CQC of significant events that happened in the service as required by law. This included allegations of abuse and injuries to people. We identified 22 incidents that required notification which CQC had not been notified of. This meant CQC were not able to effectively monitor the service or to ensure appropriate action had been taken in relation to these incidents. We discussed the requirements of this regulation multiple times with the provider and signposted them to CQC guidance, to ensure they understood what was required.

The failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.

● Relatives and professionals gave mixed feedback about the registered manager's responses to their concerns and requests.

● The service had recently sent out a satisfaction survey and at the time of the inspection was waiting for replies.

Continuous learning and improving care

● While the provider had not continually improved the care people received, they told us about improvements they had made in other areas of service provision. This included ongoing development of their monitoring systems, started in January 2020.

● The Food Hygiene rating for the kitchen had improved. A system was now in place to monitor MCA and DOLS. Staff training and supervision records showed the provider had made significant progress in these areas; including the sickness and wellbeing monitoring of staff.

● The provider told us they were working at strengthening the staff culture and team working. Staff meetings were used to support and mentor staff and they could see the positive impact this was having on staff performance.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents There was a failure to notify CQC of all specified incidents which had occurred whilst services were provided in the carrying on of the regulated activity. 18(1)(2)(a)(e)(f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There was a failure to protect service users from abuse and improper treatment. 13(2)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was a failure to assess the risks to the health and safety of service users and do all that was reasonably practicable to mitigate any such risks. 12(2)(a)(b) There was a failure to ensure the proper and safe management of medicines. 12(2)(g) There was a failure to assess the risk of, prevent, detect and control the spread of infections. 12(2)(h)

The enforcement action we took:

We have issued a warning notice in relation to the breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a failure to establish and operate effective quality assurance systems. 17(1)(2)(a) There was a failure to maintain a complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. 17(2)(c) There was a failure to act on feedback from relevant persons on the services provided, for the purpose of continually improving the service. 17(2)(f)

The enforcement action we took:

We have issued a warning notice in relation to the breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.