Gorsey Clough Nursing Home Limited

Gorsey Clough Nursing Home

Inspection report

Harwood Road
Tottington,
Bury
Lancashire
BL8 3PT
Tel: 01204 882976
Website: www.gorseyclough.co.uk

Date of inspection visit: 15 April 2015
Date of publication: 22/06/2015

Ratings

Overall rating for this service	Requires improvement
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

Gorsey Clough Nursing Home provides nursing care and accommodation for up to 59 people living with dementia. The home is situated outside the village of Tottington, which is approximately three miles from Bury town centre. The home is a large detached property in its own grounds. Accommodation is provided over two floors and can be accessed via passenger lift. Communal rooms are available on the ground floor. These include a large lounge/dining room and two smaller lounges.

This was an unannounced inspection carried out on the 15 April 2015. At the time of our inspection there were 46 people living at the service

The home had a manager who was registered with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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.

We last inspected the home in September 2013. We found the provider was meeting all of the regulations we reviewed at that time.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

We saw that care practices did not always demonstrate people were supported in a dignified manner promoting their autonomy and involvement.

Relevant checks had been completed when recruiting new staff. However records could be enhanced further to show a thorough process was followed. Staffing levels were kept under review however records did not always accurately reflect the numbers of staff on duty at all times. Further opportunities were being made with regards to staff training. Systems to support staff in the delivery of their role needed improving, so that people receive safe and effective care and support.

Whilst people's medicines were stored securely, we found people were not protected against the risk of unsafe care and treatment as the management and recording of people's prescribed medicines was not accurate and complete.

Individual care plans were in place for each person. Records provided information about people's likes, dislikes and preferences. Risk assessments were completed where areas of concern had been identified however information did not guide staff on how to minimise potential risks to people so that their health and well-being was maintained.

Those people with the mental capacity to make decisions had not been consulted with about their care and support. Staff were not provided with clear information about how people were to be cared for, particularly where risk had been identified so that people were protected against unsafe or inappropriate care and their rights were protected.

We saw effective systems to monitor, review and assess the quality of service were not in place so that people were protected from the risks of unsafe or inappropriate care.

The registered manager had a system in place for the reporting and responding to any complaints brought to their attention.

Opportunities to participate in activities in and outside the home were provided however not everyone was able or wanted to join in what was offered.

People were offered adequate food and drink throughout the day. Where people's health and well-being was at risk, relevant health care advice had been sought so that people received the treatment and support they needed.

Suitable arrangements were in place in relation to fire safety and the servicing of equipment was undertaken so that people were kept safe. All areas of the home were clean, well maintained and accessible; making it a safe environment for people to live and work in.

People's visitors told us that staff were kind and considerate and they were always made welcome. We saw staff respond quickly to calls for support from people in the lounges. Staff were seen to support people in a patient and unhurried manner. Staff respected people's privacy and were seen knocking on bedroom doors before entering.

During the inspection members of senior staff we spoke with were able to clearly demonstrate their understanding of their role and what was expected of them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not always safe. Staff did not complete full and accurate records to show that people received their medicines as prescribed. Where potential risks to people had been identified, assessments did not clearly guide staff on how to minimise such risks so that people were kept safe from harm or injury.

Whilst staff levels were kept under review, staff rotas did not always accurately reflect the number of staff on duty to support the needs of people. We found relevant recruitment checks were completed however could be enhanced to demonstrate a thorough process has been followed.

People's visitors told us they felt their relatives were safe living at Gorsey Clough. Staff had received training in the safeguarding of vulnerable adults and knew how to recognise and respond to abuse.

Is the service effective?

Requires improvement

The service was not effective. The registered manager was aware of their responsibilities with regards to the deprivation of liberty safeguarding. Where equipment was being utilised to minimise risks to people, records did not clearly show if people had consented or that decisions had been made in their best interest to keep them safe.

Staff told us they had not received all the necessary training and support needed to carry out their role. More effective ways of supporting and guiding staff would help them to develop their knowledge and skills in delivery of the care people needed.

Suitable arrangements were in place to meet people's nutritional needs. Relevant advice and support had been sought where people had been assessed at nutritional risk.

Is the service caring?

Requires improvement

The service was not always caring. Routines were relaxed and staff responded to people requests for help. However we found from some of observations that staff did not deliver care and support in a dignified way.

People spoke positively about the staff and care provided. Staff were able to tell us how they would promote people's privacy and dignity.

People were provided with comfortable, clean accommodation.

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive to the individual needs of people. People's social, emotional and physical needs were considered. People's preferred routines, likes, dislikes, activities and hobbies had been explored and a range of activities and social opportunities were offered. However not all the people were able or wanted to join the activities provided.

People had access to information about how to raise concerns. We were told and saw records to show that issues and concerns had been raised and were addressed by the registered.

People were assessed prior to moving into the service ensuring their needs could be met. Information gathered was used to develop individual care plans to guide staff about how people were to be supported.

Is the service well-led?

Requires improvement

The service was not always well-led. The service had a manager who was registered with the Care Quality Commission (CQC). Staff told us that management and leadership within the service could be improved to promote better teamwork.

We saw systems were in place to monitor and review the service however some checks were not effective and did not demonstrate people were protected from the risks of unsafe or inappropriate care and support.

The registered manager had notified the CQC as required by legislation of any accidents or incidents, which occurred at the home. However CQC had not been formally notified of safeguarding incidents and deprivations of liberty. This information helps us to monitor the service ensuring appropriate and timely action has been taken to keep people safe.

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 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 was an unannounced inspection and took place on the 15 April 2015. The inspection team comprised of an adult social care inspector, a bank inspector and a specialist advisor.

Most people living at Gorsey Clough were not able to answer direct questions about their experiences. However we did speak with two people who used the service and four visitors. We were also contacted following the inspection by the relatives of two wanting to tell us about their experiences.

We spoke with five care and nursing staff as well as the cook, training co-ordinator and care quality supervisor. We also spoke briefly with the registered manager however they were not available during the inspection.

As most people living at Gorsey Clough were not able to clearly tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also looked at eight people's care records, four staff recruitment files and training records as well as information about the management and conduct of the service.

Prior to our inspection we contacted the local authority commissioning and safeguarding teams to seek their views about the service. Feedback was received from the commissioning team. We were not made aware of any concerns about people's care and support.

We also considered information we held about the service, such as notifications, safeguarding concerns and whistle blower information. We did not ask the provider to complete a Provider Information Return (PIR), prior to this inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Requires improvement

Is the service safe?

Our findings

Systems to help protect people needed improving so that people were kept safe. We looked at people's care and support to see if their needs were being met safely. We spoke with staff, talked with people's visitors and observed how staff interacted with people. We also checked to see how medicines were managed and looked at people's care records.

People's visitors we spoke with told us; "They [the staff] are lovely people. She's very safe", "It's clean and fresh. We can't fault it" and "There is no one cruelly treated."

Medicines, including controlled drugs, were stored securely. We looked in the medicine room and found it to be clean and tidy. Nursing staff had been made daily checks to make sure medicines were being stored at the correct temperatures.

We looked at the systems in place for managing medicines within the home. We saw there was a medication management policy and procedure in place to guide nursing staff. We found that records did not accurately show that people had received their medicines as prescribed. We looked at medicine administration records (MAR) for thirty people who use the service. A daily audit was being completed to ensure all medicines were given as prescribed. Seven MAR charts showed entries that were written by hand and not printed by the pharmacy. These entries had only been signed by one nurse. Handwritten entries should be checked and signed by two nurses to ensure that handwritten information is accurate. We saw that twelve people were receiving 'as and when required' medicine. Six of these people had no guidance available to inform staff when and how to give this medicine and why it was needed.

The nurse on duty told us that three people living at the service received their medicines covertly. This means that medicines are disguised when being administered to people. When we checked, four people had information within the care plans that showed they were receiving medicines covertly. We saw that the service had a signature from a GP on each of the medication risk assessments for those people where medicines are given covertly. This is important because some medicines cannot be given in this way as it may alter the way they work.

Three records we looked at were for people who were using topical medicines. A topical medication is a medication, such as cream, that is applied to the skin to treat ailments. One person was prescribed a cream, which was to be applied four times each day. The record showed that over the past sixteen days, the cream had only been applied four times on one day. On two days it had not been given at all, on ten days it had only been administered twice. Another record showed that a topical medicine had not been administered for six days out of sixteen.

A further record showed that the person was prescribed two different topical medicines. One was to be given as and when required and the other to be given twice a day. When we checked the record, we could not see which medicine had been given at which time as only one record was being completed. The record showed the word 'cream' had been recorded however did not identify which medicine had been applied.

We asked to see records of supplement medication given to help people who are at risk of weight loss. The nutrition champion told us that these would not be done until later in the day as people have their supplement drinks at lots of different times. This meant records were not completed at the time supplements were being given.

We observed during a tea round that one pot of a thickening agent was being used for multiple people. This thickening agent is a prescribed medicine and should only be use for the person it is prescribed for.

This was a breach in Regulation 12(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protection against the risk of unsafe care and treatment as the management and recording of people's prescribed medicines was not accurate and complete.

The care records we looked at showed that plans to help reduce or eliminate the risk to people's health and well-being had not been put into place. One person's records identified they used bed rails. The daily record told us on 13 April 2015, this person repeatedly tried to climb out of bed. Bed rails are not safe to be used for people who climb out of bed as this may potentially place the person at risk of harm or injury.

Requires improvement

Is the service safe?

The CQS showed us that an annual bed rail assessment was undertaken. This assessment was not specific to individuals and could not show that individual's specific needs had been assessed.

A second care plan was for a person who at times displayed behaviours that challenge. The behaviour charts showed us that on five separate occasions this person had become challenging when staff were assisting them to shave. The care plan for this person did not offer staff any guidance or support on how to manage this situation.

A further plan we looked at informed us of a serious incident that occurred on 7 March 2015. There was no evidence within the care plan to show that the service had reported this to the local safeguarding team or reported it to CQC. When we asked the CQS about this incident, they were unaware it had occurred. One of the nurses told us that they were only aware of a previous incident having been reported where the person had left the home. This person's care plan did not contain information to show what additional support this person needed to keep them safe.

The provider had not taken all reasonable steps to mitigate the risks ensuring the health, safety and welfare of people. This was a breach in Regulation 12(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment process followed by the registered manager when recruiting new staff. We saw the provider had a policy and procedure to guide them on the relevant information and checks to be gathered prior to new staff commencing; ensuring their suitability to work at the service with vulnerable people. We examined the files for four staff. Records included an application, written references and a disclosure and barring check (DBS). The policy stated checks carried out by the DBS were to be made against the children and adult barring lists. However this practice was not followed by the service. On one file we saw gaps in employment had not been explored and a satisfactory explanation recorded. We also found that references had not always been dated or verified to check authenticity of information. These additional checks help to demonstrate a thorough process has been undertaken when appointing new staff.

We asked the care quality supervisor (CQS) about the checks completed on nursing staff with regards to their registration with the Nursing and Midwifery Council (NMC). The CQS said they were not aware of any formal system in place to periodically check the register as this was undertaken by the registered manager. The registered manager advised us following the inspection that an electronic system to check nursing staff registration was in place. Arrangements had also been made so that senior staff were able to access this information in the absence of the registered manager, where necessary.

We spoke with the CQS about the staffing arrangements in place to support people living at Gorsey Clough. We were told that both nursing and care staff were provided throughout the day and night. In addition to the care team there was the registered manager, CQS, an administrator, a training co-ordinator, activity co-ordinator as well as kitchen, domestic and maintenance staff.

The relatives of two people who contacted CQC told us, "There are not enough staff to help people with their meals" and "There seems to be inadequate staffing levels at times and the lounge is often left unattended. People are waiting to be taken to the toilet, waiting to have their meals and then are rushed."

Staff spoken with told us they were "just managing" at current staffing levels. However they said that if a member of staff had to escort a person to a medical appointment an additional carer was put on the rota. Staff said they did not often have time to sit and talk with people during the day or if a person displayed behaviour that challenged. A staff member said "It can be hard to provide 1:1 support to keep everyone safe." However during the inspection we saw staff sat talking with people and taking part in an activity.

We were told that a lot of staff had left and the provider had been slow to recruit. However the CQS told us that further recruitment had and continued to take place to fill vacancies. The CQS said that staffing arrangements were kept under review and regularly discussed between the management team, taking into consideration the levels of care people required.

An examination of staff rota's showed that staffing levels were not always maintained. We saw that were staff had called in sick, alternative cover had not always been identified on the rotas. However some staff spoken with staff said that they were willing to work extra shifts to cover for sickness. This meant the staff rotas did not always

Requires improvement

Is the service safe?

accurately reflect the numbers of staff available at all times. The registered manager and CQS said that agency staff were not utilised as managers felt they were unreliable and did not offer continuity of care.

We saw policies and procedures were in place to guide staff in areas of protection, such as safeguarding adults, whistle blowing and managing behaviours. We also saw from training records that staff had been offered in-house training in this area these areas. This was confirmed by those staff we spoke with. Staff spoken with were able to describe the different forms of potential abuse and what they would do if they encountered any concerns.

We found suitable arrangements were in place with regards to the safety and suitability of the premises. General risk assessments had been completed where potential hazards had been identified. These had been reviewed and updated, where necessary, on an annual basis. Records showed that equipment and main circuits, such as electric wiring, were serviced and maintained in accordance with the manufacturers' instructions Maintenance staff competing general repairs and refurbishment of rooms. This helps to ensure the safety and well-being of everybody living, working and visiting the home.

Systems were in place to follow in the event of an emergency occurring within the home, for example a fire. The records showed that a fire risk assessment was in place, checks had been undertaken regularly on the fire alarm system and the emergency lighting, and fire drills had taken place. The CQS had also completed personal emergency evacuation plans (PEEPs) for people living at Gorsey Clough. Information could be easily located by both staff and the emergency services in the event of an emergency evacuation being needed.

Requires improvement

Is the service effective?

Our findings

The service was not always effective. The Care Quality Commission (CQC) is required by law to monitor how care homes operate the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. We spoke with the care quality supervisor (CQS) at the service who told us that seventeen DoLS applications had been submitted to the supervisory body (local authority). We were told that one application had been authorised. All applications made were in regard to people, who lacked the mental capacity and were not free leave the home.

We saw policies and procedures were available to guide staff in areas of protection, such as safeguarding adults, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and consent. An examination of training records showed that the majority of staff had completed in-house training in MCA and DoLS between 2012 and 2014. We spoke to five staff about the MCA and DoLS, each confirmed they had received training. However staff were not able to demonstrate their understanding. One staff member told us "I know I did the training, but I am not really sure what it all means. This training is important and should help staff understand that assessments should be undertaken, where necessary, to determine if people have capacity to make informed decisions about their care and support. It should also help staff understand that where a person lacks the mental capacity and is deprived of their liberty, they will need special protection to make sure that they are looked after properly and are kept safe.

We looked at care plans and spoke with staff about restrictive practices. We found that in order to keep people safe the service had explored the use of suitable equipment such as bed rails, reclining chairs, alarm mats/ alarm beams and wheelchair straps. People's records however did not show if an assessment of capacity had been completed or how the decision had been made in the person's best interest in relation to the use of this equipment.

Two care plans we checked did contain mental capacity care plans however these were generic and not decision specific. This meant the service did not assess individual situations before deciding if a person was able to consent or not.

We asked staff how they involved people in planning their care. One staff member told us "They can't really join in as they have dementia." Another staff member told us "I don't think we do really." We saw no evidence in the care plans we examined to show people and their relatives had been involved in the on-going review of their care.

This meant there was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had not obtained valid consent, acting in accordance with people's wishes. The principles of the Mental Capacity Act 2005 should be complied with where it is considered the person lacks the mental capacity to make such decisions so that their rights are protected.

We looked at the training, development and support offered to care and nursing staff. The CQS told us that all staff completed a 13 week induction programme. This was in line with the new Care Standards Certificate, which has been recommended by government to all care providers from the 1st April 2015. We were told new staff were expected to complete a workbook and spend two weeks working alongside existing staff before being allocated shifts. During the induction process the CQS would carry out assessments of practice to check staff understood their role and carried out tasks safely and effectively.

We asked staff about the training and support they received. Care staff we spoke with confirmed they had completed an induction on commencing their employment and had 'shadowed' an experienced member of staff for 5 days. One staff member said they felt "thrown in" at this stage as there was not enough guidance and monitoring to support them. Another staff member said, "We have got some good staff, everyone is willing to help each other" and "Everyone knows what they are doing."

The training co-ordinator, was employed as an apprentice and was new to post. They told us that courses had been provided by the local authority, Bury Training Partnership as well as in-house training provided by the previous training co-ordinator. Records showed that the majority of staff had completed training in areas of health and safety such as moving and handling, infection control, food hygiene and first aid. In-house training had comprised of dementia awareness, MCA and DoLS and safeguarding adults. Staff training records did not evidence all training detailed on the training record.

Requires improvement

Is the service effective?

We did not see recent evidence of nursing staff having completed clinical updates in areas such as catheter care or pressure care prevention. The CQS told us that competency assessments were completed on nursing staff in relation to the safe management and administration of medication. One nurse spoken with told us that an assessment of their practice had not been completed for some time. Another nurse had recently returned to the service and an up to date assessment had not been completed following their return to work. An examination of three training files for nursing staff showed two nurses were last assessed in 2013 and there was no assessment for the third nurse.

We saw minutes from a management meeting, which showed that the training needs of the service had been explored and that a new approach was to be explored to 'close the gaps' in staff training. The training co-ordinator told us that alternative training had been sourced however had not yet been implemented. We saw information to show this included specific health care topics as well as dementia care.

Staff spoken with also told us that they had not received formal supervision for some time. The CQS told us meetings were held every 6 to 8 weeks and that they were responsible for supervising care staff, whilst the registered manager supervised nursing staff. Records examined showed that the three nursing staff had not received supervision since August 2014. Staff told us that since the 'senior sister' had left there had been no supervisions. We were also told that appraisals were due however no one reported having had one. We found that supervision meetings did not evidence a two way discussion about the needs and expectations of staff as well as management. Supervision sessions should provide staff with the opportunity to talk about their work and any learning needs they may have.

This meant there was a breach in Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary training and support to carry out their role.

We looked at how people were supported in meeting their nutritional needs. People who use the service told us they enjoyed the food. One person commented "The food is really nice, especially the chips."

We looked at the kitchen, which was clean and well organised and sufficient food stocks were available. We saw information sheets and monitoring records were in place in the kitchen with regards to health and safety and food hygiene standards. Regular audits had also been completed so standards within the kitchen were maintained.

We were told the home had a 'nutrition champion' who met with the chef and visiting dietician on a monthly basis to discuss those people assessed at nutritional risk. The chef told us about how they tried to make soft and pureed foods more presentable to encourage eating. We were told that one person had a fridge in their own room where they kept food appropriate to their culture. This was checked regularly to make sure items were not out of date.

We saw the staff taking orders for lunch during the morning. We saw food was nicely presented and portion sizes were good. People also saw were offered second helpings of food. We observed one staff member assisting a person who was struggling to eat their sandwiches. The staff member was kind and spent time helping support the person to eat We saw that some people were being given food fortified with milk, butter or cream People were also offered snacks during the day such as smoothies, yoghurts & biscuits. This helped to increase calorific input and prevent weight loss. The kitchen was open throughout the day and night so that staff could access food for people during the night.

A review of people's records and discussions with staff confirmed that people had access to relevant health professionals. Care records showed that where people were at risk of poor nutrition or weight loss, risk assessments had been completed. We saw that additional monitoring charts were put in place and where necessary, additional support and advice was sought from the person's GP or dietician. One visitor told us "They monitor [my relatives] eating and could tell us they hadn't eaten today."

Requires improvement

Is the service caring?

Our findings

We found the service was not always caring. The family member for one person who had recently moved into the home said, "So far I'm happy", "The staff are very nice, good hearted people", "[relative] is now walking again." They were also pleased that staff had paid attention to their relative's appearance. This person always liked to wear a shirt and tie; this had been considered by staff when assisting the person to dress. We saw visitors come and go throughout the day. One visitor told us, "They [staff] are excellent and very obliging to visitors."

For those people not able to tell us about their experiences, we spent some time observing how they were spoken to and supported by care staff. We saw staff respond quickly to calls for support from people in the lounges. Staff were seen to support people in a patient and unhurried manner. Staff respected people's privacy and were seen knocking on bedroom doors before entering. Staff spoken with described how they provided care for people ensuring their privacy and dignity was maintained, such as keeping curtains closed and ensuring people were covered whilst personal care was carried out. Staff told us they had also received training in dignity and respect. Training records showed that of the 51 staff listed only 21 had recently completed this training.

We saw some people did not generally move throughout the day. People spent time either sitting in a lounge chair or at the dining tables. People remained where they were sat to have their meals. We noted in the minutes of a staff meeting, staff were instructed that people should be moved away from tables after meals and that people should be toileted at 1pm. We discussed this with the CQS as we had identified people did not move around throughout the day and toileting people at specific times of the day was not personalised care.

We saw staff put plastic aprons on people, to protect their clothing; however this was done without explaining why. We saw two people pull these off and put them around their neck, which could cause a safety risk.

We saw one person, with swallowing difficulties, was provided with a meal which had been pureed. This person was unable to feed themselves. We saw this person was leaning back in a 'reclining chair' and in a poor position for eating. After a short period of time a staff member sat with the person and began to feed them without asking them or informing them of what they were doing. We did not see the staff member encourage or engage in conversation with the person. The meal was served using a large metal spoon, which was overloaded with food. As the person ate very little the meal was taken away, again without comment. This person was then left holding a hot drink precariously balanced on their lap. After a few minutes another staff member came to the person and helped them to drink talking pleasantly to them.

We also visited one person and their visitors in their bedroom. We saw this person had been left sat on the sling used in conjunction with a hoist to assist in their safe moving and handling. This practice is not dignified and potentially places the person at risk as the sling could possibly cause damage to the person's skin if they are sat on this for long periods of time.

The relative of one person who contacted CQC said staff started to help people get ready for bed following the evening meal. We spoke to three staff about the people's routines. One staff member showed us an allocation list that detailed when people were to have a bath, when people were to go to bed and when people were to go to the toilet. However another staff member told us that "Residents can get up and go to bed when they want to."

This did not demonstrate people were supported in a dignified manner promoting their autonomy and involvement. This was a breach of Regulation 10(2) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found the home to be clean, tidy and free from malodours. The registered manager told us there was a programme of redecoration taking place to the bedrooms. We saw that people had personalised their rooms with belongings from home. We saw some of the refurbished bedrooms during our inspection. Rooms had been decorated to a good standard, were nicely furnished and provided comfortable accommodation for people.

Staff told us that people's care records were stored securely within the treatment room, which was kept locked. This meant information was not easily accessible for care staff to refer to at any time as only nursing staff had access to

Requires improvement

Is the service caring?

this room. The care staff told us, and we saw, senior care staff update care records twice daily. A written briefing was used during the shift handover, providing an update for care staff on any changes in people's needs.

Suitable arrangements were in place when people needed support to attend appointments or in the event of an emergency. We were told staff would always provide an escort unless the person was with a family member. We were told relevant information about people's medication and specific health needs would be shared with relevant health care staff so that people received continuity in their care.

Requires improvement

Is the service responsive?

Our findings

We found the service was not always responsive. People were provided with a 'welcome pack' following their move into Gorsey Clough. We saw copies of the packs were available in people's bedrooms for them and their visitors to refer to. A copy of the complaints procedure was included in the pack.

We asked people's visitors if they had knew how to raise any issues or concerns if needed. The relative of one person told us; "You have to keep on top of them [care staff]", adding "I have no hesitation in speaking with the manager and she has sorted things out." Family members we spoke with following the inspection expressed their concerns about staffing levels, people routines, meal times and attending to people's personal care needs. Both families said they had previously raised the issues directly with the service.

We saw the provider had a system in place for the reporting and responding to people's complaints or concerns. There had been four complaints received since our last inspection. Information was recorded along with copies of any correspondence sent to people in response to their concerns. We were told that one matter was still under investigation. The registered manager had liaised with the person's relative as well as the local authority safeguarding and commissioning teams.

The home employed an activities co-ordinator. Their job was to help plan and organise social and other events for people, either on an individual basis or in groups. We looked at how people spent their time and spoke with the activities co-ordinator about their role.

We saw records completed by the activities co-ordinator of activities offered along with names of people who had joined in and what their individual response had been. Each activity was recorded by type (physical, social, mental, creative or emotional) to help identify what activities stimulated people best. Activities provided included a weekly entertainer, quizzes, colouring, word search, jigsaws, cinema afternoons, and walks through the gardens and outings to Radcliffe Civic Hall for tea dances. Some people had previously taken part in day trips to Blackpool, Southport & Knowsley Safari Park. Staff were also encouraged to engage people in activities, such as, board games, magazines and nail care were encouraged.

People living at Gorsey Clough are supported with various health care needs and whilst some were able to join the activities, others were not. The home uses NAPA (National Association for Providers of Activities) as a guide to meeting the individuals needs of people. The activities co-ordinator told us they had received some specific training in the development of activities and said they researched ideas online. During the afternoon we saw a small group of people colouring or playing a game. The activities co-ordinator also went out with one person for a short walk. However some people in the main lounge spent much of their time sitting looking around or sleeping. Some people watched television in one of the lounges and others had the company of visitors. We spoke with the CQS and nurse about our observations.

We found the assessment process was thorough. The eight care records we looked at showed that people were assessed by a senior member of staff and a nurse from the home before they were admitted. This helped to ensure their individual needs could be met. As part of the assessment process the home asked the person's family, social worker or other professionals, who may be involved, to add to the assessment if it was necessary at the time.

The care quality supervisor (CQS) told us and we saw records to show that all enquiries made to the service were recorded. Information showed that some people had been advised that a placement at Gorsey Clough would not be suitable. We were told the service also accepted people as an 'emergency admission'. Information would be requested from the CCG so that staff had some information about the needs of the person.

All care plans we looked at contained pre admission assessments. This included an assessment of needs and details of people's food preferences, routine for getting up in the mornings and going to bed and their communication skills. We saw that an initial care plan was produced by the nurses following a pre admission assessment. We saw these care plans included maintaining a safe environment, personal hygiene needs, eating and drinking, activities and hobbies and personal care.

We did note on one plan for a person who had been living at the home for sixteen days that information was incomplete and did not contain the necessary information to guide staff in the correct care and support this person needed. We found only two completed plans in relation to sleep and medicine. Three other care plans sheets were in

Requires improvement

Is the service responsive?

the file but had no information recorded in them. None of the completed records had been dated or signed. Some of the care records we looked at were difficult to read due to poor handwriting. The CQS told us that care plans were to be typed so that information was clear.

We were told the registered manager was introducing a new care plan format to make them more readable, accessible and personalised. We saw the language used was in the first person "I need" although the person concern did not have the communication skills or capacity to express these ideas.

Requires improvement

Is the service well-led?

Our findings

We found the service was always well-led. The home had a registered manager in place that was registered with the Care Quality Commission (CQC). The registered manager had been in post some considerable time and was supported by a care quality supervisor (CQS), administrator, training co-ordinator as well as a team of nursing, care and ancillary staff. The registered manager was not available during the inspection however briefly met with inspectors the morning of the inspection.

One visitor we spoke with told us; “The manager and her deputy are lovely with you. They are really nice people. They are approachable.” However staff spoken with told us they did not always feel supported by the management team. We were told “There is no one overseeing nurses. Management have not got the skills and knowledge to know things need to improve” and “Staff are not managed”. Staff were complementary of the CQS, adding; “The deputy is very good with the carers” and “You can go to the deputy and offload.”

The registered manager was responsible for managing and supervising nursing staff as well as overseeing the running of the service. We were told nursing staff audited the medication system and reviewed care records. Whilst systems to monitor and review the service were in place some checks had not identified some of area of improvement identified during the inspection.

We found that systems to support and develop the staff needed improving. Staff told us team meetings were held infrequently. We were told a care staff meeting had been held that week. We saw minutes to show care staff meetings had been held every three months however nurses had only met once over the last year. Staff meetings help promote good teamwork and encourage shared responsibility with clear leadership and support.

The CQS outlined areas within the home they were responsible for managing. The CQS told us they provided support and supervision for care staff as well as reviewing policies, observations of staff practice during the induction programme or performance review, carried out night visits, fire safety checks as well as audits of care plans, health and safety, infection control and activities.

Policies and procedures were in place to guide staff. Information had been reviewed on an annual basis. Some information needed updating as some information was out of date and referred to guidance or agencies no longer in place.

Before our inspection we checked our records to see if accidents or incidents that CQC needed to be informed about had been notified to us by the management team. Information about events within the home had been provided. The CQC were not informed when a deprivation of liberty safeguard had been authorised for a person or a safeguarding incident had been reported to the local authority. This information helps us to monitor the service ensuring appropriate and timely action has been taken to keep people safe.

This was a breach of Regulation 17(2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as effective operations to assess, monitor and improve the quality and safety of the service were not in place.

The CQS told us that annual questionnaires were sent to people and their relatives as well as staff. We saw a report which had been completed in December 2014 summarising the feedback received and any action required. Information showed that 16 responses had been received. These showed 87% of responses were rated good or very good. Where people had raised issues about certain aspects of the service, such as hygiene standard, activities or food, a summary had been completed detailing action taken. The CQS also said questionnaires were sent to prospective residents and their families following an enquiry or assessment completed by the service. We were told this helped to review the process and whether sufficient information had been provided during the assessment process.

The service had been inspected by the food hygiene inspector in October 2015. The home was awarded the highest level of compliance, 5 stars. The local authority had also carried out a quality monitoring visit in January 2015. They awarded the service an ‘A’ grade.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	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 People were not protection against the risk of unsafe care and treatment as the assessments, management and recording of people's prescribed medicines was not accurate and complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not taken all reasonable steps to reduce the risks to people so that their health, safety and welfare was maintained.

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 obtained valid consent, acting in accordance with people's wishes. The principles of the Mental Capacity Act 2005 should be complied with where it is considered the person lacks the mental capacity to make such decisions so that their rights are protected.

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 People were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary training and support to carry out their role.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People were not always supported in a dignified manner promoting their autonomy and involvement.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Effective operations to assess, monitor and improve the quality and safety of the service were not in place.