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

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**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 area of accommodation known as The Manor and The Lodge.. At the time of the inspection 52 people were living in The Lodge and eight people living in The Manor.

People's experience of using this service and what we found
People were not always protected against the risk of harm. Unexplained injuries were not always reported or investigated. Allegations of abuse had not always reported or investigated. Following the inspection the manager and provider implemented changes to the incident reporting process to make this more effective and ensure safety.

Medicines were not managed safely. Assessment of risks for people were not always completed effectively, mitigation plans were not implemented, and staff did not always follow care plans.

The provider had not ensured that staff received sufficient induction to the service or that they had received the training they needed to be able to support people effectively, based on people's needs. People provided negative feedback about the food although we saw this was eaten during the inspection. Where poeple had lost weight it was not always clear that the cause of this had been explored or that action had been take, where appropriate to ensure people were not at risk of malnutrition. Although other health professionals were involved, we were not always confident that staff followed their advice when delivering care. People told us they were involved in making decisions about their care, and staff knowledge of the mental capacity act was adequate however, records about people's ability to make decisions was at times conflicting. We couldn't always see that national guidance was used to inform the service. For example, medicines competency assessments for staff had not taken place annually and although other health assessment tools were in place these were not always kept up to date.

Staff practice demonstrated people were not consistently treated with dignity and respect. People had not been involved in the development of care plans or reviews. However, the manager had planned to introduce a new system to ensure this happened and had care review meetings scheduled for March 2020.

People did not consistently receive personalised care. Care planning was not person centred and staff did not always deliver the care people needed. Planning for end of life care needs required improvements to ensure these needs could be met when they arose.

There had been a lack of effective oversight of the service by the provider, caused by inconsistent management and inadequate governance processes. Improvements identified in the action plan developed after the last inspection had not been addressed. Effective systems were not in place to allow continuous learning and improving care. There was not a robust process in place to monitor, act upon and analyse

incidents, accidents and near misses. This placed people at continued risk of harm.
The provider had failed to comply with the requirements of their registration as they had not notified CQC of several significant incidents.

A new manager had been in post for approximately four months. They were working in partnership with other external agencies to make improvements to the service and together had produced an action plan to support this. We were told that some positive changes to the culture of the service had been made since the new manager had started. Following the inspection the provider ensured the manager had additional support to make improvements. The manager was responsive to our feedback and supported the implementation of changes to the incident reporting process to make this more effective and ensure safety. Additional staff training was booked and the work required to make improvements to the risk assessments and care plans continued.

Recruitment processes to ensure people were supported by suitable staff were operated. Staffing levels had increased and met the needs of people but at times deployment could have been more effective. The new manager was addressing this. Risks posed by the environment were managed effectively. Complaints were effectively managed. The new manager was aware of the need to make significant improvements in the service and had engaged the support of other partner organisations to enable this to happen.

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 requires improvement (published 15 May 2019) 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 not been made and the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing, care and incidents. A decision was made for us to inspect and examine those risks.

Enforcement
We have identified breaches in relation to safe care and treatment, safeguarding people from abuse or harm, staff training and support, person centred care, treating people with dignity and respect, governance systems and reporting to CQC. We are mindful of the impact of 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.

Follow up
We will continue to monitor information we receive about the service. We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? he service was not well-led. Details are in our well-Led findings below.	**Requires Improvement**

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.

Inspection team
The inspection team consisted of three inspectors.

Service and service type
Gorseway Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 did not have a manager registered with the Care Quality Commission. This means the provider is legally responsible for how the service is run and for the quality and safety of the care provided. A manager had been recruited and was in post. They had submitted an application to CQC to become the registered manager. Throughout the report we refer to this person as the manager.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. This included the last inspection report, any notifications sent to us by the provider and any concerns or complaints we had received. We sought feedback from the local authority and professionals who work with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service

and made the judgements in this report.

During the inspection
We spoke with 13 people who live at the home and seven visitors. We also spoke with the manager, the operations manager, the chief operating officer. We spoke to eight care staff and three nursing staff in addition to housekeeping, kitchen and activity staff members.
Some people using the service were not able to verbally express their views about the service. Therefore, we spent time observing interactions between staff and people.

We reviewed a range of records. This included 15 people's care records and multiple medication records. We looked at six staff files, five supervision records, the staff training matrix and maintenance records. We also looked at records related the management and governance of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested an action plan and supporting information in order that we could be assured that where we considered risks to people, these were being addressed as a priority. We also made a referral to the Local Authority safeguarding team.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse
• People were not protected from the risk of abuse or avoidable harm.
• We found concerns reported on incident sheets and in people's daily notes had not been investigated or reported to the relevant authorities. For example, in October 2019 an incident sheet recorded bruising found on one person during personal care, with a member of staff stating it may have been due to a moving and handling transfer undertaken by three staff. The previous operations manager had recorded that this needed a root cause analysis completing but there was no evidence of this or that the incident of unexplained bruising had been reported to the Local Authority (LA).
• We found a further record dated February 2020 which stated a person had a bruise on their right forearm. There was no incident sheet and no evidence this had been investigated. The clinical lead told us they would only expect to see unexplained bruising on a body map and nothing else which would show they had been investigated. This meant we could not be assured that unexplained injuries were investigated to ensure no suspicious circumstances.
• The new manager who started at the end of October 2019, showed us an email they had circulated to all staff on 17/12/19 asking that everything be recorded on an incident form in order that they can see these and take appropriate action, however, staff were continuing not to do this.
• We also found an incident sheet dated October 2019 which recorded an allegation of abuse made by a person. However, this had not been investigated or reported to the LA. As this occurred before the manager and operations manager started working in the service, no one was able to provide an explanation to us about this. This meant we could not be assured that where people had made allegations about staff, they had been investigated and reported appropriately in order to protect people from abuse.

A failure to investigate and report incident of potential abuse and harm was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Following our inspection visit, to be assured that there were no more unknown injuries in the service we requested the manager ensure each person was checked for any bruises or injuries. This was completed and no new or unknown injuries or bruising were found.
• We also saw evidence that where the manager had been made aware of potential safeguarding issue, these were reported, investigated and lessons taken from these.
• Following the inspection, we were told the new manager had sent a further message to all staff stressing the importance of reporting all incidents. The process of incident reporting had been changed to support staff to do this appropriately and the new manager was exploring and booking further safeguarding training for staff.

Assessing risk, safety monitoring and management
• People were not protected from individual risks placing them at risk of harm.
• Permanent staff knowledge of the risks associated with people's needs was adequate however external agency workers did not have this knowledge. Agency workers are not directly employed by the provider and work on an as required basis.
• During our inspection one agency worker told us it was their first shift working at the service. They had not received an induction and had not been made aware of the computerised care planning system which held information they would need about people. They became aware of this when they were unable to find records to document people's blood sugar readings.
• A second agency worker told us they had worked six or seven shifts at the service. They told us they had not seen any people's care plans or risk assessments during this time. They told us they attended a handover meeting at the start of their shift but had not been provided with a handover sheet, containing information about people.
• A staff member told and showed us on the handheld devices they used to access information about people that they could only access the care plans. The new manager had completed and audit of assessments of risk which showed improvements in the completion of these this information had not been used to inform care plans for people. For example, for one person we saw the formal assessment of the risk of their skin breaking down was high. However, their care plan summary did not highlight this and provided significant conflicting information to their care plan about the frequency this person should be supported to be repositioned. For example, one stated 2-4 hourly and the other stated 4-6 hourly. On occasions records showed that this person was not always supported to move position for over six hours. The lack of clear guidance placed them at risk of skin damage.
• The assessments of the level of risk did not always cover all areas of risk for people. For example, we saw one person could behave in a way that could place them and others at risk of harm. No assessment of this risk had taken place. For another person we saw they could have difficulties with their elimination needs, placing them at risk but no assessment had been completed. A third person lived with contractures of their limbs. These could place them at risk of further complications, but this had not been assessed. The failure to assess all risks for individual people meant that all necessary action may not be taken to reduce these risks as far as possible.
• Where care plans were in place for an area of risk for people, these were not always accurate or up to date. For example, one person's care plan stated they were independent with movement using a walking stick and rollator. However, this person's needs had changed as we saw they required the support of a least two members of staff to stand and transfer into a chair and required a wheelchair to mobilise.
• We asked a permanent member of staff how they would know about this person's needs with moving and handling and they told us "I don't usually work with [person], [they] has only been here a few days. I don't know to be honest. We then asked where they could find out this information and they said they didn't know "to be honest".
• An agency worker we spoke with was unable to tell us about risks associated with people's care and said, "I don't know about any risks".
• A third member of staff told us they would find the most up to date information about the person from the handover sheet. However, this was not accurate either.
• This meant the person could be at risk of harm as staff were not aware of their needs and did not have access to up to date and accurate information in relation to their moving and handling needs.
• On at least two occasions we observed staff using poor and unsafe moving and handling practices. This placed the people at risk of harm.

The failure to effectively assess risks to people, to implement plans to reduce the risks and to ensure these plans were followed by staff was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
• Not all aspects of medicines management were safe.
• Medicines in the nursing home were managed by nursing staff. Medicines in the manor were managed by care staff.
• In the nursing home we found medicines were stored securely but were not always stored safely. For example, the temperature of medicines storage was not consistently taken. In the Manor we found that where medicines were stored the temperature was consistently above 25 degrees. Medicines stored in this room in the cupboard included those that should be stored under 25 degrees. A staff member told us, "Everyone is aware of it, maintenance knows, and we have asked for air con, they changed the clinical room to here don't know why."
• In the Manor we found night staff were not trained to give medicines and as such the decision had been made by the previous operations manager to give night time medicines at tea time. However, some of these medicines could pose risks to people if not given at the right time. For example, one person was prescribed a medicine for night but being given this at tea time. This medicine is recommended to be given at night-time to avoid side effects. A second person was prescribed a medicine to be given at night, but this was being given at tea time. This medicine can make you feel sleepy and the person had a known falls risk. Being given this medicine too early before going to bed had the potential to make the person drowsy and increase the risk of falls. Although this decision had been made, we could not see that consultation with other professionals such as GP's or Pharmacist had been undertaken to ensure this would be safe.
• In the Manor we found the stock check was confusing as some staff included stock in the medicine trolley and cupboard, whereas others only counted those in the trolley. This meant it would not be possible to check that all medicines had been given as prescribed. This process was much clearer and accurate in the nursing home.
• In both the nursing home and the manor we found that for medicines that were prescribed on a PRN basis, guidance for staff on when to administer or escalate the use of these to a GP were not consistently in place. This meant people may not receive PRN medicines when they needed them or in a consistent manner.

A failure to ensure medicines were managed safely at all times was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• We were not assured that lessons would be learnt following accidents or incidents meaning people would be at risk of potentially avoidable harm.
• Not all incidents were reported as incidents, demonstrating that there was a lack of awareness as to what constituted an incident. Where some had been recorded and stated a root cause analysis was needed, we found no records to show what analysis had taken place.
• In addition, whilst an incident tracker was used there was no evidence of analysis and lesson learned.
• Where people were at risk of falls and fell on a frequent basis, we saw no analysis of these for the person that would help staff to identify any patterns or trends and put in preventative or additional support measures.
• The manager had raised internally the need to make improvements to the incident recording approach to ensure trends and patterns could be identified and action take when they had first started working at the home, however at the time of our inspection visit this had not changed. Following the inspection the reporting on all incidents and accidents was changed to include a daily review of these by the manager.
• The chief operating officer told us that a new system had been implemented which would help to identify cause and lessons to be learnt. However, this had only started in February 2020 and as such had not had time to be embedded and to evidence it would be successful.

The failure to operate effective systems to ensure incidents which placed people at risk were analysed to

ensure improvements were identified and implemented was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At the last inspection we found the providers systems for assessing staff deployment were not utilised effectively to accurately determine the care and support people required with all elements of their care. As such we could not be confident the system used to determine staffing needed in the home, was operated effectively and this was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the section of regulation 18 relating to staff levels was no longer a breach, but further work was needed to ensure effective deployment of staff at all times.
• Staffing levels had been increased since the last inspection and were suitable to meet the needs of people but at times the deployment of these could be more effective. For example, on one occasion a person was crying out and despite the inspector walking the floor twice to find staff, no care staff could be found. • Although call bells could be regularly heard, these appeared to be responded to relatively promptly.

• We asked people and relatives whether there were enough staff on duty to provide adequate care and support. None thought there were. One person told us, "This place is definitely short staffed. They (staff) are running around all the time". Another person said, "They are always short staffed. At Christmas, the girls were worn to shreds". A third person told us, "I don't need much in the way of care, but I feel a bit sorry for those that do. They have to wait". A fourth person told us, "I can wait up to half an hour if I ring the bell. It's not the staff's fault; they are just so busy".
• A visiting relative said, "The staff are always very busy. I've noticed they don't seem to have much time to chat with the residents". However, one relative in a feedback form sent to us stated they were pleased to see the staffing levels had increased and the consistency of staff had improved.

We recommend the registered person consider the deployment of staff throughout the day.

• People were supported by staff who had been appointed following safe recruitment processes. These included obtaining character, employment and background checks of good conduct in previous employment prior to the staff member starting work. The checks included satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers make safer recruitment decisions by preventing unsuitable people from working with vulnerable people.

Preventing and controlling infection
• Staff received training in infection control and food hygiene. There were hand hygiene stations around the home. All hand basins contained hot running water, soap and disposable towels. Bathrooms and toilets were clean and free of litter or debris. We saw personal protective equipment such as gloves and aprons were readily available around the home.
• The home was visibly clean and tidy.
• Systems were in place to monitor, control and prevent infection control risks.

Inadequate

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 requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience
At the last inspection we found where areas for development were recognised in registered nurses competency assessments, there was no evidence this had taken place. We also found that staff did not always receive effective learning and development opportunities. Records and competency assessments did not consistently demonstrate staff received appropriate support, supervision and training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found sufficient improvements had not been made and this remained a breach of regulation.

• Staff had not always received appropriate training to ensure they had the skills to meet the needs of people they supported
• Of the 38 staff who provided direct care, only 11 of these had received practical moving and handling training. Throughout the inspection we observed poor and unsafe moving and handling practice. In addition, a comment made by a person living at the home indicated that what we saw was usual practice. The manager had arranged for three members of staff to undertake a train the trainer course in moving and handling, but this was not booked until May 2020. This meant people continued to be at risk of physical harm due to staff using unsafe moving and handling practices. Following the inspection the manager sent us an action plan which stated that practical moving and handling training had been booked for March 2020 for 30 staff.
• In September 2019 we received concerns about end of life care for people. We were sent an action plan from a provider representative which said that training on end of life care had been made available and that all staff were to complete this. However, only four staff had completed specific training for this at the time of our inspection and 11 staff had completed the care certificate which covers at a basic level, End of Life Care. Although we were told no one was receiving end of life care at the time of the inspection, if this were to occur rapidly for people they would be at risk of not receiving all necessary care to ensure they had a comfortable end of life. Following the inspection the manager sent us an action plan which detailed that training had been booked for three staff in end of life care and that these staff would then take a lead role on this within the service.
• Some people living at the home could behave in a way which placed them and others at risk of harm. For example, we found records showing that one person could kick, punch and slap staff. However, only 11 staff had completed training in behaviours that challenge. This meant staff may not respond appropriately and avoidable incidents may occur.
• We found numerous concerns about the assessment and management of risk and the planning and

delivery of person centred care (reported in safe and responsive). At the time of the inspection records showed that only three of 34 staff who provided direct care had received training in this. However, the manager told us that prior to the inspection all staff had been given a care planning guidance document written by the local Clinical Commissioning Group (CCG).
• In the Manor we found night staff were not trained to give medicines despite people being prescribed medicines to be taken at night.
• Although the provider had a competency assessment framework this had not been implemented in the service. Medicine competency assessments provided to us for staff showed four of five staff had not had their competency assessed for over a year and two of staff had not been assessed for their competence since Agincare took over running the service in October 2018.
• The staff we spoke with had mixed opinions about training. One staff member told us, "We do it online and complete a workbook. That's fine but I don't think that's the best way". Another staff member said, "I don't think it's been a priority in the past. I think it is now though with this new manager. We've been told there's a lot more training on the way".

The failure to ensure staff were trained to be able to meet the needs of people effectively was an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Improvements in the frequency of supervision had started and the new manager had a plan in place which aimed to ensure these took place regularly for staff. No appraisals had taken place for staff since 2018 but the manager had a plan in place to address this and planned to have these completed by end March 2020.

Following the inspection the manager sent us an action plan which told us of some training that had been booked subsequent to our visit. In addition, they had already met with an external team who would be able to provide training in skin care. Supervision training would be booked for supervisors and the providers competency assessment framework would be implemented.

Supporting people to eat and drink enough to maintain a balanced diet
• Where people were at risk of malnutrition or dehydration appropriate action was not being taken.
• Although we saw some people's records reflected that some people had gained weight we also identified a number of people who had lost weight or whose weight was very low. We found little evidence of how this was being effectively monitored for everyone and of the action being taken to ensure all of these people did not become malnourished and develop further health complications. For example, nutritional assessments were not always up to date to identify the risk, care plans did not always reflect that the cause of the weight loss had been considered and we found little action taken to refer the weight loss to other health professionals. Following the inspection we asked the manager to undertake an audit of all people's current weight and weight loss over the previous three months and to ensure care plans were reflective of their needs. We received a copy of the audit completed.
• Where care plans guided staff to give people who had lost weight fortified milkshakes and supplements, food and fluid charts did not reflect this was provided.

A failure to effectively monitor and assess risks associated with nutritional needs was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We spoke with people about their experiences of food and drink at the home. We were told the manager and provider had received no negative feedback about the food however we received no positive comments. Comments included that the food was "odd", "a bit iffy", "boring and plain", "repetitive" and "tasteless and lukewarm". However, we observed people ate the meals provided.
• People made their choices on the day from a four week rotating menu. We asked people if they were

involved in the process of food provision at the home. One person told us there had been a meeting two weeks previously on the subject but little had changed. Another person told us they had been visited by the chef and discussed their preferences. The person mentioned that they liked spinach but it had not subsequently appeared on the menu. The majority of people we spoke with on the subject felt the food had deteriorated of late.
• We spoke with the head chef and the chef about the provision of food and drink at the home. There were six staff employed in the kitchen, providing seven day a week cover. We were told people new to the home were visited by kitchen staff in order to find out their likes and dislikes, any allergies or religious/cultural needs. This was recorded and accessible to all kitchen staff. The head chef told us they attended residents meetings in order to gauge opinions about food and drink and discuss future provision. Most food was made from fresh ingredients, bought locally.

Supporting people to live healthier lives, access healthcare services and support
• People were supported to access other health professionals as this was needed. People records confirmed the involvement of GP's, dentists and other specialist services such as speech and language therapy.
• However, it was not always evident their advice was followed. For one person we were not confident they had received the care recommended by the dentist. The handover sheet stated they needed to brush their teeth twice a day. The care plan did not match these instructions and we found no record that their teeth were being brushed in line with the guidance.

The failure to ensure recommendations and advice from health professionals was followed was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At last inspection we found no formal consent had been obtained and concerns regarding the assessment of people's mental capacity and process of best interests decisions being made. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made and this was no longer a breach of regulation 11 but the records required improvement.

• The manager had a good understanding of the MCA, staff had been trained and their knowledge of this was adequate They were able to tell us how they would support people to make their own decisions as much as possible. For example, In the part of the home which predominately cared for people living with dementia show plates were used to help people to choose their meal.
• However, we found conflicting information in records about people's capacity. One person's care plan summary stated that they had full capacity and 'is able to make [their] own decisions' but may need support with bigger decisions. However, they had capacity assessments for medication and bed rails which stated they did not have capacity. This was not clear in the care plan summary which could cause confusion.
• For another person the capacity assessment for the use of bed rails and other equipment stated that they did not have capacity, we saw these being used but there was no evidence of consultation of others to inform best interest decisions. A mental capacity care plan was in place but this was blank. A care plan summary was in place which made a generalised statement that the person did not retain capacity. This did

not reflect decision specific assessment and there was no information in the care plan that showed staff that the person lacked capacity around the use of hoists and bed rails.
• For other people we saw MCA's and best interests decisions had been completed but the information had not been included in the care plans which was the only document staff told us they could see on the handheld devices they used to access information about people. Following the inspection the manager confirmed that all electronic records could be accessed by all staff but that some staff were unaware of how to do this. As such further training was provided to ensure they were aware.

The failure to ensure accurate records about people's ability to make decisions was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

• Staff and the manager understood their responsibilities with DoLS. Where required for people DoLS had been applied for and the manager was tracking progress of applications. We did not find any conditions attached to the DoLS we looked at.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• A range of nationally recognised tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, a nationally recognised tool to assess people's risk of pressure injuries was in place, as well as nationally recognised assessment tools for risks of malnutrition and falls. However, we found some of these assessments for some of the people whose records we reviewed were not kept up to date. For example, falls assessments had not been consistently reviewed following a fall and nutrition assessments had not always been reviewed following a change in a person's weight. This meant there was a risk that risks to people were not fully known and all action taken to minimise the impact of these risks.
• National guidance suggests medication competency assessment are conducted annually for staff however this was not taking place.
• The Equalities Act 2010 is designed to ensure people's diverse needs in relation to disability, gender, marital status, race, religion and sexual orientation are met. We found no evidence that people's preferences and choices regarding some of these characteristics had been explored with people and had been documented in their care plans. For example, spiritual and cultural care plans were blank. We saw no evidence that anyone who used the service was discriminated against and no one told us anything to contradict this.

Adapting service, design, decoration to meet people's needs
• Further adaptions could be made to support those living with dementia. Although staff made use of technology, such as sensor mats and entry key systems to keep people safe. We found no evidence of technologies used in the provision of communication of activities, such as Skype or use of electronic tablets. The home's activity co-ordinator who told us of their plan to introduce a meditation type area which would use an Amazon Echo device but this was not in place during our visit.
• People were looked after in an environment which aimed to meet their needs. It was spacious and well lit.

• Rooms were laid out to enable people to understand the purpose of the room. Bedrooms were spacious, and people were able to personalise their rooms.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
At the last inspection feedback from people and relatives did not demonstrate dignity was always respected and we observed people did not always receive emotional support when they required it. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
At this inspection we found improvements were still required.

• Whilst we observed some positive and kind interactions between staff and people we also observed interactions which demonstrated at times not everyone was treated with respect. Some staff showed kindness, compassion when interacting with people while others did not.
• For example, on one occasion a staff member came into the dining room in response to the call alarm. This had been set off by the activities member of staff because a person wanted to move. The staff member just turned the alarm off and left the room. On a second occasion a person was observed to be crying, and we saw on two occasions that two different staff members walked past without responding.
• On a third occasion one person had slipped in their chair and asked to be moved as they were uncomfortable. A member of permanent staff told an agency worker "well she will just have to wait for a hoist" and walked away.
• One set of relatives told us how a person had been dressed in another person's clothing which was very obviously not their size.
• Records demonstrated that the language used was inappropriate at times and disrespectful. On the handover sheet, one person had been described as whining. On a record describing a person's challenging behaviour a smirking face emoji had been used following a description of the behaviours.

This was an ongoing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• At this inspection feedback from people was mostly positive about the staff. Comments included; "The staff are very kind"; "Well I can only speak for myself and most of the staff are very good. Some are better than others, some, especially the young ones can be a bit flippant but that's life I suppose"; "The staff are lovely, all of them. I do trust them. You do hear some tales about people being abused in care homes, but I've never seen anything like that". A relative told us; "I can see that the staff are really caring, and they treat her with a lot of respect";
• Following the inspection, the manager sent us an action plan. This stated that the manager had arranged

further training for staff to ensure they were aware and understood the need for dignity and understanding.

Supporting people to express their views and be involved in making decisions about their care
• We asked people to what extent they had a say in the provision of care and whether they felt supported in doing so. One person told us, "They will always ask me before they do something. They do listen to me". Another person said, "I wouldn't say I'm in charge of the care I get but I am kept informed. I know that if they (staff) wanted to make changes, like to my tablets, they would tell me".
• The staff we spoke with were aware of people's rights to be involved in their care but did express concern about the amount of time they had to spend with people. One staff member told us, "The trouble is, when you're so busy it's easy for things to just turn into a list of things to do, especially if you're working with agency staff. Sometimes I think I give more attention to them than to the residents. It's been like this for a long time though. I'm hoping the new manager will make a difference".
• There was little evidence in care plans and care plan reviews that people had been involved in these. However, the manager had planned to introduce a new system to ensure this happened and had care review meetings scheduled for March 2020.

Respecting and promoting people's privacy, dignity and independence
• We asked people if they felt supported in maximising their day to day independence. One person told us, "Yes I do. If you can do it for yourself, they will encourage you to do it". Another person said, "They do let you get on with things. The cynic in me thinks that might be because they're so busy".
• We asked staff how they encouraged people's independence. One staff member told us, "We do try to encourage people to do things for themselves. But we obviously have to keep people safe". Another staff member said, "I think that's really important. The trouble is that it takes more time to let someone do something for themselves, which we don't have".
• Our observations demonstrated that people's privacy was maintained. Doors were closed during personal care and staff knocked on doors before entering.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
• Care plans, including those for people approaching the end of their lives were either incomplete or were not person centred. This meant people may not receive the care they required.
• At the last inspection we found no evidence that end of life or advanced care plans had been developed. At this inspection we found this still required improvement.

• No one was receiving end of life care at the time of our inspection. Although at least one person had been prescribed anticipatory medication. Anticipatory medication is are prescribed when a person is expected to be reaching the end of their life.
• Previous concerns about end of life care had been raised with the service and following investigation we were sent an action plan in September 2019 which stated that end of life care plans would be in place for everyone. Following the inspection the manager told us that this action plan had been amended to reflect the need to implement advance care plans (ACP). ACP are used to make clear a person's wishes for their end of life care. It is important to help people to plan their end of life care in advance as this will ensure staff understand what is important to a person and ensure they receive the care they want. Whilst we saw an end of life care plan was in place for the person who had been prescribed anticipatory medicines, this contained no information about their wishes. Other advance care plans or end of life care plans we looked at either did not contain information about people's wants and wishes or were not complete.
• Other parts of care plans had not been developed based on individual preferences as well as needs. Care plans were at times blank [not completed], incorrect and lacked personalised detail. One person's care plan regarding their mental capacity was blank. They were under a deprivation of liberty which permanent staff knew about but the care plan for this was blank. Their medication care plan was generic and provided no personalised information about how the person liked to take their medicines.
• Another person's care plan regarding their elimination needs was poor and lacked clear guidance. The handover sheet recorded they had not had a bowel movement for six days. However, the care plan did not reflect the potential for this person to suffer from constipation. We found no evidence the service had responded to this need. Despite being prescribed regular medicines for their bowels which could be increased as required, it had not been increased. Their care plan stated that nursing staff should be informed and the clinical lead told us they remembered it being mentioned that the person was coming up to day 4 and said "that's why we like to keep the same staff." However, they were not able to tell us what action nursing staff had taken.
• For a third person a moving and handling assessment stated that they should be supported daily with gentle exercises to help with their limb contractures but there was no evidence this was taking place. Where care plans said that people should be supported to have fortified milkshakes and snacks, we found no

evidence these were being given. This meant people were at risk of further deterioration in their health and well-being.

The providers failure to ensure care was planned and delivered in a person centred way was an ongoing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• Where people had a specific communication need we could not be assured that this would be met.
• For example, We saw for one person their care plan stated they had a communication book in place to help staff and the person communicate day to day. Staff we spoke with were not aware of this book and we observed two members of staff attempting to communicate with this person in English without any communication aids.
• The manager provided a good example of using an interpreter when completing a mental capacity assessment and best interest decision for this person who was unable to speak English.
• The manager was aware of the need to make improvements to the care plans including in relation to communication needs but had only started at the end of October 2019 and had not had time to complete this.

• Following the inspection the manager sent us an action plan which said specific guidance from care plans would be incorporated into handover sheets for staff. Care plans would be updated and a weekly check by the night nursing team will be completed to ensure the handover is sheet is accurate.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
At the last inspection we identified a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always provided with meaningful activities or social and emotional interaction. At this inspection we found that some improvements had been made and this section of the regulation was no longer in breach but further work was ongoing to continue to make improvements.

• At this inspection we found a variety of activities were available to people including; games, craft, reminiscence and external activities such as music, exercises and pet therapy.
• People gave us mixed views of the activities. One said, "It's much worse than it was. There used to be a lot of activities on offer but that's tailed right off". Another person said, "There are no trips out, not lately anyway. And there's not much in the home either. I know it's winter so we don't go in the garden, but I just sit here in this big room, pretty much on my own all day". However, a fourth person told us that something was offered to people every day and it was up to them if they joined in.
• The provider was in the process of recruiting further staff to support activity provision for people and the manager was keen to ensure that all staff understood their role in supporting people's recreational and social needs.

Improving care quality in response to complaints or concerns
• The provider had a policy and arrangements were in place to deal with complaints. This included information on the action people could take if they were not satisfied with the service being provided.

• There were no open complaints at the time of inspection and records of complaints showed the manager took appropriate action to address the issues raised.

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 remained the same. This meant the service management and leadership had been inconsistent. Leaders and the culture they created had not always supported the delivery of high-quality, person-centred care. However, the new manager was making steps to improve on this.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;
At the last inspection we found a breach in Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because leadership and management did not ensure person-centred, high quality care was delivered. The provider had failed to ensure there was sufficient and effective oversight and governance at the service. Systems had not always been effective in identifying shortfalls and unsafe practices. As a result, safe standards of care were not consistently delivered. Poor records were not identified through auditing. Systems were not effective in identifying sufficient deployment of staff to meet people's needs at all times and training for staff was not always effective. Governance systems failed to identify people were not always treated with dignity, equality and respect. The provider failed to create a person-centred culture within the home.
• At this inspection sufficient improvements had not been made and this remained a breach of regulation.
• At the last inspection the provider was in breach of regulations 9, 10, 17 and 18. Following the last inspection we requested an action plan from the provider telling how and when they planned to meet the requirements of the Health and Social Care Act. We received this in May 2019 and it stated they would be compliant with the regulations by November 2019. We looked at the reviewed action plan held in the service which documented that the actions were completed. We found that only one of these regulations had been met in full and was no longer a breach. Whilst we found that the element of regulation 9 that was previously met, we found that further sections of this regulation was now in breach. Although an element of the previous breach of regulation 18 had been met, this had not been met in full at this inspection. Breaches in regulation 10 and 17 were ongoing and we found additional breaches of regulations 12 and 13. Ongoing and new breaches demonstrate that effective systems and procedures to monitor safety and quality of the service and to drive improvements were not operated effectively.
• Although the provider had undertaken quality assurance visits, these focused on CQC's last report and the requirements from that. Provider quality assurance visits had identified areas that required improvement, we requested the action plans as a result of these and were not provided with any.
• Incidents that should be reported to others but had not, had not been identified by the provider demonstrating a lack of oversight of incident reporting. The new manager took immediate action to change the reporting of incidents following the inspection.
• We identified a number of concerns regarding the management of medicines. The manager told us she had requested the previous operations manager do a complete medicines audit of the Manor but no record of this could be found. We also requested the most recent internal medicines audits and were only provided

with audits dated August and September 2019. However, we were told that the manager was working in partnership with the CCG to make improvements to the management of medicines and auditing processes.
• Although the manager had undertaken an audit relating to weights this only related to the date the persons weight was last checked. It did not identify any unexplained weight loss, a lack of updated nutritional assessments and care plans.
• We identified concerns regarding care plans. These were inaccurate, incomplete and lacked personalised detail. The last provider audit of care plans in the nursing home that we were provided with was dated July 2019 and whilst this identified a number of care plans not complete for a number of people, no action plan was in place to take this forward and make improvements. The last provider audit of care plans in the Manor that we were provided with was dated September 2019, and whilst this identified a number of care plans not complete for a number of people, no action plan was in place to take this forward and make improvements.
• The new manager had completed an audit in January 2020 of all risk assessment and MCA records. This work had moved forward for some people and were now in place. However, the risk assessments only related to certain elements of care and did not cover all risks areas based on individualised needs.
• The manager confirmed she had not had time to audit care plans since she started at the service. She said she intended to start this but following the risk assessment and MCA audit had found that assessments such as those related to skin, choking, bed rails, falls and people's capacity had not been completed. As such she had focused on this as an area that needed to be completed before the care plans could be re-written.
• We did find that the manager had worked in partnership with the LA and CCG on developing an action plan which included the review and update of care plans to ensure these met all people's needs and were person centred, although no timescale for completion had been set against this action.

• As we continued to find at this inspection, areas that needed improvement at the last inspection as well as new areas we were not confident the provider systems were effective in recognising safety and quality concerns and in driving improvement. The failure to assess, monitor and improve the quality and safety of the services provided meant people continued to be at risk of not having their health and personal needs met in a safe effective way.

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

The provider was responsive to our feedback and ensured additional support and resources were provided to the new manager. The manager was responsive in producing an action plan and carrying this out. The LA and CGG confirmed to us that improvements had been made to the service following our inspection.

• Registered persons are required to notify CQC of significant events that occur in the service. This includes any allegations of abuse and serious injuries. The records held in the service identified one incident whereby an allegation of abuse had occurred in October 2019 and three incidents where serious injuries had occurred that we had not received any notification of. It is important for CQC to be informed of these incidents in order that we can ensure appropriate action is taken and all relevant authorities have been informed.

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

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 had a policy in place regarding their responsibility in relation to duty of candour. We identified an incident where a person suffered a serious injury which was not attended to promptly. The manager had

investigated this and identified some failings from the service in terms of information provided to agency staff. We requested to see records of duty of candour letters that had been sent on several occasions and were not provided with these.

We recommend the registered person review their system to ensure that where required duty of candour is applied in full.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
The new manager had started their role in the service at the end of October 2019 and was open and honest about the work that was needed to ensure the service was delivering high quality care to people. They informed us they had spent the first couple of months dealing with relative's and people's complaints or concerns as well as staffing related issues. It was evident that the manager was working proactively with other organisation to make improvements to the service and to change the culture. They had an in depth action plan in place to drive improvements. However, due to some action taken by the new manager it had meant that some management staff that were in post at the time were no longer in those positions and the appointment of a deputy manager had just been made. As such and until recently the manager had been attempting to make significant changes in the service on their own.
• During the inspection, the chief operating officer told us that a new clinical operations manager had been recruited and was starting employment the week after our inspection. They told us they would be working three to four days a week in Gorseway, alongside the manager to support the changes that were needed.
• The manager had identified the need to change the culture in the staff team, ensure people were at the centre of their care and that staff took accountability for their roles. To do this they had delivered some personality training, team building training and quality improvement training to staff. The manager told us they recognised that sustainability was key in this service and planned for all staff to be trained in quality improvement in order to support this. They told us they felt the "culture is now shifting" and "definite feeling of light at end of tunnel and we can now move forward." They told us they felt morale was better and staff we spoke with reinforced this.
• One staff member told us, "We've had six managers in three years so it's not been consistent. The new manager is really good though. I think things are improving". Another staff member said, "It's been a bit of a mess but the new manager is getting a grip. There's a new deputy starting in the Spring too so that should help". A third staff member told us, "I don't think staff have had the right support up until now. We've been asking for it but it's not been there. I haven't had any supervision or an appraisal for over a year".
• Systems were in place to engage with and involve people, relatives, staff and professionals in the service.
• The provider sought feedback through surveys, resident and relative meetings as well as staff meetings and shared information about the service. However, it was unclear how the results had previously been used to make improvements due to a lack of action plan. Following the inspection the new manager included all previous actions from past feedback into their action plan to make improvements.
• Following the inspection the manager sent us feedback forms from 14 relatives that had been completed after our inspection visit. These showed that they were generally satisfied with the service provided to their family member.
• Staff meetings demonstrated that the new manager was keen to keep staff up dated, to share learning and make improvements to the service.

Working in partnership with others; Continuous learning and improving care;
• The manager was keen to build relationships with other partner organisations. They had been working with the clinical commissioning group (CCG) and local authority (LA) quality teams to audit the service and develop action plans to take forward. The CCG were also aiming to support building the relationship

between the service and the local GP practices.
• The manager was waiting for Healthwatch to visit to review the service.
• The manager had made links with the LA training department and the Care Homes Team to discuss training opportunities for staff, including moving and handling and care planning. They had engaged with a hospice to upskill staff in end of life care.
• They were also working with a pharmacist from the CCG in an attempt to make improvements to the management of medicines.
• The manager had also engaged with dementia friends and carers support to help raise awareness and change culture.
• Throughout the inspection it was evident that the manager was aware of the need to make many improvements and was keen to ensure this happened.

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The providers failure to ensure care was planned and delivered in a person centred way was an ongoing breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The providers failure to ensure people were treated with dignity and respect at all times was ongoing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The failure to effectively assess risks to people, to implement plans to reduce the risks and to ensure these plans were followed by staff was a

breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A failure to ensure medicines were managed safely at all times was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment A failure to investigate and report incident of potential abuse and harm was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 The failure to operate effective systems to ensure incidents which placed people at risk were analysed to ensure improvements were identified and implemented was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The failure to ensure accurate records about people's ability to make decisions was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A failure to operate effective systems and process to assess and monitor the safety and quality of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing

Treatment of disease, disorder or injury	The failure to ensure staff were trained to be able to meet the needs of people effectively was an ongoing breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.