Cieves Limited

Gorselands Residential 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 unannounced inspection took place on 22 May 2018.

Gorselands Residential Home provides accommodation, support and care for up to 21 older people, some of whom are living with dementia. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 18 people were using the service.

There was no registered manager in place but a new manager had been appointed who had previously been the registered manager and they had applied to be registered again. 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.

At our previous comprehensive inspection which was carried out on 22 and 23 February 2017 we rated the service as Requires Improvement. During that inspection we identified breaches of regulation relating to the unsafe management of medicines and poor monitoring of risk. The service was also in breach of the same regulations at the previous inspection in July 2016, alongside breaches relating to person centred care, consent and staffing.

Following our February 2017 inspection we placed additional conditions on the provider's registration. We required the provider to send us monthly audits relating to medicines and the analysis of accidents and incidents to ensure a better overall management of risk. The provider has not always complied with this requirement and the quality of the information supplied has not always been acceptable. We had not received any monthly update in the four months leading up to this inspection.

During our current inspection we found some improvements with regard to the management of the service under the new manager but we also identified some significant concerns about people's safety. We have identified continued breaches of regulation relating to the management of medicines and the management of risk. In addition we found that staffing levels constituted a breach of regulation.

We could not be assured that medicines were always managed safely as stocktaking measures were not effective. We also identified some recording errors relating to the administration of controlled drugs which audits had not picked up.

Risks were not always well managed. Hot water posed a potential risk as did the lack of effective security for people who were not safe to go out into the community without support. Staffing levels meant sometimes people were left without staff support which increased any potential risks.

Staff understood their responsibilities with regard to keeping people safe from the risk of abuse but some safeguarding matters had not been promptly notified to CQC.

Infection control procedures were in place and staff demonstrated an acceptable knowledge of how to reduce the risk and spread of infection.

Staff were well trained and supported in their roles. They were positive about the support of the new manager and supported the initiatives she had put in place to try and drive improvement at the service. Further relevant training, such as that for end of life care, was planned to increase staff skills and knowledge.

People had good and prompt access to healthcare and staff worked well with other healthcare professionals to meet people's healthcare needs. Some improvements were needed with regard to the oversight of people's eating and drinking to ensure people always had their needs met.

The service needed to improve their practice with regard to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. We found that staff understanding of MCA and DoLS was not clear and people were effectively denied their liberty in a way which was not in line with the Act.

The environment required some updating and refurbishment to bring it up to a fully acceptable standard. A programme of refurbishment was in place.

Staff were kind and caring and demonstrated that they had built up good relationships with the people they were supporting and caring for. People were supported to be as involved in decisions about their care as they could be. Although staff were respectful, staffing levels sometimes meant decisions were taken by staff which did not always reflect people's preferences and expressed wishes.

Opportunities for people to follow their own hobbies and interests were limited and this was an issue for some people. The provider had recruited an additional member of staff to provide some activities but they were also to have caring responsibilities so it was not clear exactly how this would work, although it was a clear improvement.

Care plans were person centred and reflected people's individual needs and preferences. Regular reviews of plans were taking place, although some current information had not been recorded. Care for people at the end of their life was good. There was a commitment to ensuring people had a dignified and pain free death and were not left alone, unless this was their wish. People's wishes were clearly documented.

A clear complaints procedure was in place and complaints were appropriately managed. People who used the service and relatives were given the opportunity to provide feedback and raise informal complaints via the twice yearly survey which was sent out.

The new manager had begun to address some of the historical concerns at this service which were identified at previous inspections. Although a lot of work had been undertaken to improve the quality and frequency of staff training and support and to review the care plans, a great deal of work is still needed to bring about further improvement.

Concerns relating to medicines and risk management continued to be highlighted at this inspection, as they were at previous inspections. We also found that the provider had not complied with the additional conditions we placed on their registration. This was unacceptable practice. However, the new manager has begun to send us good quality current information in a timely manner since the inspection visit.

Both the manager and the provider understood that the service needs to make significant improvements and maintain them. Both told us they are prepared to do this work and to engage with any external support such as the local authority quality assurance team.

The overall rating for this service is 'Inadequate' and the service is 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. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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?

Inadequate

The service was not safe.

There were not always enough staff to make sure people were safe.

Medicines management had improved but poor stocktaking procedures and poor quality audits meant we could not be sure people always received the correct medicines.

Risks were not all well managed and there were significant risks relating to fire, hot water and people leaving the service without staff being aware.

Staff understood their responsibilities to keep people safe from abuse and were confident about reporting any concerns.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not clear about all the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Some people were being unlawfully deprived of their liberty as correct procedures were not in place.

People's needs related to eating and drinking and to their health were managed reasonably but better oversight was required in some cases.

The environment required some updating to ensure it was suitable for the needs of the people who used the service.

The service worked in partnership with other healthcare professionals to maintain people's health.

Staff were well trained and knowledgeable.

Is the service caring?

Requires Improvement

The service was not always caring.

People were mostly involved in decisions about their care but sometimes staffing levels meant staff did not act in accordance with people's wishes and preferences.

Staff were patient and treated people with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

There was little in the way of meaningful occupation for people. Recruitment for new activity staff was in place.

There was a complaints procedure in place and people were given opportunities to raise concerns formally and informally.

Care plans had been reviewed and reflected people's individual needs.

Staff demonstrated an understanding of the important features of end of life care but had not yet received training in this area of work.

Is the service well-led?

Inadequate

The service was not always well-led.

The provider had not complied with all the conditions placed on their registration at the last inspection.

There was poor oversight of health and safety which placed people at risk.

The new manager had begun to address some of the concerns facing the service and to drive improvement.

Gorselands Residential 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 May 2018 and was unannounced.

The inspection was carried out by two inspectors. Prior to the inspection, we reviewed all information available to us. This included statutory notifications. Notifications are information about specific events that the provider is required to send us by law.

We spoke with five people who used the service. We also carried out a SOFI observation. This is a structured observation that helps us understand the experiences of people who are not able to communicate with us easily. We spoke with seven members of the care staff including one senior staff member, two care assistants, the cook, the manager and the provider. We also spoke with representatives from the local authority quality assurance and safeguarding teams. We reviewed care records for four people, four people's medication records, two staff files and other records relating to the quality and safety of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection on 22 and 23 February 2017 we rated this key question as Requires Improvement and identified a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to the unsafe management of medicines. The service was also in breach of the same regulation at the previous inspection in July 2016, relating to unsafe management of risk and unsafe management of medicines. Following our last inspection we required the provider to send us monthly audits relating to medicines and the analysis of accidents and incidents to ensure a better overall management of risk. The provider has not always fully complied with this requirement.

When we arrived at the service we noted that the member of staff had to unlock the main door with a key. The staff member told us that all staff had a key on them to unlock the front door in an emergency such as a fire. We quickly established that one member of staff did not have a key and later in the day the provider had to go looking for a key. This represented a significant risk should the premises need to be evacuated in an emergency.

We discussed our findings with the provider who told us that it was their intention to replace the locked door with a keypad system as soon as possible. However, since the inspection, we have been informed that the provider had given the same assurance to the local authority safeguarding team in April 2018. This was following an incident where a person was able to let themselves out of the premises and access the community when it was not safe for them to do so. We do not feel that the provider has addressed the safety issues posed by the front door in a timely way and has therefore continued to place people at risk.

Since our inspection we have been informed that a second person was able to access the local community when it was unsafe for them to do so. Staff were not aware that they had gone missing and prompt action was not taken. The potential risk of this person leaving the service and placing themselves at risk of harm had not been fully assessed and effective actions were not taken to reduce this risk.

We noted other unsafe practice regarding the storage of wheelchairs and equipment near fire exits and we noted two doors wedged open, including one where the person was using oxygen. This represented an additional fire risk. Fire exits were not able to be easily operated, for example by a push bar. One door required both upper and lower handles to be operated in different directions at the same time. This could present an additional delay when evacuating people from the building in an emergency. There had not been a fire evacuation at the service since June 2017 although the manager told us they were aware this was overdue and one was planned.

We noted that the hot water felt extremely hot to the skin and could not be tolerated for more than a few seconds. We concluded that the routine monitoring of the water temperatures was not effective. We suggested that the thermometers used to test the water were not accurate and that this placed people at risk. The manager has since confirmed that they have ordered new thermometers and have put notices on the affected taps to warn staff. They also arranged for a repair to be carried out promptly. However, we were concerned that staff had not identified this potential risk and action had not been taken before we noted the

issue.

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

Other risks to people's safety and welfare were managed more successfully. Equipment such as window restrictors, pressure relieving equipment such as air mattresses, and sensor mats were in place to reduce the risks of falls from height, pressure sores and falls. The manager had assessed these risks and those relating to people's poor eating and drinking. We saw evidence that the manager had referred people promptly to the falls team for further advice when a person had an increased number of falls. We also saw that the manager had worked hard to reduce a risk relating to one person's distressed behaviour and had been persistent in trying to secure the person the correct support. We understand that this support is now in place.

We looked at how the service reduced the risks posed by people not eating or drinking enough. Although staff used the Malnutrition Universal Screening Tool (MUST) to assess people's risks of not eating enough, this was not always used correctly. MUST is a recognised industry tool designed to identify when people are at risk of unplanned weight loss and gives staff a structured action plan to follow. We saw that although people had been identified as being at high risk of losing weight they were not always weighed weekly to monitor any unplanned weight loss or their eating plan changed to ensure their calorie intake was boosted. One person's fluid chart did not document what their daily fluid intake should be and contained no information to guide staff as to what to do if the person's intake was low. Records showed that in the previous six days this person had received less than 600 mls of fluid on three days and there were no records for the other three days. This meant that we could not be fully assured that people were always receiving the fluids they needed, although we noted that staff promoted drinks throughout the day during our inspection visit.

We also continued to have concerns about the unsafe management of medicines, although some processes had clearly improved. We noted that staff ensured the medicines trolley was not left unattended at any time so the medicines carried within did not pose any threat to the safety of the people using the service. Staff received training in the administration of medicines, although the provider did not carry out spot checks to ensure people's practice remained in line with best practice. We found that staff and had an understanding of people's medicines and demonstrated a working knowledge of issues such as side effects of particular medicines and time sensitive medicines.

However we also found that stocktaking measures were not robust. This meant we could not be fully assured that all the people who used the service had received all their medicines as prescribed. For example, stocks of one person's blood thinning medicine, the dose of which was regularly changed, had not been carried over from the previous month and recorded accurately. This meant we could not tell if the person had received the correct dose on each occasion.

Stocktaking of other medicines was also not robust. We noted that two medicines had been incorrectly accounted for which meant we could not be sure the people had received the correct dose. There were also stocktaking errors in the controlled drugs book. We noted that one person's controlled release morphine patches had been booked in incorrectly and the error had not been noted by other staff. However, staff told us this was a recording error and sought to assure us that the person had received their pain relieving medicines as prescribed. In addition to this we found that on four occasions controlled drugs had been administered by one person without a witness present, which is not in accordance with the provider's own procedure.

We also noted that, although staff completed a body map to record where they had sited a pain relieving morphine patch, previous body maps were not easily accessible to staff and could not be located when we asked for them. The site of some pain relieving patches needs to be regularly rotated and sometimes left free for several weeks in between applications. If this is not done there is a risk of a person's skin breaking down.

We were concerned to find these errors relating to the administration of medicines as the service had been in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the unsafe use of medicines, since 12 July 2016. However, we had some confidence in the new manager, who had already put in place a more effective medicines audit. Since the inspection they have also notified us of robust action they have taken in response to an error in the administration of medicines. Although this is encouraging, we remain concerned that the provider has not acted more quickly and robustly to address all the issues we had previously found relating to the administration of medicines.

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

People told us that staff responded fairly quickly if they needed help or support and said they used their call bells when they were in their rooms. However, one person also commented that they had not liked to bother staff when they did need something, because they knew they were very busy around 5.30pm, assisting others. The provider was not able to carry out any audit to assess the response time to call bells as the call bell system did not facilitate this, although they told us they intended to start carrying out spot checks.

During our observations after lunch, there was a period of 20 minutes when there were no staff available in the lounge to support people. Two people had become distressed and one person became angry with another. Fortunately this did not escalate or require intervention. Only one person had access to a call bell, but they subsequently left the room. This meant there was no effective way of summoning assistance from staff. We also observed nine people for a period of 35 minutes and saw that they received no interaction at all from staff.

Staff told us that, of the 18 people who used the service, six needed the assistance of two staff to make sure they were able to move safely. There were only two staff on duty during a two hour period in the afternoon and we were concerned about the impact the staffing levels had on staff's ability to meet people's needs. The provider told us that they had recently recruited an activity co-ordinator who would act as a third person and this would ensure that there would always be at least three staff on duty. Until this was in place the provider told us that they or the manager would be the third person. However there were periods during our inspection when both the provider and manager were attending to other matters and not available to support staff in this way.

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

We checked staff recruitment records and found that there was an acceptable recruitment procedure in place. This included face to face interviews, job references, proof of identity and a history of the applicant's previous work experience. The provider also carried out Disclosure and Barring Service (DBS) checks to make sure applicants did not have any convictions which would mean they were not suitable or safe to work in this setting.

Measures in place to protect people from the risk and spread of infection were not as robust as they needed

to be. The kitchen, for example, was well organised and mostly very clean. However, some daily, weekly, four weekly and eight weekly cleaning tasks in the kitchen had not been carried out, according to the records we saw. We found that this may have been a recording issue in part but also noted that the cutlery drawer was dirty and some opened jars in the fridges were several weeks past their 'use by' date. This could place people at risk.

Some areas of the service, including the bathrooms, had worn or damaged surfaces which made them impossible to keep properly cleaned. This meant people were not always fully protected from the risk of cross infection. The provider told us they had a refurbishment plan in place and intended to upgrade the areas we were concerned about. We also observed staff using moving and handling equipment with three people. Each of them used the same sling. We noted that one sling had faeces on and the sharing of slings in this way, without appropriate infection control measures in place, exposed people to potential risk. The provider told us that each person was supposed to have their own sling and assured us that sharing was not usual practice.

Staff received training in keeping people safe from abuse and knew how to recognise the signs that someone might be at risk of harm. Staff understood how to raise a safeguarding concern both within the company and externally. Two people told us they felt safe in the service and that staff treated them well. They had no concerns about their welfare or the attitude of staff. One said, "They are really very good. I have never seen anything happen [with staff] that worries me."

On the day of our inspection we became aware of a safeguarding matter which had not yet been notified to CQC. We saw that the manager had tried to work in partnership with other agencies to safeguard people at the service but had been frustrated by the responses they received. Although the manager had taken appropriate action we found that matters should have been notified to us and escalated more quickly to ensure people were fully protected. Since the inspection the manager has successfully managed to ensure additional support is in place and people are now safeguarded from this potential harm

The service had notified CQC and the local authority of other safeguarding concerns appropriately but had not always cooperated promptly with local authority safeguarding investigations. The new manager assured us that this would not be the case in the future and demonstrated an acceptable understanding of safeguarding procedures.

As part of additional conditions imposed on the service after the last inspection the provider was required to send CQC an analysis of falls and incidents to ensure that patterns and trends were identified and action taken to learn from incidents and reduce future risks. This had not always happened and analysis of incidents and falls had been poor in recent months. However, the new manager confirmed with us exactly what was required and has, since the inspection visit, sent us robust analysis which clearly identified that learning had taken place and action had been taken in response to perceived risks.

We also noted that following a period where the service had been unable to support a person's complex physical and mental health needs, the manager had reviewed the service's pre-admission assessment. The new assessment format was designed to ensure that significant information was captured at that initial stage to help the service make an informed decision as to whether they could meet the person's needs.

Requires Improvement

Is the service effective?

Our findings

At our last inspection on 22 and 23 February 2017 we rated this key question as Requires Improvement. Our current inspection identified some improvements had been made, particularly relating to training, but further improvements were still required.

People told us they trusted the staff to look after them and support them. One person explained that they felt staff, "Know what they're doing and are competent". People's needs were assessed before they began using the service to ensure that the staff team could support them effectively. The assessment included information about people's physical health and psychological needs. There was also information about what was important to people, their routines, histories and backgrounds. Staff were knowledgeable about people's needs and the information they gave us matched that in care records, with one exception where we found some confusion about a person's risk of choking. Staff were not entirely clear about the consistency of food this person should be having to ensure they were not at risk. The manager told us they would review the records and make sure all staff were clear about this risk.

Staff received the training they needed to carry out their roles effectively. When staff were first employed they underwent a structured induction. Staff received a variety of training including moving and handling, fire safety, basic life support, food hygiene and health and safety. The provider ensured staff had further training and refreshers. The new manager had recently provided training in dementia, diabetes and governance. Staff told us that they liked the fact that training was face to face with a recognised trainer as this enabled them to ask questions if they needed to.

Staff told us they felt supported and we saw that there was a supervision and appraisal system in place. Staff told us that, since the new manager came into post, supervision and staff meetings were improving. They said they felt well supported in their roles and able to ask about anything they were not sure of. We saw that all staff had received a supervision session in March 2018.

We saw examples of effective partnership working across the service. On the day of our inspection the manager, who had previously had limited success in securing additional support and funding for one person, had visited the local GP service. They ensured that they did not leave the GP service until they had secured the promise of additional help and action required to keep the person, and those around, them safe. We saw that people's health and welfare was promoted and staff referred issues to other health and social care professionals when needed.

During the course of our inspection visit, we observed staff working with members of the district nursing team to provide people with care. Staff received specific training about certain health conditions such as dementia and diabetes, and were knowledgeable about people's needs relating to their health.

Staff told us about one person who had received support and advice from the dietitian but was now discharged because they had achieved a healthy weight. They confirmed people received support from the chiropodist for foot care and records showed this. The optician was due soon and staff had received support

and advice from the Dementia Intensive Support Team (DIST). Staff said that, in common with many areas, they struggled to get support from a dentist when people needed it. However they had recently taken one person to a surgery in a nearby village although this had been difficult to achieve.

People's needs were assessed in line with MUST which helps to identify the level of risk relating to people's eating and drinking and gives a structured action plan to follow. However staff did not always follow the action plan and we saw examples of MUST being used to record a person's weight and current risk without the required actions being identified and put in place. For example one person's plan indicated they were losing weight. However, actions such as weekly monitoring of the person's weight and adding calories to their food by using extra cream and butter were not recorded to guide staff. We discussed this with the manager and the provider and they told us that they were beginning to introduce a 'Food First' approach based on the British Association for Parenteral and Enteral Nutrition guidance.

People told us that they liked the meals provided. There was one main option for lunch which, on the day of our inspection visit, was fish cakes with parsley sauce and vegetables. However, people were able to have alternatives. One person said, "If you don't like it you can have something else like sausages or eggs. I get enough to eat and drink." They went on to explain that they liked to have their tea in their room, usually sandwiches and cake. Another said, "Oh yes, the food is good."

One person told us about when staff had forgotten to give them a drink. They said, "They forgot to bring a drink with my tea. I've got a jug of water in my room but it gets warm in the day so it isn't nice. I sucked some sweets to quench my thirst." They told us they did get a drink later in the evening at 8pm as usual. They agreed that they could have rung their call bell to request a drink at teatime but they knew staff would be busy helping people to bed. Staff monitored some people's food and fluid intake but records were not always fully completed which meant staff did not have an accurate picture.

The Mental Capacity Act 2005 (MCA) provides a legal framework for decision making on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that people's capacity to make their own decisions is assessed. As far as possible, people should be supported to make their own decisions but where they lack the mental capacity to do this, decisions are taken in their best interests according to a structured process. People who lack the mental capacity to consent to care and treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS.

Staff demonstrated some knowledge of the Mental Capacity Act 2005 (MCA) and DoLS but there was also some confusion. We found that people consented to their care and treatment but often, for those who did not have capacity to make this decision, their next of kin had signed without any assessment having been completed. There was not always a record confirming that the next of kin had the legal right to give this consent. Care plans contained forms recording people's consent to care, to sharing their records with essential professionals and whether they agreed to their family members having access. We noted that people's next of kin were appropriately involved in discussing care as they knew their family members well. Staff confirmed that they had received training to help them understand how to support people who might find it difficult to make decisions.

We found that understanding and practice relating to DoLS required considerable improvement. The service had a locked front door which prevented all the people who used the service from leaving. There was a lack of clarity in individual assessment processes that this was the least restrictive option for ensuring people's safety as everyone was subject to the same restriction. Staff told us that nobody living in the home was subject to an authorisation to deprive them of their liberty in accordance with DoLS. However this was not

the case.

One person was seen to be trying to leave through the main door a number of times. They asked a staff member 'Would I be allowed to go out from that door?" and the staff member told them, "Unfortunately not". The staff member confirmed that the person did not have a DoLS in place. They did not understand that, if this was the case, they were effectively depriving this person of their liberty. We later established that the manager had made a DoLS application for this person but staff were unaware of this.

The building was not always well suited to the needs of the people living there and required some routine maintenance and upgrading. The access to the front door and fire doors did not ensure people were both protected for their own safety and also free to enter and leave the building should they have the capacity to do this.

Some areas required redecorating and the provider told us they were treating this as a priority. We found that bathrooms were very basic and we noted smashed tiles in one bathroom with rough edges. The water was too hot in two bathrooms which posed a risk to people. Storage of equipment such as wheelchairs and walking frames was a challenge, as it often is in smaller services such as this. However, we found that equipment was blocking a clear path to fire exits in two places and asked for equipment to be moved immediately. The provider arranged for this to be done.

The garden was a secure and pleasant space for people to relax in and some people told us they like to pop out there. The lift made the upper floor easily accessible and we observed people using this independently. People received their visitors in the main lounge or in their rooms and we saw people taking themselves off to their rooms if they wanted this. People told us group activities took place in the main lounge.

Requires Improvement

Is the service caring?

Our findings

People who used the service told us staff were kind to them and found Gorselands to be a caring place. One person said, "They are lovely." Staff were kind and spoke to people with compassion, empathy and respect.

Although staff were often very busy, we observed them taking time to talk to people and listen whenever they could. We noted staff having a laugh and a joke with people and managing to use distraction techniques to refocus one particular person who was unsettled.

Relationships between staff and the people they were caring for and supporting, appeared warm and friendly. Staff provided people with guidance and reassurance and we saw one staff member spend time with a person who was calling out and a little tearful. They sat alongside the person, making eye contact and chatting to them. The person reminisced about their life and interests and their mood improved while the staff member was there. However, due to the staffing levels, it was not always possible for staff to provide this kind of comfort.

We noted that staff interactions did not always take account of people's wishes and offer choice. One person, who was walking around the service frequently and occasionally wanting to go outside, was repeatedly encouraged to go and sit down and watch the television. This was until another member of staff intervened and suggested they may like to go into the back garden.

Another person was anxious and asked one of our inspectors, "What do I do? Do I have to sit here for the rest of the day?" When a staff member did intervene, they suggested that the person "…have 40 winks." The person asked what that meant and when told it was about having a nap, said, "The best place to sleep is in bed then." They were not asked if they wanted to return to their room or offered assistance to do so. Staff did not offer other activities or sit and chat with the person, who remained distressed. A second person was also encouraged to sit and have an after lunch nap without being offered any alternatives or asked what they wanted to do.

However we also saw evidence that people, or their advocates or next of kin if appropriate, had been involved in making decisions about their care and support. Where people had capacity to do this we saw that they had been involved in reviews of their care. The manager told us that regular care plan review meetings had not been held for some time but she had already started to reintroduce these. These gave people who used the service, and their advocates or next of kin, a chance to discuss the person's care in depth and raise any particular issues related to it.

Staff respected people's privacy and their personal space. We observed staff knocking and waiting before entering people's rooms and asking people's permission to provide care and support. Staff mostly spoke very respectfully to people throughout our inspection, although we did observe two occasions when staff talked publically about private matters relating to health and welfare.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we rated this key question as Requires Improvement. We found that care plans did not always accurately reflect people's needs or give staff adequate guidance about how to meet people's individual needs. At this inspection we noted that the provider and new manager had been working hard to improve the quality of the care plans and ensure they were comprehensive. Plans identified people's requirements relating to a variety of needs including social behaviour and inclusion, sleep, sensory, mobility, continence, diet and personal care.

After an initial assessment of people's needs the service drew up a care plan which included the person's personal history, wishes and preferences and their past life history. Plans documented exactly how people liked to receive their care and support. When people's needs changed, we found that care needs were reviewed and updated to reflect the new circumstances. However we did note that one person had developed a pressure sore and their care plan relating to pressure care had not been updated to reflect this.

There were clear procedures for handing over information from shift to shift. However, filling out handover information was observed to take staff some considerable time and left people without staff to attend to them during this time. Staff demonstrated that they were very clear about people's needs and knew people well. Information about people new to the service was shared with staff to enable them to provide people with the care they needed.

The service was without a member of staff to oversee activities for people so they could follow their own hobbies and interests. Staff did their best to provide people with meaningful occupation but this was limited as they were so busy. We observed staff regularly encouraged people to remain in the lounge either to watch the television or to have a nap after their lunch. One person wanted to walk around the service and another asked if they had to stay in their chair all afternoon. This suggested that staff were not always able to respond to people's preferences.

During the morning of our inspection visit, staff put some music on, which some people sang along to. However, during that time, staff also left the television on with the volume turned down. For people living with dementia, this would present as confusing as they would not be able to relate the images to what they were hearing.

Records of activities people engaged in showed that sometimes a person came in to provide "Sing-along" sessions or skittles. However, the majority of the entries referred to people chatting with staff and watching television. One person told us, "We have skittles sometimes but they have television on all day on DIY and cookery. I don't like it." We saw a noticeboard which documented future outings but there were no dates set and staff were not sure when these trips would take place. We saw little evidence of people being involved in the life of their local community. The provider told us that they had employed a staff member to be the third person on the shift and to oversee activities and hobbies for people and that this would be starting the following week.

The service had a complaints policy and formal complaints had been investigated and responded to appropriately in writing. There had been no formal complaints since the new manager took over. We asked two people who used the service how they would make a complaint if they needed to. Neither of them was able to identify the manager but told us they were confident they could speak to staff. One person named a staff member they were confident to approach.

Information about people's wishes and plan of care for the end of their life was recorded in care plans. People who used the service and families, if appropriate, were involved as much as possible in decisions about end of life care and staff respected people's wishes. The manager told us that medicines to control any pain and anxiety were arranged as soon as it was clear a person was coming to the end of their life.

Staff worked with district nursing staff and hospice professionals and we saw that care was taken to provide people with reassurance. We noted that one person had a plan which stated that they did not wish to go to hospital should their condition suddenly deteriorate and staff were aware of this decision. We also saw that the service had worked in partnership with the local GP service to ensure the person's anxiety was relieved. The manager told us that staff had not yet received any training in supporting people's end of life care but that this was being arranged and would be delivered to relevant staff.

Inadequate

Is the service well-led?

Our findings

The relatively new manager was open, transparent and honest. They had previously been registered with CQC at this service and had applied to become registered again following a period in a different role. They were aware of the responsibilities relating to being a registered manager, although they had not reported a recent incident to us where people who used the service had been placed at risk. We found that some of the provider's paperwork referred to the former 2010 Health and Social Care Act regulations rather than the current regulations which were updated in 2014. The provider told us they would review their paperwork.

At the last inspection this key question was rated as Requires Improvement and a breach of regulation was identified relating to the leadership of the service. Following that inspection we placed conditions on the provider's registration which required them to send us regular reports about medicines management and audits and analysis of falls and incidents. These had not always been supplied to us and some of these reports were of a poor quality. We discussed this unacceptable response with the provider and the manager at a meeting held before our current inspection took place. However, regular audits and analysis of falls were still not provided to us after this meeting.

Oversight of some aspects of health and safety at the service was not good enough and a more thorough and robust approach was required to ensure people were not placed at risk. We remain very concerned about the circumstances where people were able to leave the service on two occasions without staff being aware. This placed the people concerned at considerable risk of harm.

We discussed one case with the manager who told us that the potential risk had not been highlighted to them during the pre-admission assessment. They have now changed their assessment to ensure that relevant information about people's likelihood of trying to leave the service is established and communicated to staff. However a second person left the service in similar circumstances since the inspection. This demonstrates that the risk has not been sufficiently reduced. The provider assured us that they were replacing the main door with a new door and keypad system. However, they had previously given a similar assurance to colleagues from the local authority safeguarding team and, several months later, the door had still not been replaced.

Health and safety audits were in place but were not always effective and senior staff had not provided effective oversight of these audits. Kitchen cleaning audits had lots of gaps and the medication audit was brief and had been carried out by a staff member who had themselves made a significant medication error and not identified this. We discussed this with the new manager and they have since reviewed the medicines audit and those we have seen since the inspection are robust. We also noted that effective actions had been taken to address staff errors or poor performance relating to the administration of medicines. The new manager assured us that such issues would continue to be dealt with robustly in the future.

Staff tested the emergency lights each month. However, we noted concerns had been documented regarding dim lights in March, April and May but no action was taken in response to this. The manager assured us they would look into this. They also assured us they would have better oversight of the hot water

testing as a serious concern with the temperature of the hot water in some taps had not been effectively communicated by staff and the risk reduced.

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

In the weeks since the current inspection visit, the new manager has supplied us with the information we require in a timely way and reports are of a good quality. Reports demonstrate that incidents and accidents are being analysed for patterns and trends and demonstrate that appropriate and prompt action is now being taken which aims to ensure people's safety with regard to falls and medicines management.

The manager demonstrated an eagerness to learn, and was intending to arrange a meeting with quality assurance staff from the local authority. The manager was clear that this support could be of assistance in raising the overall quality of the service and was positive about the opportunity.

We received positive feedback about the new manager from staff. One staff member described feeling 'safer' in their work because of the support and oversight of the manager. The manager had gained the confidence of the staff and we saw that relatives also had a good relationship with her. The manager provided practical support to staff and acted as role model. We also noted that they worked professionally when seeking extra support for one person and were keen to access the right support rather than move the person and effectively pass the concerns onto another provider. This was caring and demonstrated a commitment to getting the person the right support even though this was extremely challenging.

The manager had quickly identified the areas for improvement at the service and had begun to take action to address these with the help of the staff and with the support of the provider. However, we noted that it has taken until the arrival of this new manager for the provider to begin to address many of the issues at the service which have been present for more than one inspection.

We found a commitment to continued improvement at the service and honesty about the issues which still required attention. The majority of the issues we found on inspection had already been identified by the manager and actions were already planned or in place. Care plans had been reviewed and the format improved, staff training and supervision had been organised and was now more structured and staff were very positive about training and support. Records were clear, well organized and kept securely. Equipment such as hoists, slings and the lift were regularly inspected and serviced and the fire alarm was tested and checked. An external company had carried out a risk assessment relating to legionella bacteria in the water system and found no concerns.

Quality assurance surveys were given to people who used the service and their relatives, with the most recent one being carried out in March 2018. This was carried out twice a year and a meeting was arranged following the receipt of the completed surveys so that any issues raised could be discussed.

Despite the recent improvements we remain concerned at the lack of significant improvement over time. Similar concerns have been raised over a number of inspections at this service and the provider has repeatedly failed to take effective action to address issues which affect the quality and safety of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure that risks to people's health and safety were assessed and reduced where possible. They also failed to ensure that medicines were managed safely. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to operate effective systems to assess, monitor and improve the quality and safety of the service. Regulation 17.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure that there were always sufficient numbers of staff available. Regulation 18.