Gorsey Clough Nursing Home Limited

Gorsey Clough Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 26 and 27 September 2018.

Gorsey Clough Nursing Home is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Gorsey Clough Nursing Home is a large detached property which provides accommodation for up to 50 older people. The accommodation is situated over two floors with lift access. At the time of this inspection there were 44 people living in the home.

We last carried out a comprehensive inspection of this service on 22 November 2016. At that inspection it was found to be Good overall.

At this inspection we identified nine breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

You can see what action we told the provider to take at the back of the full report. We are currently considering our options in relation to enforcement in response to some of the breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

Medicines were not all managed effectively. Some medicines including creams and thickeners were not being stored properly and administration of them was not being recorded.

Equipment was serviced, but health and safety checks including fire and water checks were not completed. The provider had not addressed actions identified in the last fire and legionella risk assessment.

On the first day of our inspection there was a malodour throughout the home and areas of the home were visibly dirty. Suitable arrangements were not in place to ensure people were protected from the risks of cross infection.

Although recruitment was on-going there were insufficient staff on rota to provide people with the support they needed. The provider did not have a systematic way of assessing staffing needs. Staff spoke politely towards people, however we found that interactions were often task orientated. Staff were unable to spend time with each person, as they needed to provide support to someone else. People's dignity was not always protected because of this.

Checks were completed before staff started to work at the home. Staff received supervision but not all staff had received all the training they needed to carry out their roles effectively.

The provider had not ensured that staff had acted in accordance with the Mental Capacity Act 2005. Best interest decisions were not all documented. Staff did not have a good understanding of MCA and DoLS.

Records relating to managing peoples challenging behaviours were not sufficiently detailed and there was no analysis or review of incidents. Care records did not include complete and accurate information about people's current and changing needs.

There was a lack of systems to monitor and improve the quality of the service. We found governance systems were incomplete and not sufficiently robust to ensure best practice was followed and compliance with regulations.

The service is required to notify CQC of events such as accidents, serious incidents and safeguarding allegations. The service had not notified CQC of all events they are required to.

We have also made two recommendations.

We found that safety belts had been purchased for wheeled shower chairs, however they had not been fitted. We recommend the provider follows appropriate Medical Devise Alerts and Health & Safety Executive guidance, and that risk assessments and best interest decisions be undertaken where necessary.

Confidential information was left accessible to people. We recommend the service reviews its system for recording daily activities to ensure peoples confidentially is maintained.

We received mixed views on the food and found the dining experience could be improved.

People told us staff were caring. We found that staff had a good understanding of people's likes and preferences. Everyone we spoke with was happy with the activities and events provided.

Complaints were recorded and responded to. People were supported with their health needs and had access to a range of health care professionals.

The service is required to have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service did not have a registered manager. The provider had recently recruited a new manager and clinical lead. Staff were very positive about the changes they were making.

The provider was displaying the rating of the last CQC inspection as they are required to do.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not, enough improvement is made within this timeframe

so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not all managed effectively.

Records of health and safety checks were incomplete and action had not been taken to address risks identified in the last fire and legionella risk assessments.

Some areas of the home were not clean and procedures to protect people from infection were not adequate.

There were insufficient staff to meet people's needs and the provider did not have a systematic way of assessing staffing needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider was not meeting the requirements of the Mental Capacity Act 2005.

Staff received supervision, but had not received all the training they required to ensure they were able to carry out their roles effectively.

Records relating to managing peoples challenging behaviours were not sufficiently detailed and there was no analysis or review of incidents.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff interactions were caring, but were often task orientated. Staff were often unable to spend time with each person.

Confidential information was not always kept safely.

Staff knew people well and people told us staff were caring.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records, including those relating to identified risk, were not always complete, accurate or updated when people's needs changed.

People were positive about the activities on offer.

Suitable arrangements were in place for the reporting and responding to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

The systems in place to assess, monitor and improve the quality and safety of the service provided were not sufficiently robust.

All the required notifications had not been made to CQC.

The service did not have a registered manager. A new manager and clinical lead had been appointed.

Gorsey Clough Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident. This incident is subject to investigation and as a result this inspection did not examine the circumstances of the incident.

This inspection took place on 26 and 27 September 2018 and was unannounced on the first day. It was undertaken on the first day by two adult social care inspectors, an assistant inspector and a specialist advisor, who was a pharmacist. On the second day it was undertaken by one adult social care inspector and an assistant inspector.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We also reviewed information we held about the service and provider, including notifications the provider had sent us. A notification is information about important events which the provider is required to send us by law. We asked the local authority and Health watch Stockport for their views on the service. The local authority informed us that following a recent quality audit they were working on an improvement action plan with the home.

Some of the people living at Gorsey Clough Nursing Home were not able to clearly tell us about their experiences. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with three people who used the service, six visitors, the two providers, the

manager, the clinical lead nurse, a nurse, four support workers, the activity coordinator, one chef and the home administrator.

We spent time looking around the home at the standard of accommodation. This included the communal lounge and dining areas, bathroom facilities, the kitchen, laundry and a number of people's bedrooms. We carried out observations in communal areas of the service. We looked at five care records, a range of documents relating to how the service was managed including medication records, five staff personnel files, staff training records, duty rotas, policies and procedures and quality assurance audits.

Inadequate

Is the service safe?

Our findings

People who used the service told us they felt safe living at Gorsey Clough Nursing Home. They said, "Yes I feel quite safe here" and "Yes I do it seems very safe when you look outside."

We looked to see if there were safe systems in place for managing people's medicines. During this inspection we found that medicines were not always stored and administered in a safe and secure manner.

We found medicines management policies and procedures were in place. Although staff had access to information about medicines, the medicines policy was very brief and did not cover all aspect of the management of medicines within the home and made no reference to national guidance on the management of medicines.

We saw medicines in the treatment room were stored securely within appropriate cabinets and medicines trolleys and that controlled drugs were stored appropriately. Controlled drugs and are subject to stricter controls to prevent them being misused or obtained illegally.

The medicine storage room contained suitable lockable fridges. The temperatures of the medicines fridges and the medicines room had been recorded, however we found there was a gap in the recording of the fridge and treatment room temperature records. We saw that the minimum temperature of the fridge had been just outside the recommended range since the beginning of September, no action had been taken to address this. We also observed that prescribed liquid thickeners and supplementary liquid feeds were being kept in the kitchen and emollient creams were being kept in resident's bedrooms. The temperature of these areas was not being monitored to ensure it was within the recommended range. If medicines are not stored at the correct temperature they may become less effective or unsafe to use.

During the inspection we found that that the administration and disposal of medicines was not always recorded appropriately. We observed that registers were used to record the receipt, administration, disposal of medicines and a regular stock check for the controlled drugs was completed. The home used an Electronic Administration Record System (EMAR). This ensured that a record was kept of the administration of most of the medicines. However, we found that where prescribed thickener or emollient creams were being administered by carers no recording of administration took place and no body charts were available to indicate where the cream should be applied.

The EMAR ordered the medicines based on the usage in the previous month and the medicines were checked by two members of staff upon receipt. We found there was no witnessed record of the disposal of any medicines refused by a resident or not used in each cycle. It was also observed that there was an excess stock of prescribed thickeners and supplementary liquid feeds as they were not being scanned when administered and were being reordered each month. Two bottles of liquid food supplement we found were out of date.

We found that where 'homely remedies' were used to provide short term relief of symptoms such as pain,

indigestion, constipation, there was no written authorisation from the GP as there should have been.

The EMAR linked the resident to the medicines using a bar- code system. It used colour codes to identify when medicines were due for administration. It included a photograph and details about the resident's allergy status and only allowed staff who had completed the competency assessment to administer medicines. During the inspection we found that medicines were not always being administered appropriately. We observed that the person administering the medicines placed the medicines in a pot and took it to the resident and did not take the electronic recording device with them, so had to return to the treatment room to record the administration. It was observed on one occasion that the person administering the medicine did not ensure that the resident had taken their medicine before returning to the treatment room.

Four residents had been prescribed thickener to be used when they were being given fluids. Three of these had an administration protocol which included details of the level of thickening required and the dosage of preparation needed to obtain this, but the fourth didn't. This paperwork was kept in the treatment room and not in the area where administration took place. We also observed that there were only two containers of thickener on the drinks trolley, one was an unlabelled container and the other was labelled for the resident who had no protocol in place. Thickener is a prescription medicine and should only be used for those it has been prescribed for. Records of administration should also be kept.

Where it was deemed in the best interest of the resident to receive their medicine covertly, a pharmacist had not been involved in the discussion to ensure that it was pharmaceutically appropriate to crush the medication or mix it with food which is good practise.

We found three tubes of emollient, a large container of another emollient and an unlabelled tube of a prescription only medicine in one residents' room in an unlocked cupboard. For the first two preparations there was no record of application since being prescribed in June 2018 and there was no record of the prescription only medicine having been prescribed for this resident.

Several residents were receiving pain relief medication via a patch. A template was being used to recorded application and removal of the patch, however it was noted that this was undertaken by the same person rather than two people, that there was no check on the position of the patch in between the application or removal days. On a two of the records no patch had been found in situ on the changeover day.

We found this was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. Systems were not in place to ensure the safe management and administration of people's medicines.

The electronic system produced a daily report which highlighted if any of the residents had not received their medication as prescribed and provided information about stock levels. Following our inspection, the service confirmed they had put cream charts in place.

We reviewed certificates and maintenance records for the home. Records showed that all lifting equipment including, hoists and personal lift appliances and the passenger lift had been serviced regularly. We could see that the provider had ensured regular checks and maintenance to gas and electricity supplies. The Portable Appliance Testing (PAT) for portable electrical items was also in date.

However, there were no records to demonstrate that regular checks were in place to ensure people's bedrooms and communal areas were checked in relation to, for example; lighting and call bells. The

manager told us that since the handy person had left in July 2018, two staff members on night duty had been given the responsibility to address some issues such as call bells. The manager confirmed no records of these checks were kept as it was a verbal handover. This meant we could not be sure the checks had happened or that any required action had been taken.

We saw a legionella risk assessment had been undertaken in November 2016. The home had been assessed at being at high risk across all areas including; hot water storage, hot & cold-water distribution and cold-water storage. Legionnaires' disease is a potentially fatal form of pneumonia caused by the legionella bacteria that can develop in water systems. We discussed this with the manager and the provider. The provider told us some carpentry work had been needed before the action could be completed. We found that the required action in the risk assessment had still had not been taken. When we toured the home, we found that one of the shower heads we looked at was visibly dirty. Records of checks of water, including flushing of infrequently used water outlets were incomplete. This is important as it helps to minimise the risk of water born infection.

An external company had completed a Fire risk assessment on 10 August 2018, several areas were identified as high priority for remedial action required. There was no evidence of action taken, the provider confirmed the work was still outstanding. The risk assessment detailed the needed signage to indicate where oxygen was being stored due to the fire risk. On the first day of our inspection we found the required signage was still not in place. It also detailed that the practise of storing wheelchairs in stair wells was a fire hazard and should stop. On the first day of our inspection we saw notices advising staff not to leave equipment in stairwells. However, in two stair wells we found items being stored; including wheelchairs, no entry signs and black refuse bags. We highlighted this to the manager and noted that by the afternoon of our first day the stairwells had been cleared and the correct signage to indicate the storage of oxygen had been put in place.

Fires safety equipment including extinguishers was regularly serviced. Each person had a personal, emergency evacuation plan (PEEP). PEEPs described the support people would need in the event of having to evacuate the building. There had been only two fire drills recorded in April 2016 and March 2018. We saw that fire safety checks including fire alarm systems, emergency lighting, fire doors, and automatic door release systems had been completed up until the maintenance person had left in July 2018. We noted that one fire extinguisher was not fixed to the wall, the manager said they would arrange for this to be fixed immediately. We found that in the boiler room there were clothes hanging from the water tanks and staff belongings on the floor. Using this area as a 'store room' was a potential fire hazard. The manager told us staff acted as fire marshals and that they had been completing the checks. There were no records of whether checks had been completed which meant that people were not protected from the risk of fire.

On the first day of our inspection we saw one of the fire exits was blocked with a hoist. The manager asked a member of staff to move it and we witnessed it being relocated. We asked the member of staff why they thought it needed to be moved and they told us; "In case someone falls over it." We advised them it was because of access being needed at all time to the fire exit.

Environmental health and safety checks including the Control of Substances Hazardous to Health (COSHH) moving and handling, legionella and showering people had not been completed since the maintenance person had left. Risk assessments relating to these had been due for review in May 2018.

We found this was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the premises or equipment used by the service were safe to use or used in safe way.

Following our inspection, we informed Greater Manchester Fire service of our findings. The provider confirmed that they had arranged for the required work identified in the legionella and fire safety risk assessments to be completed within three weeks. They also confirmed that the required checks on fire safety equipment were now being undertaken.

The manager informed us they had recently purchased an evacuation chair to ensure people who lived on the upper floor could be assisted to get out of the building safely in the event of fire breaking out. However, it was not available as the staff had not received training in its use. The manager was waiting for instructions from the provider regarding liaison with the manufacturer to organise training for staff.

The manager and provider acknowledged that since the maintenance person had left there had been a gap in identifying and rectifying any issues at the premises and a new maintenance person was due to start the next day. On the second day of our inspection we saw that they new maintenance person had started working at the home.

We saw three shower chairs, none of which had safety belts in place. We asked the manager and provider about this. They told us that a specialist company had assessed for safety belts and they had been purchased however staff refused to use them. We recommend the provider follows appropriate Medical Devise Alerts and Health & Safety Executive guidance and ensure risk assessments and best interest decisions be undertaken where necessary.

We looked at systems in place to ensure the environment was clean and to reduce the risk of outbreaks of illness and infection.

We saw that the service had an infection control policy and procedures. These gave staff guidance on preventing, detecting and controlling the spread of infection. They also provided guidance for staff on effective hand washing, disposal of contaminated waste and use of personal protective equipment (PPE) such as disposable gloves and aprons.

On the first day of our inspection at Gorsey Clough Nursing Home we found there was a strong malodour and some areas of the home were visibly dirty. This included the laundry, kitchen, bathrooms and sluices. A visitor we spoke with told us, "It's clean to a degree, when we first came to visit it was fine but I have noticed that it smells of urine and it wasn't like that when we first visited, certainly for the last few months it smells on arrival."

All the mop heads we saw throughout the home including the kitchen, laundry and storage shed outside the premises were visibly dirty and needed to be replaced. Staff confirmed there was no schedule for replacing mop heads. They told us mop heads were changed, "Every few days."

Shower chairs we saw were cracked or had peeling paint on the frames. This made it difficult to support infection control procedures and we could see one was stained with urine.

Whilst walking around the home mid-morning on the first day of inspection we saw a plate of cold mince and potatoes upstairs on one of the radiators and dirty crockery on others, we were told this was from the night time.

There were no audits available to show that mattresses were checked regularly. The manager showed us evidence of a recent contract for 12 months with an outside contractor who would be responsible for servicing and decontaminating mattresses.

We noticed the domestic staff did not have a cleaning trolley and one domestic we spoke with told us they would go back and forth to the laundry for linen or cleaning products. Instead of trolleys both domestic and laundry staff used wheelchairs to move things around the building. We saw a faeces stained pillow on top of one wheelchair, this had been placed on top of clean bedding. We asked the domestic about this and they told us they had no red alginate bags with them. These are bags that can be put straight into a washing machine and so contain any soiled items. This did not support infection control procedures.

Gorsey Clough had been awarded five-star rating from the Food Standard Agency in December 2017, this was the highest rating possible. However, we found kitchen cleaning records were incomplete. There was a build-up of dirt around kitchen door frames, skirting boards and the flooring was heavily stained.

Records relating to the checks of hot water temperatures for August and September 2018 showed that five bedrooms did not have hot water. During our inspection we also found one bathroom did not have hot water.

There were contracts in place for the safe removal of waste and sharps however there was a lack of bins for the disposal of clinical waste in communal & personal bathrooms and toilets.

The laundry staff we spoke with told us they did the cleaning between them and confirmed there were no cleaning rotas in place. We could see there was a route of dirty to clean laundry that the staff were familiar with. From our observations dirty linen was seen to be in plastic bags on the floor There were no colour coded linen bags on stands to prevent laundry being mixed up and minimise further contamination from the floor which was heavily stained.

We observed hand gel in the reception area and saw there were gloves and aprons in the bathrooms. During our first day of inspection we saw a used apron and gloves had been discarded on one of the tables in the lounge area.

We found this was a breach of Regulation 12 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. This was because suitable arrangements were not in place to ensure people were protected from the risks of cross infection.

We looked at the staffing arrangements in place to support the people who were living at the home. During our inspection, we found someone on an upstairs corridor who needed support. A member of the domestic team was trying to help them, but the person was resisting their help. We went downstairs to get assistance but were unable to find a member of the care team for ten minutes. At that point we went to the office and the manager went to assist the person. During our observations we found that staff appeared very busy and interactions were friendly but task focussed.

One staff member told us, "Everything is done, but it's all rushed and we don't have enough time to sit down with residents, especially those without families." Another said, "...I think we pull together well but it's hard to carry out tasks we need to do. It has a negative impact on carers, basic requirements get done but we can't go over and above, things get done but it's all rushed. We move from task to task rather than spending time providing a quality service" and "I think we are very person centred as we know people individually but what affects morale is staffing levels."

The provider told us that they had until recently had nursing vacancies and these had been filled with agency staff. However vacant posts had recently been recruited to and this had helped continuity of care. Staff we spoke with told us they didn't have enough staff to provide the support they needed to. One said, "I

don't think there is enough - not at any certain times its all the time it's a struggle." Other staff told us, "I think recently it's been poor – they are employing people I think. I think we need two more [staff] on each shift as we are getting more residents now", "We are getting more residents coming in and there are not always as many staff as we would like" and "Not great. I think we need more care staff. We have used quite a bit of agency lately."

Review of staff rotas showed that staffing levels were provided consistently at the same levels, but the provider did not have a formal system for assessing staffing levels. There was no evidence available that staffing levels had been designed based on people's support needs or that they had been reviewed regularly.

We found this was a breach of Regulation 18 of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. There were not sufficient staff to meet people's needs and the provider did not have a systematic approach to determining staffing numbers based on peoples changing needs.

Some people who lived at the home, on occasion, showed behaviours that challenge the service.

Records showed that not all staff had completed training on how to support people who exhibit challenging behaviour and only five care staff had training that was in date. Staff told us the training was e-learning. One said, "I think it would be better face to face that training. I think we would all benefit from face to face training in that area."

Two people's care records we reviewed showed that risk assessments and care plans relating to the behaviour of the two people might exhibit had been developed. They did not provide detailed information about what might upset the person or how they showed they were getting upset. The records stated that in the event of an incident of challenging behaviour staff should, 'de-escalate, distract' or 'remove' the person from the situation. Records did not contain any information about what form this de-escalation and distraction should take for each person or guidance to show staff on how this should be done, such as words that may help or things the person found calming. The manager and provider confirmed to us that the word 'removal' did not involve staff physically removing people; but verbally encouraging them to move away from the area they were in. There was no guidance for staff on what words they should use or how best encourage the person to move.

We saw one staff member gently encouraging one person who had become angry to undertake a specific task. They told us this helped the person to become calm, we saw that the person responded well. We asked if this was in the persons care records. They said, "No I don't think so." We checked the persons records and it did not guide staff on how to help the person become calm when they were upset.

Visitors and staff, we spoke with identified that this person had recently been regularly exhibiting challenging behaviour. We reviewed their care records. They indicated that the person was a 'predictable risk to others' and instructed that a behaviour chart should be used to record any incidents. The records contained no behaviour charts and there were no records of any incidents. The manager told us they had not been made aware of any incidents. We discussed the importance of recording and analysing behaviours that challenge and asked why they thought staff had not reported incidents, they said that this was; "Probably because staff are just used to it." Following discussion with staff they later confirmed that incidents had been occurring.

All the records we reviewed contained no evidence that when challenging behaviour occurred, incidents were reviewed or analysed to prevent future occurrences or ensure people and staff were kept safe. The

manager also told us there were no systems in place to provide a debrief or formal support to staff after serious incidents occurred. This is important as it helps staff to discuss their feelings and assess if any learning from the incident could help improve the support provided.

The home was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had failed to adequately identify, assess and manage risks to people's safety and wellbeing.

We looked to see if arrangements were in place for safeguarding people who used the service from abuse. Policies and procedures were available to guide staff in safeguarding and whistleblowing (reporting of poor practice) as well as training. Staff we spoke with were aware of their responsibilities in reporting any concerns and knew who they could speak with. One staff member said, "It's good and yes, I can raise concerns…. I would report poor practice but have never felt the need to." However, we found the provider had not always notified CQC of incidents of abuse or allegations of abuse. This meant we could not be sure appropriate action had been taken to protect people. We have addressed this under the well-led section of this report.

We found there was a safe system of staff recruitment in place. We reviewed five staff personnel files. The staff personnel files we looked at contained an application form where any gaps in employment could be investigated. They contained appropriate written references and copies of documents to confirm the identity of the person, including a photograph. There was a system for checking any nurses were up to date and remained validated with the Nursing and Midwifery Council (NMC.) We saw that checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. We did note that two files did not contain photographic identification as is required. We were told this was because the documents had been used for obtaining the DBS and then destroyed. The manager said they would ensure a photograph of the person remained on the files. These checks should help to ensure people are protected from the risk of unsuitable staff being employed.

Policies and procedures were in place to guide staff on staff recruitment, equal opportunities, sickness and disciplinary matters. These help staff to know and understand what was expected of them in their roles.

We looked at the care records for five people who used the service who had different care and support needs. We saw that risk management plans were in place to guide staff on the action to take to mitigate the identified risks. Risk assessments included; bathing, falls, personal care, skin integrity, mobility, moving and handling, nutrition and medicines. However, risk assessments had not always been updated when people's needs changed. We have addressed this in the responsive section of this report.

The service had an incident and accident reporting policy to guide staff on the action to take following an accident or incident. We looked at the records of accidents and incidents and found that incidents were recorded however action taken following the incidents was not always recorded and accident and incidents were not monitored for themes or patterns to help prevent future risk. We have addressed this in the well-led section of this report.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). During this inspection we checked to see if the registered manager was working within the principles of the MCA.

A review of records showed that consideration was given to people's mental capacity and whether they were able to consent to their care and support. Applications for DoLS had been submitted to the relevant local authorities where appropriate and a record of this was kept.

Training plans we looked at and staff we spoke with showed that, of 34 staff, most care staff had received training in MCA and DoLS, however 10 had not completed the training and 11 were overdue a refresher. This training is important and should help staff understand that where a person lacks mental capacity and is deprived of their liberty, they will need special protection to make sure their rights are safeguarded.

At our last inspection we found that that where decisions were being made in people's best interest some records of options considered were not always complete. We recommended the service considered current good practice guidance to ensure that they complied with the principles of the MCA.

During this inspection a review of people's records showed that where specific decisions needed to be made, for example in relation to medicines or restrictive practice, a mental capacity assessment was completed along with a 'best interest' meeting. However, during our inspection, we saw that two people were having their intake of cigarettes controlled by staff. We heard one person who used the service ask for a cigarette and was told by a staff member, "Wait another 15 minutes you've just had one." We asked the manager if this restrictive practise was based on a best interest decision. They told us it was and explained the reasons for it. They were unable to provide any records to show who was involved in the best interest decisions, what options were considered or how that decision was reached.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that staff had acted in accordance with the Mental Capacity Act 2005.

We looked to see if staff received the induction, training, supervisions and support they needed to carry out their roles effectively.

Review of supervision records for 2018 showed that staff were receiving regular supervisions, although not

all at the providers specified frequency of six per year. Staff told us they had regular staff meeting.

Training records also showed that staff received training in moving and handling, infection control. health and safety, safeguarding adults & children, food hygiene, emergency first aid, dementia awareness and fire training. However, a review of the records showed that for each subject, most staff were either overdue attending refresher training or had not completed the course at all. Staff we spoke with did not have a good understand of either MCA or DoLS. We asked one staff member what they knew about MCA. They said, "I don't know what that is." Staff also told us that most training was e- learning and they would prefer some face to face training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff had not received all necessary training and support needed to carry out their role so that people using the service received safe and consistent care and support.

At our last inspection we saw that some efforts had been made to create a dementia friendly environment for example themed pictures on the corridors of cars and movie stars. There were also pictures on doors to identify toilets and bathrooms. At this inspection we found people's bedroom doors were all painted similar colours. We saw there were photograph frames at the side of each door, which we were told were for photographs or pictures to help people find their rooms. Most were empty. We discussed with the manager that further consideration was still needed so that people living with dementia were provided with accommodation that promoted and enabled them to live well.

We looked to see if people were provided with a choice of suitable and nutritious food. The chefs were aware of people who had allergies or were diabetic and had knowledge of people's preferences and choices. We received mixed views on the food at the home. People who used the service were satisfied, but some staff we spoke with said the food and choices could be improved. People who used the service said, "It's alright I have had worse" and "It's very good since about 6 months ago. Very often we have mashed potato and mincemeat." One staff member told us, "The meals aren't great and it's not the kitchens fault. There's not enough on the plate there's not much variation in food."

We saw one of the carers setting the tables and the knives and forks were set the wrong way around which could be confusing for people. We mentioned this to the manager who pointed it out to the member of staff, but the table settings were not changed.

During our observations on the first day of inspection we saw one person in the lounge at 11am who was asleep in their chair with their breakfast, which had become cold, resting on the arm of their chair. When we asked staff about this they told us the person could feed themselves but needed prompting. They replaced the breakfast but by that time it was almost lunch.

We observed that the dining area was set out in a way that did not allow for social eating, with tables against the walls and people sitting mostly alone. We discussed this with the manager who said it was so that people weren't distracted when eating and that people had fallen over furniture when tables were in the middle of the room. They told us they would review how meal time and the dining area were arranged.

People who lived at the home had access to healthcare services and received on going healthcare support. Care records contained evidence of visits from and appointments with their GP, dietician, speech and language therapists, dentist and opticians.

Requires Improvement

Is the service caring?

Our findings

People and their visitors spoke positively about staff who worked at Gorsey Clough Nursing Home. They said, "Yes [staff] they're excellent", "I think the majority are ok I have no complaints really about anyone" and "Yes they are quite good."

Visitors we spoke with told us, "Yes definitely [caring], even the cleaners here are lovely", "Absolutely, can't knock any of them at all. They have time for me as well as [person who used the service]. They always can tell me how [the person] is." Others said, "I can only say about this home that they are very caring. They do put up with a lot, there are a lot of aggressive people in this home so you see a lot but the staff cope well" and "Yes, I think the staff are excellent here."

We spent time observing the care provided by staff. Staff spoke politely and caringly towards people, however we found that interactions were often task orientated. Staff were often unable to spend time with each person, as they needed to provide support to someone else. We witnessed one person who required 1:1 observation was sat with a care worker. Whenever we walked through the lounge we did not hear or see them speak to the person.

During our inspection we saw that the general appearance of a number of the people who lived at the home was unkempt, including clothes that were stained. On the first day of our inspection we were in the lounge at 10.15am. We noticed a person had spilt their breakfast down the front of their jumper. We saw staff attempted to wipe it but it was very stained. When we returned to the lounge at 12.15pm the person had not been changed. Staff attended to this straightaway at our request. We discussed with the manager that people needed support and encouragement to help people maintain their dignity. We have addressed staffing levels in the safe domain of this report.

We found that staff had a good understanding of people's likes and preferences. Staff said they knew people well. "We will sit down with people who can communicate and talk about their pasts and speak with families. The care plans have information in as well" and "I would say I know some of them quite well, I would say I know what a lot of music and things people like."

We asked staff if they would be happy for a member of their family to live at Gorsey Clough. One staff member said, "No." When asked why they said no, "Because of staffing levels and lack of time to look after people." Another said, "I feel the actual care is good here, I think there is a good basis here ….. I think I would because of the staff. But if I didn't work here maybe not."

We looked to see if people's independence and choice were promoted and maintained. A visitor told us, "They do try encourage him to do things himself but they will also help him." Staff told us people were encouraged to continue to do what they could for themselves. They said they also ensured people were able to make choices they could. One staff member said, "We give them choices but we make the questions we ask as simple as possible. We show them two items of clothing or give them choice on foods."

Visitors we spoke with told us they were always made to feel welcome. Throughout our inspection we saw lots of visitors coming and going. One visitor said, "I think a lot of the staff have come up to me and been able to tell me about [person who used the service] and how [person] has been."

Care records identified whether people who used the service had a specific religion or faith and also whether they would require support to practise this.

We found that care records were not always stored securely. On the first day of our inspection we found a file used to hold daily records. This had been kept unsecured on a table in one of the lounges. The file contained records of people's dietary intake and output. We discussed this with the manager who said that the records would be removed. On the second day the file was still present, and although most documents had been removed some personal information such as; if the person had been to the toilet was still in the folder. We recommend the service reviews its system for recording daily activities to ensure peoples confidentially is maintained. □

Requires Improvement

Is the service responsive?

Our findings

Before someone started to live at the home an assessment of their needs and preferences was completed. We saw this assessment was used to develop care plans and risk assessments. The assessment process helps to identify if the service can meet people's needs and ensures staff know about people's needs and goals. The manager and clinical lead told us they wanted to improve the assessment used and were in the process of reviewing how it was done.

We looked at five people's care records and found that records included risk assessments and care plans were detailed and written using respectful terms. They gave information about things that were important to and for the person including; communication, personal care and hygiene, oral health, eating and drinking, moving and handling, mobilisation, falls and capacity.

We found that three of the people's records had not been reviewed at the identified review date. We also found that records were not always updated when people's needs changed. One person's records indicated they were 'high risk of falls'. They indicated, '[person] tends to walk around the home and is a known high falls risk. Extra vigilance is needed of [persons] whereabouts.' We were told by the manager that this person had not walked around the home for some months and was now nursed in a supportive chair during the day. There was no indication of this in their records or guidance to staff on how the person support should now be provided.

Another person's care plan for eating and drinking, dated September 2017, stated that following admission they had been reassessed by SALT (speech and language therapist) and were now to be given 'normal diet and fluids.' The risk assessment for eating and drinking dated September 2018 stated that; '[person] requires a pureed diet and normal fluids as per SALT– assessment prior to admission.' If people who have swallowing difficulties are given incorrectly prepared food and fluids it poses a risk of choking'. We discussed this with the manager, who confirmed that the person was given normal diet and fluids that the risk assessment was incorrect.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care records did not include complete and accurate information about people's current and changing needs.

The manager told us that the week following our inspection the clinical lead nurse was starting a review all care records to ensure they reflected people's current needs.

We asked staff how they were kept informed when people's needs changed. One staff member said, "Every morning we have a hand over and talk about it then." We saw that records were kept of the handover. It detailed important things that had happened for each person during each shift and any appointments of events planned for the following day.

Everyone we spoke with was happy with the activities and events provided at Gorsey Clough Nursing Home.

One person who used the service said, "Yes I went yesterday [to Blackpool]. It was alright, there was not music though. I thought we were going to go in the tower but we didn't we just drove up the lights. I enjoyed the weekend before we went to Radcliffe and had a dance." One person said, "I would like to go in the garden more."

On admission the activities coordinator completes a personal profile. This helps them to get to know new residents and what they like. They complete this with the person and their family. A visitor we spoke with said, "[Activity coordinator] was very good on the first day, trying to get to know [person who used the service] and things."

We spent time with the activity coordinator and found them to be enthusiastic and committed to providing meaningful activities for people. They told us, "We give out an activities profile survey and we try to incorporate things they like. We ask everyone what kind of trips they want to go on. Tonight, we're going to Blackpool and some relatives are coming. I do risk assessments on residents for outings as well. We go to the 'decaf' which is a local café for people with dementia and the rotary club put events on for local nursing homes and we go to them also."

Visitors were positive about the social outings. One visitor said, "We are going to Blackpool tonight a few of us, were getting fish and chips and going to the lights then coming back. There doing a bonfire party and a Christmas party too."

Records showed there were specific events to celebrate certain times of year, also one to one sessions with each resident based on activities they liked. We saw that there were performances from singers, exercise and Zumba sessions. The home was a member of 'bright copper kettles' which is an activities forum. People were supported to attend story reading sessions at Bury museum once a month.

We looked at whether the service complied with the Equality Act 2010 and in particular how the service ensured people were not treated unfairly because of any characteristics that are protected under the legislation. A policy was available to guide staff which reflected the protected characteristics exploring people's religion or beliefs, race and sexual orientation and the implications for care practice. It guided staff on action to take when planning and delivering care and support. This helped to promote people's human rights.

We looked at how the service was meeting the requirements of the Accessible Information Standard (AIS) as required by the Health and Social Care Act 2012. This requires service providers to ensure those people with disability, impairment and/or sensory loss have information provided in an accessible format and are supported with communication. People's communication needs were assessed and care plans included details about people's communication needs. We were told that when needed information could be made available such as in larger print.

We looked to see how the service dealt with complaints. We found the service had a policy and procedure, which told people how they could complain and what the service would do about their complaint. It also gave contact details for other organisations that could be contacted if people were not happy with how a complaint had been dealt with. A copy of the complaints procedure was fixed to the back of every bedroom we went in. Records we saw showed that there was a system for recording complaints, compliments and concerns. This included a record of responses made and any action taken.

Inadequate

Is the service well-led?

Our findings

During this inspection we looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help registered providers to assess the safety and quality of their services. This ensures they provide people with a good service and meet appropriate quality standards and legal obligations.

We asked the manager how often they walked round to ensure day to day processes were in place in respect of the running of the service and they told us they did this when they had the opportunity but not every day. The manager told us they had started to walk about and check the premises and records showed they had done this on 13, 21, and 24 September. We saw that issues had been identified including a leak in one bedroom. There was no record of what action had been taken after the walk round. The manager told us the provider had been informed and a plumber had visited the same day. They told us that going forward they intended to record all actions and outcomes.

We asked the manager what audits were undertaken to monitor and review the service provided and requested quality assurance and governance records for 2018.

There were no records available to demonstrate there was a system of on-going weekly and monthly audits. The manager confirmed that there were no records of audits or quality checks. The provider did not have a system or audit or monitoring in place. Governance systems in place had failed to identify or address the concerns we found during this inspection.

Monitoring and checks in areas such as; staffing levels, staff training, cleanliness and infection control, medicines storage and administration and the environment had not been completed.

There were also incomplete health and safety and maintenance checks and no audits of these checks had been completed.

Where tasks had been delegated such as health and safety checks, the provider did not have systems to ensure these checks had taken place. Fire and water safety checks had not been completed and where issues had been identified no action had been taken to resolve issues. The provider had not acted on areas of concern identified in the fire and legionella risk assessments.

Care records did not always reflect people's current needs and there was no evidence of meaningful regular review or audit by managers.

Where serious incidents including falls and challenging behaviour occurred, action taken following the incidents was not always recorded. There was no overview record kept by managers of the service. This meant that there was no analysis for themes, patterns or action taken to prevent reoccurrence.

We looked to see what opportunities people had to comment on the service they received. Satisfaction

surveys had been sent out but only five had been returned. They were generally positive. However, we saw comments on issues including, "How bare my relatives room is", "How cold my relatives room is" and "The curtains don't close." At the time of our inspection the manager confirmed no action had been taken to address the issue raised.

We found this was a breach of regulation 17 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Systems were not in place to assess, monitor and improve the quality and safety of the service provided.

Providers are required to notify CQC of certain significant events that occur within their services, including deaths, serious injuries, safeguarding incidents and DoLS authorisations. A review of CQC records of notifications and records held by the service showed that the service had failed to notify CQC of three safeguarding's incidents that had occurred and one serious injury. This meant we were unable to see if appropriate action had been taken by the service to ensure people were kept safe.

We found this was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. Notifications of other incidents. The provider had failed to make the required notifications to the Commission.

The service is required to have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service did not have a registered manager. The provider told us that since the last registered manager left in September 2017 they had appointed two people who were going to apply to register but left before doing so. The current manager had been working as deputy manager since March 2018 and had been promoted to manager in August 2018. They told us they were in the process of applying to be registered with CQC. The provider told us that to strengthen the management arrangements, and to support the manager, they had also appointed a new clinical lead nurse, who had started the week before our inspection.

Visitors said "Yes, [manager] is really approachable. I wanted to chat with her today but I only got five minutes as you are here, but she gave me her email address and everything and said I can talk to her anytime" and "Yes, [manager] is lovely. Yes, she is a nice girl, [Clinical lead] oversees the nurses and she is also very good."

Staff were very positive about the manager and the clinical lead. They told us, "I think they are really great and [Clinical lead] is amazing, [manager] is nice. I think [Clinical lead] is really motivational she has only been here a few days and its already making an impact", "I like [manager] she is really loving she likes to help. I think [Clinical lead] will be a star." Others said, "I do want to say the new clinical lead is good for here", "I think the new clinical lead will be great. She has come at the right time" and "I think they have a lot on. She [manager] is very approachable, but I think she could do with more support but maybe she has that now there is a clinical lead."

We saw there was a resident handbook and statement of purpose. These documents gave people who used the service the details of the facilities provided at this care home. These also explained the service's aims, values, objectives and services provided. These documents helped to ensure people knew what to expect when they used this service.

It is also a requirement that the provider display a copy of their last CQC inspection report and overall rating

for the service. We saw a copy of the last inspection report including the rating was displayed in the reception area and was easily accessible to people living at the home and their visitors. Information was also detailed on the provider's website.

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 provider had failed to make the required notifications to the Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had not ensured that staff had acted in accordance with the Mental Capacity Act 2005.

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 Systems were not in place to ensure the safe management and administration of people's medicines. The provider had not ensured the premises or equipment used by the service were safe to use or used in safe way. Suitable arrangements were not in place to ensure people were protected from the risks of cross infection. The provider had failed to adequately identify, assess and manage risks to people's safety and wellbeing.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

There were not sufficient staff to meet people's needs and the provider did not have a systematic approach to determining staffing numbers based on peoples changing needs.

Staff had not received all necessary training and support needed to carry out their role so that people using the service received safe and consistent care and support.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Care records did not include complete and accurate information about people's current and changing needs. Systems were not in place to assess, monitor and improve the quality and safety of the service provided.

The enforcement action we took:

Warning Notice.