Gorseway Nursing Home Limited

Gorseway Nursing Home

Inspection report

354 Sea Front
Hayling Island
PO11 0BA

Tel: 02393233550
Website: www.agincare.com/care-homes/hampshire/gorseway-nursing-home-hayling-island

Date of inspection visit:
17 November 2020

Date of publication:
14 January 2021

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Gorseway Nursing Home is both a residential care home providing personal care and a residential care home providing nursing care. The service is registered to provide support for up to 88 people. It is split into two areas of accommodation known as The Manor and The Lodge. At the time of the inspection there were 39 people living in The Lodge and 11 people living in The Manor. 'Memory lane' is part of the Lodge and specialises in providing care to people living with dementia.

People's experience of using this service and what we found
Improvements had been made in the management of risks to people. However, the actions taken to mitigate risks were not always recorded as delivered which meant we could not be assured they were always completed, and this could place people at risk of harm. The provider was acting to address this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, the records to support this in practice were not always accurate or complete.

Although there had been significant improvements in the monitoring and evaluation of the safety and quality of the service, the system had not identified the concerns we found in respect of the above. There were plans in place to address this.

Improvements had been made in the reporting and management of incidents, including safeguarding people from abuse. People and relatives told us safety in the service had improved and staff were using tools to help them identify learning from incidents and make further improvements for people. Staff were safely recruited and there were enough staff effectively deployed to meet people's needs. Peoples medicines were managed safely, and procedures were in place and implemented to prevent the spread of infection. We have offered some guidance to develop the provider's approach.

Staff had completed training to support them to carry out their role effectively. Staff received supervision and told us they were supported by managers in the home. People's needs were assessed by a variety of healthcare professionals. However, improvements were required to evidence their guidance was always followed by staff to promote people's wellbeing. People's nutritional needs were assessed, and risks were identified and monitored. People had achieved good outcomes from the management of their nutritional needs. People and relatives spoke positively about the food on offer in the home.

We received feedback from people, relatives and staff telling us about improvements in the leadership and culture of the home. Their comments described a safer, happier, more caring and effective service. The registered manager submitted information to CQC as required and continued to work in partnership with others to support the development of the service.

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

Rating at last inspection and update
The last rating for this service was Inadequate (published 29 May 2020) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found improvements had been made. However, the provider was still in breach of two regulations.

This service has been in Special Measures since 29 May 2020. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
We undertook this focused inspection to check the provider had followed their action plan and to check they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Effective and Well-led. Safe and Effective were rated Inadequate at the previous inspection.

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 coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from Inadequate to Requires Improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Gorseway Nursing Home 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 monitor the service to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to safe care and treatment and good governance at this inspection. Please see the action we have told the provider to take at the end of this report.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.
Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.
Details are in our effective findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.
Details are in our well-Led findings below.

Gorseway Nursing Home

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 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.

Service and service type
Gorseway Nursing Home 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
Inspection activity started on 9 November 2020 and involved reviewing records, seeking feedback from people, relatives, and other health and social care professionals. We gave the service 30 minutes notice of the inspection visit as we needed to be sure the inspection could be undertaken safely.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used information from our on-going monitoring meetings and related information received from the service. We spoke with 10

people who used the service and one staff member using zoom and nine relatives by telephone about their experience of the care provided. We reviewed a range of records. This included elements of 20 people's care records. We used all of this information to plan our inspection.

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.

During the inspection
We spoke with 10 members of staff including the chief operating officer, registered manager, operations manager, two deputy managers, a team leader, a nurse and three care workers. Some people using the service were not able to verbally express their views about the service and we spent time observing the support and interactions between people and staff. We also reviewed the environment and equipment in place. We looked at multiple medication records and the management of medication in the Lodge and the Manor.

After the inspection
We spoke with three members of staff and the registered manager and we continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We looked at four staff files in relation to recruitment and staff supervision and a variety of records relating to the management of the service, including policies and procedures. We spoke with a local authority adult services team manager who has regular contact with the service.

Requires Improvement

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 Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant some aspects of the service were not always safe and there was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to effectively assess risks to people, implement plans to reduce risks and to ensure these plans were followed by staff. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made further work was required to ensure the care people received was safe and reduced any risk posed to them. The provider remained in breach of Regulation 12.

● Staff we spoke to were knowledgeable about people's risks and were able to confirm actions taken to reduce risks. However, actions taken to manage risks were not always recorded as delivered which meant we could not be assured these were always completed.
● For example, for one person we noted wound records identified an old wound had reopened. Whilst a skin integrity care plan was in place and reflected the need to reposition the person every two hours, their repositioning records did not reflect staff were supporting this person to reposition regularly in line with either the care plan or the wound record. This meant we could not be assured the wound had not reopened because staff had not been supporting the person to move on a regular basis. We found other examples related to risks with nutrition, diabetes and continence support.

Risk management was not robust enough to demonstrate actions to mitigate risks were always followed by staff. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider responded after the inspection and told us about the improvements they were making to risk management. Meetings were being held with nurses to improve the monitoring and evaluation of risk management plans and 'resident of the day' reviews were being used to check care records reflected the actions required to reduce and manage risks.
● Information available to staff about risks to people and the actions to reduce risks had improved. Staff confirmed they were able to access risk information on their hand-held devices as well as information included in daily handover records and meetings.
● Where equipment was required to reduce risks, we observed these were being used effectively.
● We received feedback from people and relatives to confirm improvements had been made, their comments included; "Yes, [person] is safe now, I am more confident as now got better over-view of general care plan, got an arrangement where I speak to the manager weekly" and, "Risks were not clearly

communicated but they are now, they [staff] are aware of my [person] risks, so they are now on the ball." A person said, "I have an example for you today [on risk] when the toast was on, the alarm went off, doors shut closed, the maintenance man was there, it was as if it was a fire alarm test, he stopped the alarm, repaired the toaster and we got our toast."
● Checks of the building and equipment including fire safety were undertaken.

Systems and processes to safeguard people from the risk of abuse

At our last inspection the provider had failed to investigate and report incidents of potential abuse and harm. This was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 13.

● Improvements had been made in the identification, reporting and investigation of incidents of potential abuse or harm. Records confirmed incident reporting had increased significantly since our previous inspection and where applicable safeguarding referrals were made.
● Staff we spoke with understood their safeguarding responsibility, how to report incidents and what signs could indicate potential abuse. Staff had completed safeguarding training and in addition some staff had attended 'huddle training' on safeguarding. This is short and focused training aimed at supporting staff learning based on current examples in the home.
● The registered manager told us, "We have been really transparent and open in reporting [to safeguarding] because we have wanted to get that support and to share that risk." We discussed an example of how the service was working with the safeguarding team to ensure concerns about a person were shared, monitored and acted on. A team manager from the local authority adult services confirmed communication had improved.

Learning lessons when things go wrong

At our last inspection the provider had failed to operate effective systems to ensure incidents which placed people at risk were analysed to ensure improvements were identified and implemented. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of Regulation 17.

● A monthly analysis of incidents was completed which showed action taken in response to incidents as well as the identification of any trends and factors influencing the incident. When asked about incident reporting a supervisory staff member said, "Everything, bruising any mark you can see, one [person] had a graze, so I checked to see it had been reported anyway – I always say get the nurse to check it. They [staff] have been really good and they are brilliant now – I just tell them if it's not written down it didn't happen."
● The registered manager had introduced a root cause analysis process which helps to identify why an event occurred. We saw examples which showed this process had been used to investigate incidents and identify preventative or improvement actions which had positive outcomes for people.
● Staff were supported to learn from incidents using a reflective supervision process which helps to identity improvement actions and practice development.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were always managed safely. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of Regulation 12.

● Temperatures of all medicine storage areas in the home were regularly monitored. In addition, an air conditioning unit had been installed in the medicines room at the Manor to control the temperature so medicines could be stored safely. Records showed temperatures were checked daily and action was taken when the temperature was above safe limits.
● People were supported to take their medicines as prescribed. Night-time medicines for people living at the Manor were now administered by a nurse from the Lodge. This meant people could receive their medicines at the time prescribed.
● The management of medicines at the Manor had improved. Stock was regularly counted and monitored. The medicines room was clean, tidy and well organised. The deputy manager had good oversight of people's medicines and these were audited daily. We saw this process was effective in identifying and acting on errors promptly to promote people's safety.
● PRN protocols were in place and included information for staff to understand when these medicines should be given.
● There were systems in place to ensure that medicines were ordered and disposed of correctly and safely.
● Medicines were administered by registered nurses or suitably trained staff who had been assessed as competent to do so safely.
● Medicines that have legal controls, 'Controlled drugs' (CD's) were appropriately managed in the Lodge, there were no CD's in use at the Manor.

Staffing and recruitment

At our last inspection we recommended the provider considered the deployment of staff to ensure people's needs could be monitored and met more effectively. At this inspection we found the deployment of staff had improved.

● The registered manager told us a staff member was always available in the lounge, on memory lane and were present to monitor and check people were safe. We observed call bells were answered promptly and people did not appear to be calling out or waiting for staff.
● Some relatives told us there had been issues with staffing including; the high use of agency staff, retention of staff and staffing numbers but indicated there had been improvements over the past few months and a relative told us the time taken to answer call bells had improved. They said "[Person] is much more content now and said it [call bell response] was definitely better."
● People told us, "If I need staff I buzz, they come fairly quickly, I do use it, they come very quickly, it is a comfort to me. I wear it always, night-time I don't wait long, same on weekends as weekdays, they come quickly" and, "Got a buzzer in my room, got an alarm and I wait very little time, they are helpful."

● The provider had successfully recruited permanent nursing and care staff for day shifts which meant the use of agency staff had significantly decreased. Permanent night staff had also been recruited at the time of the inspection and were due to start working in the home shortly following the inspection.

● When agency staff were used, they were block booked and as far as possible familiar with the home and people's needs. Agency staff worked solely in the service to minimise the risk to people from cross infection of COVID-19.
● Staff continued to be recruited safely.

Preventing and controlling infection
● We were somewhat assured that the provider was meeting shielding and social distancing rules. We signposted the provider to resources to develop their approach to include individual risk assessments to identify people's level of vulnerability and actions to mitigate risks.
● We were somewhat assured that the provider was using PPE effectively and safely. We signposted the provider to develop their approach about PPE worn when assisting people with eating.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Inadequate. At this inspection this key question has now improved to Requires Improvement. This meant the effectiveness of people's care, treatment and support was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

At our last inspection the provider had failed to ensure accurate records about people's ability to make decisions. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider remained in breach of this element of Regulation 17. Records about people's consent and mental capacity still required improvement.

- Applications had been made for people assessed as requiring a DoLS. However, the assessment did not include a mental capacity assessment. This is important to establish and confirm whether the person does lack the capacity to consent to their care and treatment arrangements prior to application. The registered manager assured us this was being put into practice immediately following the inspection.
- Some people's records stated they did not have the capacity to manage their own medicines. However, when we looked for the mental capacity assessments to confirm this, they had not been completed. On discussion with the registered manager and deputy manager this appeared to be a recording error and people had chosen to have their medicines managed by the service which meant these records were inaccurate.
- We found four examples of consent forms which had been signed by people but had not been fully

completed to show what they had consented to. For example, the consent form provides options for the person to select whether they understand and agree they have been given full and detailed information about the service including costs. That they understood and agreed to their care plan and the management of risks to them and whether they consented to sharing information about their care. These records were incomplete and did not show what people had consented to.

Systems were not robust enough to demonstrate records relating to people's ability to make decisions and give their consent was effectively managed. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●The provider was in the process of reviewing records relating to people's decision making and mental capacity to ensure information was accurate and complete.
● Improvements had been made in the recording of mental capacity and best interest decisions for people who required bed rails and this was monitored.
●Staff had completed training in the MCA and those we spoke with were aware of the MCA and how to use the principles in their role. A staff member said, "You presume people have capacity and support them in their decisions. We try to make the best decision with them and in the least restrictive way. We act in their best interests."
● One person's DoLS had conditions and these were known about and not relevant at this time.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to demonstrate staff received appropriate support, supervision and training. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18.

●Records of staff training showed all staff had completed training identified as mandatory by the provider. This included training in Infection prevention and control which included COVID-19 training.
●Some of the provider's plans for face to face training had been disrupted due to the COVID-19 pandemic. However, the provider had used experienced staff to deliver in house training on end of life care and the service planned to work with a hospice to deliver future end of life training when safe to do so. The registered manager told us they had also introduced reflective de-briefs following people's deaths and said, "This supports staff and to see if there are any issues which we could do better or have gone well to promote improvement."
●Staff had completed training in manual handling and had their competency checked, which had been areas of concern at our previous inspection. We observed a person being supported to move which was carried out safely and the person told us the staff had done it "Alright."
● Staff we spoke with told us they received the training they needed to do their job and to support the needs of people living in the service. A staff member said, "Yes I have [received training] the registered manager is putting everything in place, first aid and everything – it's good I feel confident." A staff member confirmed they had received training in behaviours that challenge others and told us this had helped them understand how to respond more effectively. This was being rolled out to all staff.
● Nurses completed training in clinical areas including; Parkinson's awareness, tissue viability, wound and pressure care, diabetes and anaphylaxis.
● Records showed supervisions were taking place. Staff we spoke with told us they felt supported in their

role. A staff member said, "Yes, we had them recently [deputy manager] did mine, it was helpful, she is putting me in for further training and she has already put that in place. It never happened like that before, that made me really happy" and, "Yes, I do have supervisions and a lot of support from management and my team leader. Since she has been here, she knows her job, easy to talk to and she understands if we have issues, she is my go-to person."
● Staff appraisals had not taken place but had been scheduled from December 2020.

Supporting people to eat and drink enough to maintain a balanced diet

At our last inspection the provider had failed to effectively monitor and assess risks associated with nutritional needs. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of this element of Regulation 12.

● People's risk of malnutrition was assessed using a recognised tool. Records showed this risk assessment was reviewed monthly. When people were assessed as at risk of poor nutrition records showed actions had been identified to support people's nutritional needs.
● A monthly audit was carried out to monitor people's weights and progress with their nutritional plan. This had shown people's risk scores were reducing across the home and people were gaining weight.
● Whilst we could see there had been positive outcomes for people from this approach, some records could be improved to show what people had eaten. For example, an entry may state a person had eaten 25% of their meal but not what the food was or the portion size, which would enable staff to determine the calorific value of this. When people were to be offered fortified milkshakes or snacks to support their calorie intake it was not always recorded these had been offered, taken or refused. This is important to evaluate the effectiveness of the planned care.
● We saw high calorie snacks were available to people and offered during the day along with drinks. A person said, "You get crisps and KitKat on the tea trolley that comes at 10.30 and again in the afternoon. Horlicks, coffee, sandwiches if you want."
● People and their relatives spoke positively about the food on offer in the home. Comments included; "Food is 100% improvement, the menu is changing, the chef he listens, we now have salmon, more varied food", "[Person] says they feed her well and says that the food is nice" and, "You have a word with the chef and you can have fried bread, hash browns, any soup, any sandwich selection and they do it."
● When people required their food and drinks to be served at a specific consistency because of swallowing difficulties for example, this was recorded. During the inspection we observed people were given the consistency they required.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

At our last inspection the provider had failed to ensure recommendations and advice from health professionals was followed. This was a breach of Regulation 9 (Person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvement had been made at this inspection and the provider was no longer in breach of this element of Regulation 9. However, records did not always reflect care was given in line with recommendations and this still needed to be improved.

● For one person, a physiotherapist had recommended daily massage to assist with movement. The records did not evidence this was carried out daily. A dentist had recommended they were supported to brush their teeth twice daily, records reflected they were supported once a day with teeth brushing. Records did not always provide assurances actions were carried out as recommended.
● Care records did evidence other health professionals had been involved in the assessment of people's needs. This included GPs, occupational therapists, speech and language therapists and specialist nurses. We saw examples of recommendations being followed with some good detailed plans in place.
● People confirmed they were supported to access healthcare as required.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed and regular reviews were carried out to evaluate the effectiveness of their care. However, reviews did not always reflect accurate information or a full evaluation of whether planned care had been delivered.
● For example, a person's reviews had not accurately reflected their weight and progress for a period of three months. Reviews of needs associated with skin integrity such as repositioning and mattress settings had not identified these records were incomplete. Wound monitoring records were not always completed fully to show the progress and evaluation.
● We spoke to the registered manager about this, they told us work was being done with the nursing team to ensure reviews were more thorough and reflected an accurate evaluation of care delivered. More time was required to embed these improvements.
● At our previous inspection we found people's needs in relation to protected characteristics under the Equalities Act 2010 were not always assessed. At this inspection whilst the service had supported people with needs related to their age, disability and religion, other needs had not yet been explored. The registered manager was aware of this and planned to develop the approach so that people's diverse needs were assessed, and support options explored.

Adapting service, design, decoration to meet people's needs
● The home continued to provide a spacious and well-maintained environment. Some works were underway during our inspection to upgrade and adapt en-suite bathrooms. The registered manager told us this would provide improved accessible facilities for people such as a walk-in shower.
● People and their relatives spoke positively about the environment. Comments included; "The home has got a nice atmosphere, it needs more residents, beautiful building [person's] room is sunny, it is very comfortable, very welcoming, clean and it does not smell", "[person] loves sea views and they take [person] to a room where they can look out on the sea", "They are really good at putting photos I take in on [person's] walls in their room, they are really facilitating" and, "[person] says if I had to stay in a home, I would choose a home like this."
● Video calls had been used to assist people to keep in touch with relatives during lockdown. A room had been adapted to provide a safe environment for visitors during the pandemic.

Requires Improvement

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 Requires Improvement. At this inspection this key question has remained the same. Whilst it was evident there were improvements in service management and leadership some improvements still needed to be consistently applied and embedded into the service to always support the delivery of high-quality, person-centred care.

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

At our last inspection the provider had failed to demonstrate systems were effective in recognising safety and quality concerns and in driving improvement. This meant people continued to be at risk of not having their health and personal needs met in a safe effective way. This was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Significant improvements had been made to the systems used to monitor and evaluate the quality of the service and the care provided. However, further work was required to ensure this was fully effective. The provider remained in breach of Regulation 17.

● A monthly care and quality governance report was produced using data from; incidents and accidents, including falls, bed rails, pressure ulcers, unplanned weight loss, infectious incidents, deaths, safeguarding, medication, complaints and compliments. This was reviewed by the on-site clinical management team and resulted in an action plan for improvements which were monitored for completion. This system enabled the team to identify safety and quality concerns and make improvements. However, it did not identify the concerns we found in terms of daily records, recording of consent and mental capacity.
● Regular reviews of people's risks were taking place. However, the evaluations of risk management had not identified when care delivered was not in line with care plans guidance. This meant this system was not fully effective in assuring all risk management plans were followed.
● The registered manager told us they were aware of these shortfalls and plans were in place to address these.

The failure to operate an effective system to assess, monitor and mitigate risks relating to the health and safety of people was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the last inspection, the provider submitted an action plan to show what improvements they would make and by when. In addition, the provider has submitted monthly updates on their action plan and participated in regular monthly progress meetings.
● At this inspection we did not find any new areas of concern. Where concerns continued to exist as

described in this report, the registered manager was aware of these shortfalls and plans were in place to address these. More time was needed for changes to be fully embedded into the service.

● We received positive feedback from people and relatives about the management of the home and improvements in the service. Comments included; "The report before was right, but it is like they have put the home in the ships dock and refurbished it from top to bottom", "The Manager is really good at following things up, she has gone above and beyond" and, "The Manager and the staff are making people feel included and getting the right leader I think they have done that with the Manager."

● A deputy manager had been appointed to the Manor. They told us how they had been supported in their role and said, "They [registered manager] completely support me all the time and check on me, I couldn't ask for more."

●Staff were receiving supervision, training and competency checks to support them in their role.

●We saw an appropriate process was in place and was followed to address shortfalls in staff performance to achieve improvements.

At our last inspection the provider had failed to notify CQC of significant events which was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Enough improvement had been made at this inspection and the provider was no longer in breach of Regulation 18 (Registration).

● Statutory notifications had been submitted as required. Incidents and events were checked to determine if a notification was applicable.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● We received feedback from people, relatives and staff that the culture of the service had improved. Comments included; "Staff are more caring, they listen to what you say, they are conscientious, and you know with confidence anything you ask of staff they will do", "So much has changed, more steady loving carers now, got a wonderful chef, he is a pleaser, got more regular nurses, so different to six months ago and it is a good place to be, we are a family now" and, "They [service] have improved since March, taken over by new company and new manager, staff low with the previous incumbent, this manager has worked very hard to improve that. Staff she has employed have stayed, she seems to have trust, they seem to be competent and this has rubbed off on the care assistants. Improvement in how [person] looks, is clothed and in general demeanour."

● At the previous inspection the manager told us about plans to improve the culture of the service. We saw some of these plans had been implemented and had a positive impact on the service. For example; all heads of department and clinical leads had attended quality improvement training. This was aimed at supporting the team to develop and sustain improvement initiatives. As a result, training was delivered on end of life care, this included measuring the knowledge of participants before and after to check this had been effective.

● The registered manager had worked with the team at Gorseway to promote an inclusive and empowering culture. They told us this was being achieved by sharing information about issues such as COVID-19 testing and CQC regulations so the team could understand and take more ownership of requirements. A staff member said, "The service is much better especially since [deputy manager] has come in and supported [registered manager]. Training, recruitment been really good the support with the [care plan system]. Yes, the culture has changed hopefully onwards and upwards!" Another staff member told us, "It's a lovelier place to work now. It's been a lot of hard work, but I feel now the quality of care we are providing is how it should be and that's all I care about making sure they [people] are safe and well looked after."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.

● The provider understood their responsibility under the duty of candour. The registered manager told us there had not been an incident since the previous inspection which met the threshold for the duty of candour.

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

● People, relatives and staff had been asked for their feedback using a satisfaction survey. The results had been analysed and actions identified as a result. The actions were to be completed by the end of November 2020. We saw some actions had been achieved such as newsletters for relatives.

● A residents' meeting had been held on 28 October and attended by the registered manager and some of the staff. Minutes showed people's questions and feedback were responded to. A person said, "We have Residents' meetings with the manager, chef, housekeeper and maintenance, all the people we need to speak to, any queries you can ask, things get done."

● We saw examples of communications sent to residents and relatives regarding the outcome of the last CQC inspection, visiting arrangements and testing during the COVID-19 pandemic.

● We received feedback from people and relatives that communication had improved. Comments included; "Communication is better, get the bulletins, manager emails regularly, I am fully informed where they are going with [person] , I can suggest things but I respect the manager and know her views, she is working hard to get the best for my [relative]", "We as a family are beginning to build up rapport and feel that communication is better, care is better" and, "The manager and her assistant [residential] have good communication and we get emails, we spoke every night when she first went there, for reassurance, the phone contact has been good, communication has been good and they get back to you fairly quickly."

● Regular staff meeting were held. Minutes showed these meetings were used to discuss service issues and updates as well as the care and treatment of individuals, feedback to staff and learning.

.

Working in partnership with others; Continuous learning and improving care

● Following the previous inspection the registered managed had continued to work in partnership with the clinical commissioning group (CCG) and the local authority (LA) quality team to develop the service.

● The LA care homes team had delivered training, reviewed care plans and provided advice and support. The registered manager told us she had particularly valued their support during some "Tough Covid times."

● The CCG pharmacist had continued to work with the service and supported the improvements in medicines management and assisted in an improved relationship with the GP surgery.

● The COVID 19 pandemic had meant some partnership and learning opportunities had been postponed and this included; training planned to be delivered by the CCG and LA, Dementia friends training and a review by Healthwatch.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Risk management was not robust enough to demonstrate all that was reasonably practicable to mitigate risks was being carried out. This placed people at risk of harm. Regulation 12 (1) (2) (b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: Consent and other records about people's ability to make decisions were not always accurate and complete. Regulation 17(2)(c) Systems to assess, monitor and mitigate risks relating to the health and safety of people using the service were not always effective. Regulation 17 (2) (b).