Stroud Care Services Limited

Stinchcombe Manor

Inspection report

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Stinchcombe
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Tel: 01453549162

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place over two days, 9 and 10 March 2017. The inspection was unannounced. The last full inspection of the service was in June 2016. At that time there were breaches of the legal requirements and three warning notices were issued and two requirement notices. We visited the service again in August 2016 to check the provider had taken the appropriate action to meet the warning notices. At that inspection it was found that the provider had addressed the issues.

Stinchcombe Manor is registered to provide residential and nursing care for up to 36 older people some of whom may be living with dementia. The home was a converted grade two listed manor house set within large landscaped gardens. The service has three shared rooms and all others were for single occupancy. At the time of our inspection there were 22 people in residence.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. However, the day to day management of the service was led by the clinical lead nurse.

Improvements were still required to ensure people's care planning documents and care records were accurate and complete. A new care planning system had been introduced but was not fully embedded. The staff required additional training to make this effective and ensure people did not receive the wrong care.

Improvements were also required with some of the providers quality assurance systems to ensure that any shortfalls were identified and acted upon.

The staff team understood their role and responsibilities to protect people from harm. Where safeguarding concerns had been raised, the service had worked with the local authority to address the issues raised. Any risks to people's health and welfare were assessed and appropriate management plans were in place to reduce or eliminate the risk. Staffing numbers on each shift were sufficient to ensure people were kept safe.

The management of medicines was safe and improvements recently identified by a pharmacist were being acted upon. The premises were clean, tidy and fresh smelling and there were good infection control and prevention measures in place to safeguard people.

Staff received the training they required to carry out their roles effectively. New staff to the service had an induction training programme to complete and regular refresher training was arranged for the whole team.

The service worked in accordance with the Mental Capacity Act 2005 and where appropriate Deprivation of Liberty Safeguard applications had been made to the local authority. Staff asked people to consent to receiving care and support even of the person lacked capacity to make bigger decisions about their care and support.

People were provided with sufficient food and drink and staff monitored those people who were at risk of malnutrition or dehydration. Arrangements were made for people to see their GP and other healthcare professionals as and when they needed to do so.

The staff team were kind and caring and had positive and caring relationships with the people who lived in the home. Relatives and other visitors to the service were welcomed, treated with respect and dignity and offered refreshments. People were involved in making decisions about how they wanted to be looked after and their privacy and dignity was maintained at all times. The service was working to achieve the National Gold Standard Framework accreditation for end of life care. The service had a suite of two beautifully decorated and furnished rooms, joined to but separated from the rest of the home. In this area there were facilities for visitors to rest and make tea and coffee.

People received care and support that met their individual specific needs. They were encouraged to express their views and opinions, the staff listened to them and acted upon any concerns to improve the service.

The clinical lead nurse and the registered manager provided strong leadership and management for the staff team. They were both well respected by staff, relatives and the people who lived in Stinchcombe Manor. The service has made significant improvements since the last full inspection but there were still areas requiring action.

We found breaches of one regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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 said they were safe. Staff were aware of their responsibilities to safeguard people and to report any concerns they had.

The service followed safe recruitment procedures to ensure only suitable staff were employed. The number of staff on duty ensured people's care and support needs could be met.

Any risks to people's health and welfare were assessed and then well managed. All appropriate checks were completed to ensure the premises and facilities were safe. Medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were looked after by staff who were trained and well supported. They had the necessary knowledge and skills.

People's rights were properly recognised, respected and promoted. Staff sought consent from people before helping them and where people lacked capacity, they acted in accordance with the Mental Capacity Act 2005. The service was meeting the requirements of the Deprivation of Liberty Safeguards.

People were provided with sufficient food and drink and supported to access the healthcare services they needed.

Is the service caring?

Good

The service was caring.

People were looked after in the way they wanted and the staff took account of their personal choices and preferences. People were involved in making decisions about their care and support.

People were treated with dignity, kindness and respect and the

staff team provided the support they needed.

Is the service responsive?

Requires Improvement

The service needs some improvements to be responsive.

Improvements were required with care planning to ensure people always received the specific care and support they needed. Staff responded to changes in their needs and adjusted their plan of care.

A meaningful programme of activities for people to participate in was in place. People were listened to and any comments they had were acted upon.

Is the service well-led?

Requires Improvement

The service was partly well-led.

The monitoring systems in place had not been effective in ensuring that care records were accurate, complete and contemporaneous. Other audits had identified shortfalls and gaps and remedial actions had been taken

The service used any comments and suggestions people made about the service to drive forward any improvements.

A programme of improvements to the premises ensured people were looked in comfortable and pleasant surroundings.

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 an up to date rating for the service, under the Care Act 2014.

This inspection took place on 9 and 10 March 2017 and was unannounced. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise included dementia care as well as care of the older person.

Prior to the inspection we looked at the information we had about the service. This information included the inspection reports published in August 2016 (full inspection report) and September 2016 (a focused inspection to assess whether the provider had taken action to meet the warning notice we had issued). We reviewed the statutory notifications the provider had sent to CQC. A notification is information about important events which the service is required to send us by law.

After the last full inspection the service was placed in 'Special Measures'. The purpose of this was to ensure the provider made the required improvements and then sustained those improvements. During this inspection we will check that the two requirement notices were met and the improvements we found during the focused inspection had been sustained.

We contacted social care professionals prior to the inspection and asked them for some feedback about the service. Their feedback had been included in the main body of the report.

Some people were able to talk with us about the service they received, others were unable to because of their frailty. We spoke to 12 people. We carried out one period of focused observation based upon the Short Observational Framework for Inspection (SOFI 2) assessment documentation. SOFI 2 provides a framework for directly observing and reporting on the quality of care experienced by people who cannot describe this for themselves. We also spoke with five visiting relatives.

We spoke with 13 staff, including the registered manager, the clinical lead nurse, nursing staff, two care coordinators, care staff, catering staff and housekeeping staff.

We looked at the care records of six people using the service, two 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 and the management of medicines.

Good

Is the service safe?

Our findings

When this service was inspected in June 2016 we found it not to be safe and we rated this area as inadequate. This was because there were three breaches of regulations in respect of staffing levels and the storage and administration of medicines was unsafe. Also fire fighting equipment was not secured properly or accessible and fire doors were propped open. At the focused inspection in August 2016 the provider was found to have taken the appropriate action in order to meet the warning notice.

The service used a specific formulae to determine safe staffing numbers and repeated this on at least a monthly basis. Staffing numbers were adjusted according to people's needs and increased when people were unwell or there were activities planned to take place. The clinical lead nurse said extra staff were brought in for specific reasons. Shifts were covered with a mix of management, ancillary and care staff (nurses and care staff). Nurses were always on duty for every shift including weekends and overnight but the clinical lead nurse referred to just one shift where due to late sickness a short period of time overnight had not been covered by a nurse. CQC and the local authority were informed at the time of this event. Staff told us staffing levels were appropriate. Since the last full inspection there has been a significant turnover of staff however this has now settled and the staff team was stabilizing. The service continued to use agency nurses but the long term vacancy for one qualified nurse had been covered by an agency nurse for over 18 months. People were looked after by staff who were familiar with their needs and preferences.

The measures in place for the management of medicines was now safe. Improvements had been made since the last full inspection and now medicines were stored correctly in temperature monitored environments. Prescribed medicines were stored, administered and disposed of in line with current regulations and guidance, however we did observe during the inspection that two people were administered their medicines not in line with good practice. This was discussed with the nurse and the clinical lead during the inspection and an extra clinical supervision and reflective practice exercise had already been scheduled by the end of our inspection. Those medicines which required additional security were stored correctly and the drug register was completed each time medicine was administered. In addition a weekly stock check of these medicines was undertaken.

Fire fighting equipment was now securely stored and did not pose a risk to people. The equipment was accessible in the event of them being required and fire doors were not obstructed or propped open.

We asked people if they felt safe living at Stinchcombe Manor. Their comments included, "I suppose I feel safe because they look after me" and "My bedroom is cleaned very well, I should say daily I think". Relatives said, "(named person) has been here since 2015, no harm has come to her", "Yes, she is safe. Some people do come into her room but there is a mat that sets off an alarm so the staff can come and help" and "Her requirements aren't extreme. She's well fed, kept hydrated and kept clean".

The service had a safeguarding adults policy and this included a safeguarding incident reporting flow chart. The chart would benefit from some fine detail being added for example contact telephone numbers, however these details were available in the main office. Staff were aware what constituted safeguarding

and of their responsibility to report any concerns they had. They would report to the registered manager, the clinical lead nurse or the nurse in charge. Staff knew they could report directly to Gloucestershire County Council, the Police or the Care Quality Commission, and information about whistle blowing was displayed in the reception area. All staff are required to complete a Safeguarding Level 1 computer based training module prior to their employment start date. They then complete a Safeguarding Adults in Gloucestershire Level 2 foundation course, delivered in house by our approved Training Manager. The clinical lead has completed both the Level 1 and 2, and is due to attend the level 3 safeguarding training for managers, with Gloucestershire County Council.

A visiting health care professional felt there had been an improvement in the home in relation to the staff's awareness of safeguarding issues stating "There has been an improvement in communication around safeguarding." They said they thought people were safe in the home and that the staff were "very caring."

Staff recruitment files contained an application form, two written references, evidence of the person's identity and a Disclosure and Barring Service (DBS) check. Appropriate pre-employment checks had been undertaken and evidenced that safe recruitment procedures were followed before new staff were employed to work in the service. We spoke to one member of staff who had worked at the service for five months and they confirmed the recruitment procedures.

People's care plans contained risk assessments relating to moving and handling, falls, nutrition and hydration, fire evacuation and tissue viability. However not all assessments had been reviewed monthly as part of the care plan review. The risk assessments were part of the new care planning and recording system that had been introduced six weeks previously but was not fully embedded.

A fire detection system was installed and all bedroom doors had been fitted with automatic closures. Covers were fitted to heating radiators in order to reduce the risk of contact burns. Records indicated that fire safety checks were undertaken regularly and a fire risk assessment had been carried out. We noted that one fire drill had been recorded in August 2016 but other false fire alarm events had not been recorded as a fire drill and staff reactions had not been tested.

The provider had an emergency and business continuity plan in place. This included information about what to do in the event of an emergency such as the loss of accommodation, transport failures affecting staff ability to get to work, communications failure, failure of essential services and pandemic illness . Personal fire evacuation plans had been prepared for each person: these detailed what support the person would require in the event of a fire and them needing to be assisted from the building.

Maintenance records were seen that indicated essential equipment, such as the passenger lift, lifting equipment and the air mattresses had been serviced. Staff reported any maintenance issues promptly in a folder kept in the reception area.

The provider stated that thermostatic control valves (TCV's) were now fitted to all hot water outlets. It is recommended that a selection of TCV's be tested each month (to include them all in a 12 month period) in order to further reduce the potential risk to people living at the home of scalding.

Risk assessments relating to the building and general environment were not available during the inspection but we were told by the registered manager there were arrangements already in place for these to be repeated again in March 2017. The registered manager agreed to send copies of these to the inspector.

The chef and catering staff had a programme of checks to complete including fridge and freezer

temperatures, hot food temperatures, food storage and cleaning schedules. The environmental health officer (EHO) had recently visited and the service was awarded four stars. Recommendations were made by the EHO regarding remedial works that needed attention as soon as possible and other longer term refurbishment works. The provider had already started acting upon the recommendations.

People were cared for in a well maintained, clean and hygienic environment. Staff completed an infection control training module as part of their mandatory training and regular audits were completed of the whole home to ensure it remained clean and tidy. These checks included the cleanliness of the wheelchairs, walking frames, commodes and the sluice rooms. The clinical lead told us they will be completing the next audit and was adding checks of the air flow mattresses and bed mattresses. The housekeeping staff had daily and monthly cleaning schedules to complete and these were signed off by the clinical lead. We found that the equipment used to assist people was fit for purpose, regularly maintained, serviced and kept clean.

Good

Is the service effective?

Our findings

When this service was inspected in June 2016 we found there were areas that required improvement but there was no breach of regulations. This was because there was no system in place to monitor Deprivation of Liberty Safeguards (DoLS) applications and ensure compliance with the Mental Capacity Act 2005 (MCA). The clinical lead had put administrative systems in place which identified applications that had been submitted to the local authority but not yet processed, the expiry dates of DoLS and each person's representative. The clinical lead demonstrated good awareness of people's needs and the principles of the Mental Capacity Act 2005 (MCA).

The 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 are called the Deprivation of Liberty Safeguards (DoLS).

People's care plans contained statements relating to their mental capacity. Where they had been deemed as not having capacity to make decisions, then assessments were recorded relating to issues such as personal care needs, social care needs, nutrition, medicines and health care.
Where applicable, copies of Deprivation of Liberty Safeguards (DoLS) authorisations were available in people's care files.

Where appropriate people's care files contained the Do Not Resuscitate (DNR) form (used by all Gloucestershire CCG GPs)and these were signed by the GP. However, where people had been assessed as not having mental capacity there was no supporting documentation available to indicate that this decision had been subject to a best interests meeting, although for one person had a relative who had power of attorney. This issue was discussed with the clinical lead nurse and the person's GP. The manager stated that they would consider using an alternative DNR form in order to record resuscitation decisions and this would be discussed with the GP.

People felt their needs were met by staff who knew what they were doing and their consent and agreement was sought when personal care was provided. Relatives said, "Staff come and go, but they all know what they're doing", "They look after her – and the GP keeps an eye on her, I have no qualms" and "(named person) fell last week because she really needs a wheelchair, but she should be walking. The GP says she should be walking and is arranging physiotherapy". Both visiting health care professionals we were able to speak with were happy about the level of care and support provided by the staff.

People were offered choices in regards of daily activities. They were asked for example, about what they would like to eat and drink, whether they wanted to take part in activities and where they wanted to sit. Staff told us they would always ask for people's consent before providing assistance with personal care.

Staff were knowledgeable about the people they were looking after and demonstrated an awareness of their needs. They were able to talk about their individual preferences and daily routines. For example one member of staff told us about the support the person required to ensure they did not develop pressure damage. Another talked about the actions taken when a person had started to lose weight. One healthcare professional told us they had been concerned last year about the stability of the staff team but this had now settled. We found that people were looked after by staff who were familiar with their needs.

Staff told us they were now well supported. There was a programme of individual supervision meetings for each member of staff and this was shared between the clinical lead nurse , the nurses and the care coordinators. Supervisions were arranged on a two monthly basis and records were kept of the discussions. The clinical lead told us they had introduced sickness management procedures in order to reduce the level of 'last minute' sickness (this had previously been a problem at weekends). Staff all confirmed that the clinical lead nurse was always available and they could talk to them at any time about concerns or training requirements.

Staff received the training they needed to do their jobs. New staff had an induction training programme to complete and 'new-to-care' staff also completed Care Certificate training. This training ensured new workers were suitably trained to good care. A fairly new member of staff told us they were well supported by the staff team when they first started and they "all worked well together". New staff completed 'shadow shifts' with an experienced member of staff initially.

Staff had a programme of mandatory training to complete with refresher training arranged on a yearly basis. Training was delivered via online training courses, face to face training and attendance at external training courses. A training matrix was kept which alerted the training manager who monitored training, that a refresher was due. Mandatory training for all staff included for example, food hygiene, infection control, nutrition and hydration, moving and handling and dementia awareness. Staff were not allowed to assist people to move using hoisting equipment until they had received their practical training. We were told that the service had plans to get one of their staff trained to deliver moving and handling training (train the trainer). Nurses had completed training in catheter care, safe medicines administration and verification of death.

People were provided with sufficient food and drink. They were able to choose from two hot meals at lunch time although alternatives were prepared for them if needed. The main dining area was named The Sunflower Café and 'opening times' were displayed along with the menu for the day. People were helped to go up to the 'counter' and choose what they wanted to eat as they would in a café. One person who was confined to a large chair was shown two plated meals so they could make a choice.

A file containing people's food and drink preferences was kept in the dining area. The kitchen catered for people who had specific dietary needs including those who needed a pureed or soft diet. People were regularly weighed and kitchen staff were informed about those people who were losing weight. They provided fortified meals for those who needed extra calories. Where people required their intake of fluids and food to be monitored the electronic recording systems showed gaps. This was discussed with the care staff and the clinical lead and paper records to record foo/fluid intake were reintroduced whilst the staff got used to the electronic care record system.

Another person had difficulty swallowing fluids and required their drinks to be thickened. At the start of the inspection there were no clear instructions available to staff to indicate what consistency was required and how much thickener was needed. Staff spoken with gave conflicting answers with regard to how much was to be used. We informed the clinical lead of this and specific details relating to the use of thickeners were on

display in the kitchen and the person's care file on the second day of our visit.

Each person, with one exception had filled water jugs and glasses within reach in their rooms. There were soft drinks and snacks (fruit, biscuits, sweets and crisps) in the dining room and the lounges and also the main entrance hallway. This meant there was food and drink easily accessible for people to help themselves to.

People were each registered with a local GP practice but the majority were registered with one GP who had a contract with the home to provide medical cover. This GP visited on a weekly basis and saw those people who needed to be seen. Home visits were also requested whenever people were unwell. Other GP's were asked to do a home visit as and when necessary. Arrangements were also in place for people to receive support from visiting opticians, dentists and chiropodists. Opticians visited the service on day one of the inspection. The service also worked alongside community and hospital social workers, therapists, and the community mental health care services in order to make sure people were well looked after.

Most communal areas of the home had been decorated with different themes, such as murals of a greengrocers and a bakery adjacent to the dining area, a laundry area and a seaside area. A large sitting room, decorated in soothing pastel colours, was available as a quiet area. Another lounge area had been set out as a railway waiting room. The conservatory or garden room was decorated with trees, birds and flowers. The toilets were identified with hand-painted artwork of a large old-fashioned toilet with pull-chain. The member of staff who had done all the art work was a qualified creative colour therapist and had used their skills to provide an environment suitable for people living with dementia.

The doors to people's rooms had been decorated to reflect individual themes. The bedrooms had been personalised for the person, for example one lady had a large vase of flowers painted on the wall above the mantelpiece and a gentleman had hand painted planes on the wall – rooms were decorated to reflect the person's life or occupation if they wished. Some rooms were for shared occupation but the clinical lead said the service was moving away from shared rooms. We noticed that one of the shared rooms was smaller than others and were told the two people had shared for many years.

Two rooms had been allocated for use by people who were receiving end of life care. People at this stage in their illness had the choice of moving to these rooms if they so wished or remaining in the room where they already lived. The rooms had recently been redecorated using calming pastel colours and were situated in a quiet area of the home, with a separate entrance for visitors. There was also a sitting area for the visitors where tea and coffee making facilities were available.

Good

Is the service caring?

Our findings

When this service was inspected in June 2016 we found that improvements were required. This was because of concerns around the shared rooms and the privacy screens. As stated in June 2016, it was the providers long term plan to move to all single bedrooms with en-suite facilities. At the time of this inspection there was only one shared bedroom in use. The clinical lead told us the two people had shared a room for many years and there had been discussions with them and their family about moving to alternative rooms. Neither wanted to do this. We were assured by the staff and the clinical lead that the privacy screen were always used appropriately.

Staff had good relationships with people living in the home and also the relatives who arrived to visit their loved ones. People were relaxed and enjoying their interactions with the staff. One person who had very recently moved to the service was anxious being in new surroundings but a member of staff had taken them into the quiet lounge and spent time with them. They had coffee and cake together and had talked through what was worrying them. Later on we saw this person looking much more relaxed. The member of staff said they would always make time for people if they became distressed, talking to them and reassuring them.

We found the staff to be caring. Staff knew the people they were looking after well and we heard them addressing them in an appropriate manner. The majority of people were called by their first name. People were looked after in a caring way and it was evident they were treated with respect and dignity. Their privacy was maintained when needed. For those people who shared a bedroom, screening was in place. Staff knocked on bedroom doors before entering or waited for a period of time if they received no response. Each person was well dressed and well cared for. Their clothes were well laundered and each person was encouraged to wear the style of clothing they were used to. The clinical lead nurse told us about one person who had always liked to wear a scarf each day and that it was important for their son that his mother continued to do this.

We looked at the compliments folder and made a note of the most recent comments made, sent by relatives. The cards were full of positive comments for example, "A big thank to everyone who looked after (named person)", "We came to look around for a nursing home placement and found everyone here very friendly", "I cannot praise the staff enough – they are fantastic and the care is wonderful" and "The team made (named person) 80th birthday very special".

We saw that relatives and other visitors were welcomed by the staff upon arrival to the service and offered refreshments. On visitor old us, "It is always very jolly here, I enjoy visiting". All staff we spoke with confirmed they would recommend the service to family and friends and enjoyed working at Stinchcombe Manor.

The service had a programme of activities in place to ensure people's social and emotional needs were met. There was a hair salon and a hairdresser visited the home each fortnight. Relatives and friends were able to visit at any reasonable time throughout the day and evening.

People were encouraged to make choices about their daytime activities, what they would like to eat and where they would like to spend their time. They were also encouraged to express their views and be involved in making decisions about their care treatment and support. This included those people who lacked the capacity to make bigger decisions. We found that the staff respected people's views and preferences. From speaking with the clinical lead nurse it was evident that feedback from people and their relatives/friends was always listened to and acted upon where necessary.

The service looked after people who had palliative care needs or were at the end of their life. The service had signed up to a training programme in order to achieve the Gold Standards Framework accreditation for end of life. Two members of staff were completing this and were working with the local hospice to achieve this. Their training will be cascaded to other staff members. Improvements made so far included making sure people's end of life requests were known and the use of a better template to record these conversations. Also, leaflets had been sourced and made available to families, telling them about the next steps after death. The service had sufficient specialist equipment to aid people's comfort and this included profiling beds and air flow mattresses. The clinical lead nurse told us the care of people's relatives and friends was also important. The service had recently received feedback from the local funeral directors regarding the level of compassion showed by the care staff following the death of a person. They said that care staff had "prepared" the person nicely to leave the service and "respected them even after death". One person had written to the service after their relative had died and said, "Thank you for making (named person) last days safe, warm comfortable and peaceful".

Requires Improvement

Is the service responsive?

Our findings

When this service was inspected in June 2016 we found that the service was led by routines and tasks rather than being person centred. We also found that the provider did not have a system in place to monitor any issues and complaints made, to analyse the issues or to respond appropriately to the complainant.

We asked people what they thought about the way they were looked after. Some people were not able to respond to our questions but others felt that their care was focused on their individual needs. They said they were involved in reviewing their care on a constant basis. Comments included, "Cannot fault it here", "I don't have to worry about anything now because it's done for me", "I am asked if I am happy with things…..and I am" and "Everyone knows I like watching television and there are programmes I like to watch. In the evenings they make sure I am ready to watch them". One relative said, "(named person) knows she can 'phone me if there's anything else she needs or is unhappy about".

For those people who were unable to tell us about their care and support we spent a period of time watching their interactions with the staff team. From our observations it was evident that the staff knew how each person liked to be looked after and provided them with person centred care. For example, we noticed during the lunch time period that people were provided with a cold drink in different receptacles. Some people had their juice served in wine glasses, others in beakers. One person told us they were fearful of breaking the glasses and so had asked to have a beaker. Another example was the different way people were supported at meal times and the different times of day they had their lunch.

We looked at care planning documentation. Some care plans seen did not fully detail the actions required to meet the person's needs. For example, one person's plan stated they needed a thickener added to their drinks in order to reduce the risk of choking. There were no details recorded on the plan as to how much thickening powder had to be added to the fluid and what consistency was required. This had the potential to mean that the risk of choking had not been fully mitigated. The person also required an air flow mattress, but the required inflation pressure of the mattress was not stated on their care plan. This requires improvement.

People had individually prepared care plans and these were kept in files in the main office. The clinical lead nurse told us a new electronic system for producing care plans was introduced six weeks ago therefore was not fully embedded. This meant the care plans we looked at during the inspection were a mixture of the old and new systems. We looked at a selection of care files along with other care related records. People's details were entered onto a computer tablet in order to generate a care plan. This meant that staff could access information regarding the person's care from either the tablet or from their files. As a result of our findings when looking at the care files and our conversations with staff, it was evident that not all staff were able to or confident in using the new system properly and that further training was required. The clinical lead nurse was made aware of this and agreed to arrange further training.

One person's tissue viability risk assessment indicated they were at risk of developing pressure sores and had a pressure wound. The wound was reported to be improving. The person had a pressure relieving

mattress and cushion in order to reduce the risk and their position was to be changed every two hours when they were in bed. Records seen for 8 and 9 March 2017 indicated this had not been achieved. The person said they had been moved "a couple of times" during the night of the 9th. The records relating to another person, who needed to be repositioned every two hours day and night, were incomplete. The person was unable to tell us how often they had been moved.

A third person's care plan stated they required 'hourly checks day and night.' Their care records included a 'sleep monitoring record' but this had only been completed twice, at 00.25 and 02.45hrs for the night of 8 March 2017.

We informed the clinical lead of our findings. They assured us the staff had carried out the interventions, but had not recorded this on the hand held computer tablet (part of the paperless computer based care planning system the service had introduced six weeks ago). The clinical lead reintroduced paper records to be used alongside the new system and arranged for further staff training.

People who were assessed as at high risk from developing pressure sores had been supplied with air mattresses. However, in some cases, specific instructions to inform staff of the correct inflation pressure the mattresses were to be set at were not available. Having air mattresses set at an incorrect inflation pressure may increase the risk of pressure damage. The manager stated that she would access information relating to the correct inflation pressures.

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

However other risks were well managed. Where needed, people had a moving and handling plan which described the type of lifting aid and lifting sling required. We visited the person and saw that the lifting equipment was available and saw they were attended to by two members of staff. One person was at risk of falling out of bed. Their bed had been lowered and that a soft mattress had been laid alongside. Risk assessments were in place for those who needed bed rails to maintain their safety whilst in bed, and protective covered these.

If people required equipment or interventions to reduce risk, such as pressure mattresses, sensor mats or weekly weighing, then this was recorded on a list of current people living in the home displayed on a white board in the main office.

Those care files we looked at contained a care needs summary designed to provide staff with a short summary of the person's needs for quick reference. Where required, wound care records were completed by nurses. Two were reviewed which indicated that wounds had been treated regularly and appropriately. Other information included statements on the person's mental capacity, ability to communicate, nutritional needs for example along with other relevant information about their choices and likes and dislikes. Not all care plans had been regularly reviewed with one person's not reviewed since December 2016.

One of the care coordinators had taken a lead role in activities. They told us about the morning household activities that took place each day. People were able to help out with washing and drying up the breakfast dishes, light dusting tasks and matching up socks. There was a doll available for those people who found comfort from caring for the 'baby'. Group activities were arranged for ladies and gentleman however the male member of staff who led the gentleman's group had recently left the service. Examples of activities that had been arranged included arts and crafts sessions, exercises, cooking and chats about sporting events. There were plans in place to start a gardening group now the weather was improving plus greater

use of the gardens. Social events were arranged including a summer fayre, celebrations of significant events such as Christmas and Easter.

For those people who either did not want to, or could not join in with group activities, the staff spent one to one time with them. Staff told us they spent time with one person who was now very sleepy, giving them a hand massage with fragrant creams. With another person they helped her with her with the TV magazine, cut filed and varnished her nails.

All birthdays were celebrated with a cake, a birthday card and a small present and people were encouraged to make a choice about what sort of cake they liked. External entertainers were arranged and included church people who did bible readings, a pet therapist and musicians.

There were opportunities for the people and their relatives to have a say about the service provided. The clinical lead told us 'resident and relative' meetings had not been successful in the past but two such meetings were held before Christmas and included 'mulled wine and mince pies'. These meetings had not been well attended but everyone had been told about the new management arrangements and staffing structure and plans for the service. People and their relatives had been asked how often they wanted the meetings to be arranged and these were to be scheduled six monthly. A visiting relative confirmed there had been a residents and relatives meeting held in December last year. People were encouraged to express their views and opinions about the way they were looked after in the monthly reviews and on a day to day basis when they were asked if everything was alright.

The service's complaints procedure was displayed in the entrance porch and also included in the statement of purpose and service user guide kept in each person's bedroom. A supply of comments and feedback forms were also displayed in the porch by the signing in book. The clinical lead nurse told us that one relative had made comments regarding the outside lighting. As part of the overall maintenance plan for the premises there were plans to install additional lighting in the driveway. The service had not received any formal written complaints in the previous 12 months and no concerns had been raised with CQC.

People and their relatives said they would be comfortable raising any concerns or complaints they had and would expect a response to any issue raised. Responses included, "If I wanted to change anything I'd speak to the members of staff I like, they always listen", "I would ask to speak to the manager if I was unhappy with anything" and "Straight to the top! (named person) is the person the lady in charge – and I'd expect a response, I wouldn't let it be. They're the experts".

Requires Improvement

Is the service well-led?

Our findings

Since the last full inspection of the service in June/July 2016, there has been a change in the management of the service – the previous home manager had left the service in the autumn 2016. The registered provider was still the registered manager, however the clinical lead nurse had now taken on the day to day running of the service. We discussed with the clinical lead nurse the requirement for her to apply to CQC to be the registered manager as they were providing the leadership and management role and were carrying on the regulated activities.

Each person who was able to engage in conversation knew the manager by name (they were referring to the clinical lead nurse) and confirmed that she was frequently seen in Stinchcombe Manor. Relatives confirmed the same. People and their relatives thought the staff were well managed and the positive atmosphere throughout Stinchcombe Manor reflected this.

We received many comments about the improvements that had been made with the service in respect of the management and leadership. One visiting relative said that they thought there had been an improvement in the home and put this down to "the staff not changing so often". One staff member said they thought the home was improving. They said "We have new bed linen and towels. It's much better with the new owners and this manager (the clinical lead nurse). You just ask and it's there". A visiting healthcare professional commented that the home was "moving in the right direction" and described the clinical lead nurse as "great". The healthcare professional thought the home now had a stable group of carers. The clinical lead nurse said that the registered manager usually visited the home on Monday's and Tuesday's and they described them as "very hands on".

The clinical lead nurse told us care documents were regularly audited however this had not identified the shortfalls we found in those records we looked at. Whilst we recognise the service had implemented a new care planning system six weeks prior to our inspection the gaps meant people could receive the wrong care or treatment. Care records were not accurate or complete.

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

The other audits we looked at were effective and where shortfalls and gaps had been identified, evidence of action taken was recorded. Audits were completed in respect of health & safety, audits in the kitchen area, infection control (due again in June 2017), cleaning schedules, and the management of medicines. In addition the supplying pharmacist had completed a comprehensive review of the management of medicines and there were a number of recommendations made by them. The clinical lead nurse had already taken action to implement the improvements. The maintenance staff had a programme of safety checks to ensure the premises and the gardens were kept safe.

The was a programme of improvement and refurbishment for the premises. Remedial works were in progress in the main reception area where water damage had caused staining. Bedrooms were assessed

when they became vacant and either the paint work was touched-up or fully redecorated. These measures ensured the premises remained fit for purpose and a comfortable place in which to live and work.

Those people who were able to engage in conversation knew who the manager was (the clinical lead nurse) and referred to them by name. They confirmed that she was frequently seen in and around Stinchcombe Manor. Relatives also confirmed the same. People and relatives were asked if they had taken part in any formal feedback processes about the service and they could not recall doing this. The clinical lead nurse told us their feedback was gathered during discussions.

A survey form was introduced in Autumn 2016 for professional visitors and responses had been supplied by a podiatrist, district nurses, an occupational therapist, a hearing aid technician and visiting trades people. They were asked about the welcome to the home, whether they received the assistance they needed and were given any information they needed. Comments they made included, "Always helpful", "I was welcomed and accommodated", "Nothing was too much trouble, friendly warm and charming" and "Friendly staff, nice to be offered a cup of tea".

Staff were of the opinion that the service was now better managed and the clinical lead nurse provided good management. The registered manager was supported by the clinical lead nurse and two care coordinators (there was a vacancy for one further care coordinator). These senior members of staff were visible and accessible to people, relatives and the staff team with the main office being located near the front door and reception desk.

Regular staff meetings were held. The clinical lead nurse explained these had initially been held on a two weekly basis in order to address the many areas of improvement that was required. The staff meetings were now held on a monthly basis. The clinical lead nurse had instilled in the staff team a collective responsibility for the quality of the service and had 'got them on board' in making the changes. Those staff who were unable to attend staff meetings were supplied with a copy of the meeting notes. In addition to this, the clinical lead nurse used communication sheets to inform staff of any new information, for example a new admission to the home or a change in a person's health. Staff told us that feedback from them was actively encouraged and any suggestions they made were acted upon where appropriate. One member of staff told us they had asked for new bedding and towels and these had been provided. The notes of the meeting held in the previous week included discussions about work practices, new staff and the new care planning system.

The registered provider/ clinical lead nurse was always informed about any events that happened in the home and this included any incidents, health and safety issues, complaints or concerns received, occupancy levels and staffing issues . This ensured they were aware of how the service was being run. The clinical lead nurse analysed any falls, accidents and incidents and complaints on a monthly basis in order to identify any trends. This meant they were able to make any adjustments to prevent further occurrences.

The clinical lead nurse was aware when statutory notifications had to be submitted to CQC. These notifications would tell us about any events that had happened in the service. Since the last inspection in June/July 2016 notifications the service had notified us of five expected deaths and three sudden deaths which had not been expected at that time. The service also notified us about one fall where the person sustained an injury and seven authorisations of DoLS applications. We used this information to monitor the service and to check how any events had been handled.

The clinical lead nurse explained the policies and procedures were kept under review however the key policies we were provided with copies of were not dated. As new policies were issued staff had to sign to say

they read and understood the policy and this meant the staff team worked to the same policies.

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 17 HSCA RA Regulations 2014 Good governance The systems in place to monitor the quality and safety of the service did not ensure that all shortfalls were identified and acted upon. Regulation 17(2)(a). Care records were not accurate, complete and contemporaneous. The records were not fit for purpose. Regulation 17(2)(c).