

Stroud Care Services Limited

Stinchcombe Manor

Inspection report

Echo Lane
Stinchcombe
Dursley
Gloucestershire
GL11 6BQ
Tel: 01453 549162
Website:

Date of inspection visit: 1 and 2 December 2015
Date of publication: 16/02/2016

Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Good



Is the service caring?

Good



Is the service responsive?

Good



Is the service well-led?

Requires improvement



Overall summary

Stinchcombe Manor is a care home that provides accommodation, nursing and personal care for a maximum of 36 people. At the time of our inspection 25 people were using the service.

This inspection was unannounced and took place on 1 and 2 December 2015. We previously inspected the service on 20 and 21 May 2015. At that inspection 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. The provider sent us an action plan saying what they were going to do to make the necessary improvements. During this inspection we checked if improvements had been made.

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. Like

Summary of findings

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.

People were not always kept safe. This was because safe staffing levels had not always been provided. On one night shift on the 1st November 2015 there was no qualified nurse working. Stinchcombe Manor is registered with CQC to provide accommodation for people who require nursing and personal care. The absence of a qualified nurse meant people who required nursing care were not receiving this.

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. People were protected from the risks associated with medicines because the provider had clear systems in place. Recruitment checks to ensure staff were suitable to carry out their role were in place.

The service provided people with effective care and support. Staff had received the training required to meet people's needs. People's capacity to make choices and decisions was assessed. Where people were assessed as not having the capacity to make choices and decisions and, there were restrictions upon their freedom, the provider had sought authorisation from the appropriate authorities. People's intake of food and drink was

monitored. People had access to health care professionals when they needed. The provider had carried out improvements to the home to make it easier for people living with dementia.

People received a service that was caring. People were involved in the planning of their care and support. People's independence was promoted. Staff treated people in a caring manner and ensured their privacy and dignity was maintained.

The service was responsive to people's needs. Care plans were person centred. People had access to a variety of activities that were planned taking into account their needs and interests. The provider responded appropriately to comments and complaints.

The service was not consistently well-led. The registered manager and provider had not always submitted notifications to the Care Quality Commission (CQC) as required by law. Staff gave mixed feedback on the management team. The registered manager and other senior staff had worked to communicate the vision and values of the service. Quality checks were carried out and improvements made where necessary.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe staffing levels and a breach of the Care Quality Commission (Registration) Regulations 2009 in relation to the submission of notifications.

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?

The service was not always safe.

The provider had not always ensured there were sufficient qualified staff to care for people safely. On the night of 1 November 2015 there was no qualified nurse at the service.

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

Pre-employment checks were carried out to ensure staff were suitable to care for vulnerable people.

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

Requires improvement



Is the service effective?

The service was effective.

Staff had received the training required to meet people's needs.

The service met the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's fluid and nutritional intake was monitored to ensure they received enough to eat and drink.

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

The provider had made alterations to the home to make it more appropriate for people living with dementia.

Good



Is the service caring?

The service people received was caring.

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

People and where appropriate, their families, were involved in the planning of their care and support.

People's independence was promoted.

Good



Is the service responsive?

The service was responsive to people's needs.

People received a service that was planned around their needs. Care plans were person centred.

Good



Summary of findings

People had access to a variety of activities that were planned taking into account their needs and interests.

The provider responded appropriately to comments and complaints.

Is the service well-led?

The service was not consistently well-led.

The registered manager and provider had not always submitted notifications to the Care Quality Commission (CQC) as required by law.

Staff gave mixed feedback on the leadership and management of the service.

The registered manager and other senior staff had communicated the vision and values of the service to staff.

Quality checks were carried out and improvements made where necessary.

Requires improvement



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 1 and 2 December 2015 and was unannounced. The inspection was carried out by two adult social care inspectors.

Prior to the inspection we looked at the information we had about the service. This information included the action plan the provider had sent to us following our inspection of the service on 20 and 21 May 2015. We reviewed 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 a range of health and social care professionals including, 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.

Some people were able to talk with us about the service they received. We spoke to seven people. We carried out two Short Observational Framework for Inspection (SOFI 2) assessments, one on day one and one on day two. 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 spoke with eight staff, including the registered manager, deputy manager, nursing staff, care staff and housekeeping staff. We also spoke with three relatives who were visiting people.

We looked at the care records of six people using the service, four 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.

Is the service safe?

Our findings

People told us they felt safe. One person said, “I feel safe here, it’s my home”. Another said, “Yes, I feel safe here”. When carrying out our observations we saw people were relaxed and comfortable with staff.

Prior to our inspection we had received information that a qualified nurse had not been at the service on the night of the 1 November 2015. We looked at staff rotas and saw this was the case. The registered manager said this had arisen as a result of an agency nurse cancelling a shift. They said measures had been taken to ensure a qualified nurse would be provided if this happened again. They told us they would now be informed if a nurse was not able to complete their shift in time to arrange a replacement.

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

People told us there was enough staff. Relatives also said there was sufficient staff to safely care for people. One relative said, “There’s always someone around when you need them”. Another said, “There’s plenty of staff”. The registered manager told us a dependency tool had been introduced since our last inspection. Their action plan following our inspection stated this tool was used regularly to determine the staffing levels required to care for people safely. We saw the dependency tool had been used as planned. Staff rotas showed staffing levels identified as required had been provided with the exception of the 1 November 2015.

At the time of our inspection the required staffing levels were being achieved through staff working additional hours and agency staff being brought in. Care staff said they felt there was sufficient staff and they did not feel under pressure to work additional hours. We saw the provider used agency staff to provide qualified nurses on a regular basis. The provider said they were actively seeking to recruit qualified nurses and were using a variety of advertising methods to encourage applicants.

Recruitment records for staff employed at the service contained the relevant checks. Records included 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. There was a record of checks to ensure qualified nurses were registered to practice with the Nursing and Midwifery Council (NMC).

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. One relative was very complementary about the action the provider had taken to keep their family member safe.

Risk assessments were in place and had been regularly reviewed. These assessments included personal care, moving and handling, skin care and fluid and nutritional intake. The assessments identified the risk to the person, how the risk would be minimised and any training required by staff. Staff were knowledgeable concerning these risk assessments and ensured they were followed.

People received their medicines as prescribed. Medication administration records were well maintained and easy to read. Individual protocols were in place to assist nursing staff to provide medicines in a person centred manner. There was guidance for staff on the administration of ‘as required medicines’, including medicines to control pain.

Some people’s finances were looked after by the office. We completed a random check on the finances. 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. This was identified as requiring improvement our inspection in May 2015. The deputy manager said they would rectify this by putting in place inventories and ensuring they are kept up to date. We discussed how this would be achieved. The deputy manager said an inventory was now completed on admission for any person new to the service. They had then prioritised completing inventories with people who had begun using the service after April 2015. This was the date the provider had taken

Is the service safe?

responsibility for the service. Once these had been completed they would then complete inventories with other people by liaising with families. They said inventories would be in place for each person within eight weeks.

Some people needed assistance with moving and handling. Where this required the use of a hoist and sling, the provider had ensured people had their own slings. Slings are individual lifting aids that fit to hoists to allow

people to be moved safely and comfortably. We were told these slings were laundered separately and not used by other people. This meant the risk of cross infection was minimised.

The provider had a policy in place to prevent and control the risk of infection. Staff had received training on infection control. Staff said they were provided with personal protective equipment such as, gloves and aprons. The home was clean and free from odour. Housekeeping staff were employed to assist with the cleaning of the home and to complete the laundry.

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. Comments included: "The change in my father has been fantastic, the staff have got time for him, he's a different man now", "The staff are skilled at what they do" and, "The staff always have time to sit and talk".

When we visited in May 2015 we found staff had not always received the training required to meet people's needs. The provider had told us how they would improve this in their action plan. At this inspection we found improvements had been made.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. Staff said they had access to training relating to people's specific needs. We viewed the training records for the staff team and records confirmed staff received training on a range of subjects. Training completed by staff included nutrition, safeguarding vulnerable adults, dementia awareness, medication, first aid, infection control, fire awareness, food hygiene and moving and handling. A programme of training was in place to ensure qualified nursing staff were able to update their clinical skills regarding wound care management and catheter care.

New staff were supported to complete an induction programme before working on their own. The provider ensured new staff completed the new care certificate as part of their induction. The care certificate aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. Three newly appointed members of care staff told us this had been helpful. They said, "As well as the training, shadowing more experienced staff was good", "I enjoyed the training" and, "Now, I'm starting my NVQ". This related to health and social care diploma training which was previously known as national vocational qualifications (NVQ). This is a work based award that is achieved through assessment and training. To achieve an award, candidates must prove that they have the ability (competence) to carry out their job to the required standard.

Staff gave mixed feedback regarding supervisions (one to one meeting) with their line manager. Care staff spoke positively and said they received supervision and were able

to discuss any training needs or concerns they had. One member of staff said, "I find supervision very helpful". Qualified nursing staff said they didn't always receive regular supervision and did not find them useful when they did. The deputy manager said they had planned for the clinical lead nurse to carry out supervision with the nursing staff. However, the post was vacant and they were planning to carry these out. The providers' policy states these supervisions should take place every four weeks.

When we visited in May 2015 we found people were not protected from the risk of deprivation of their liberty without the correct authorisation being in place. The provider had told us how they would improve this in their action plan. At this inspection we found improvements had been made.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

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 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 people through a process of 'best interest' decision making to ensure their needs were met. DoLS applications had been completed and submitted to the

Is the service effective?

appropriate authorities. The provider had a system in place to monitor the progress of these applications. The registered manager knew they had to inform the CQC when applications were approved.

People had access to drinks in the dining area, squash, water, fresh and dried fruit. Tea, coffee and cakes were also available throughout the day. People told us the food was good. Menus were available and included photographs of the food. Relatives said the food was good. One said, "When my father moved in the chef came to meet him and find out what his favourite foods were".

We observed people at lunchtime. The food was hot and appeared appetising. Meals were served from a heated trolley. People seemed to enjoy the mealtime experience. We saw an example of what the service referred to as 'mirrored eating'. This involved a staff member sitting with a person who found it difficult to concentrate on eating. The staff member ate the same meal as the person. The person became less anxious and preoccupied once the staff

member sat with them. They then ate their food and were engaged in conversation with the staff member. Some people chose to eat their lunch in their rooms. Staff provided the assistance people required.

People's care records contained food and fluid charts to monitor their intake. Staff said they kept an eye on people's food and fluid intake along with their weights. They said if they had any concerns they sought the advice of the person's GP. 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 provider had carried out the improvements they had told us they had planned, when we visited in May 2015. As a result the home now appeared cleaner, brighter, less cluttered and easier for people living with dementia to find their way around. A new lounge was now in use room with nice views from the windows and the dining area was less crowded. The provider had also redecorated the corridors and taken care to provide a more stimulating environment for people.

Is the service caring?

Our findings

People told us the staff were caring and friendly. One person said, “The staff are very nice and kind”. Another person said, “They’re all lovely really”. Relatives said, “They are all lovely, we’re treated as part of a family and included in all aspects of mum’s care” and, “The staff are lovely and I think everyone is happy here”.

We observed staff treating people in a caring manner. People appeared happy and contented. 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, staff sat with people and spent time talking with them about their families and other interests. People’s care was not rushed enabling staff to spend quality time with them. On another occasion we saw a staff member singing with a person whilst encouraging them to eat. The person was smiling and clearly enjoying singing with the staff member.

We overheard one example of a staff member talking about people in a manner that was not person centred. They said to another member of staff, “Is all yours done downstairs”. We spent time talking with this staff member and felt this was more a case of using an unfortunate phrase rather than them not valuing the people they were caring for.

People were treated with kindness and compassion in their day-to-day care. For example, one person appeared anxious when being hoisted from their wheelchair to an easy chair. The two staff supporting the person talked through what was happening and tried to put the person at ease.

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.

People’s care records included information about their personal circumstances and how they wished to be supported. People said they had been involved in agreeing their care plans. Care records contained information on how people and, where appropriate their relatives, had been involved in writing them.

The provider had introduced 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. Keyworkers completed a monthly report with the involvement of the person and their family. These reports were then reviewed by the registered manager.

People’s independence was promoted. Changes to the lay out of the building meant people were now able to move around the home more freely. People’s care records contained plans and risk assessments aimed at encouraging people to develop or maintain their independence. During our visit we sat in on a staff meeting. At this meeting the registered manager reminded staff not to ‘de-skill’ people. They went on to explain that staff must work alongside people to encourage them to do as much as they can themselves.

Staff we spoke with said they would be happy for a relative of theirs to be cared for at Stinchcombe Manor. They said, “The care here is really good” and, “I’d be more than happy with a relative of mine living here, I think the staff are really caring”. Staff had received training on equality and diversity. They were able to explain how people’s cultural needs were identified and met.

Is the service responsive?

Our findings

People told us the service responded to their individual needs. One person said, “When I need the staff they come”. Another said, “I get the help I need”. Relatives said staff responded to people’s needs.

Call bells to summon staff were available to people and within their reach. Throughout our visit we saw staff responding to call bells promptly. The deputy manager said they were in the process of linking the call bell system with the computer. They said this would allow them to easily monitor how quickly call bells were responded to during the day and night.

When we visited in May 2015 we found care records were not completed adequately. The provider had told us how they would improve this in their action plan. At this inspection we found improvements had been made.

The provider had introduced a new electronic care planning system. We received feedback prior to our inspection from a health care professional that the system was not easy to use and they had found they could not access the information they required. We saw staff using the system to make daily recordings during our visit. Staff said the system had taken time to get used to but they now found it to be effective. Electronic care records we looked at contained detailed daily recordings and were person centred. A copy of people’s care plan, a print out of the previous month’s daily recordings and the keyworkers monthly report were kept in an individual file. This file also contained information on people’s hobbies and interests and their likes and dislikes.

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain their own hobbies and interests, staff provided support as

required. People said they enjoyed the activities. A weekly plan of activities was displayed in the lobby area of the home. Activities suitable for people living with dementia were organised. These included tactile craft activities and age appropriate music and events. Relatives said there were enough activities for people. During our visit we saw the activities organiser and care staff engaging people in a range of different activities.

The service responded to people’s individual needs by providing individualised support and equipment. One example included a staff member instructing other staff at the staff meeting on how to support someone in a personalised way. The staff member suggested techniques for re-directing a person when they were upset. They had also found red toilet rolls and plates to assist the person to identify them. Another example was quoted by a family member. They said, “They did a mural on my father’s wall of the cricket ground he used to go to”.

The provider had a complaints policy in place. Information on how to make a complaint was on display in the lobby area of the home. Complaints received since our last inspection had been investigated and feedback given to people and their relatives. We spoke with the registered manager and the deputy manager about how complaints and comments should be viewed as an opportunity to improve the service. They said they had attended a workshop about handling concerns and complaints and intended to make improvements to how they responded to complainants.

People were encouraged and supported to develop and maintain relationships with people that mattered to them and avoid social isolation. People’s care records identified people important to them and how they wished them to be involved in their lives. Relatives we spoke with said staff helped maintain relationships between the person and them.

Is the service well-led?

Our findings

The service promoted a positive culture. Throughout our visit we saw staff caring for people in a person-centred, open, inclusive and empowering manner. The provider had made significant improvements to the service people received. These changes had been planned and communicated to people, relatives and staff. Gloucestershire County Council's quality monitoring team had recently visited the service. They told us they had noted a number of improvements to the service provided.

The registered manager had not always notified CQC of events as required by law. On the night of 1 November 2015 there had not been a qualified nurse working at the service. The registered manager said they had not been made aware of this until the following day. After becoming aware of this they did not send a notification to CQC. CQC had received notifications from the service about other events. On several occasions these notifications did not contain sufficient detail.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notification of other incidents.

The management structure of the service involved the registered manager, overseeing a deputy manager who then managed a care co-ordinator and a clinical lead. The care co-ordinator was responsible for the care staff, with the clinical lead being responsible for the nursing staff. The clinical lead position was vacant at the time of our inspection. Since May 2015 two clinical leads had been employed separately and both had resigned. We discussed this with the registered and deputy manager. They had plans to recruit a new clinical lead nurse and said they would try to ensure their role was clear and provided good leadership for the nursing staff.

Staff gave mixed messages regarding the management team. Comments included, "They're always approachable

and resolve problems", "They have made loads of improvements and have high standards", "They're nice but I think they lack ability and confidence" and, "They need to listen to staff more".

Regular staff meetings were held. We were able to sit in on a staff meeting during our visit. The meeting was well attended and chaired by the registered manager and the deputy manager. Staff were encouraged to express their views and opinions and were listened to. During the meeting staff said they felt the managers should feedback positives comments received from people and their families to them. The deputy manager said they would ensure this was done. The managers demonstrated effective leadership and ensured people's needs were at the centre of discussions and agreed actions.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. These included audits carried out by the management team and audits carried out every other month by an external advisor. These audits covered all aspects of the service people received and identified actions to be taken to make improvements. For example, the audit carried out by the external advisor in September 2015 recommended cakes on display in communal areas should be covered and, that the managers attend a workshop on managing complaints effectively. Both these recommendations had been acted upon. These audits also included feedback from people using the service, their families and other health and social care professionals.

Since we visited in May 2015 the management team had reviewed a number of the providers' (Stroud Care Services Limited) policies and procedures to make them more specific to Stinchcombe Manor. They had plans to complete this. The registered manager said this was important in order for all staff to be able to easily access guidance and advice.

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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

People who use services were not always cared for by sufficient and suitably qualified staff. Regulation 18 (1).

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 CQC (Registration) Regulations 2009
Notification of other incidents

The provider had not submitted notifications as required by law. Regulation 18 (2) (g) (i).