Mr & Mrs D J Hood and Mrs C A Bhalla

Gorsefield Residential Home

Inspection report

306 High Lane
Burslem
Stoke On Trent
Staffordshire
ST6 7EA

Tel: 01782577237

Date of inspection visit:
04 April 2016

Date of publication:
17 June 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 4 April 2016 and was unannounced. The service was registered to provide accommodation and personal care for up to 17 people. People who used the service had physical health needs and/or were living with dementia. At the time of our inspection 16 people were using the service.

At the last inspection on 18 November 2014, we asked the provider to take action to make improvements because people were not supported to receive person centred care that met their preferences and because effective systems were not in place to assess, monitor and improve the quality and safety of the service provided. At this inspection, we saw that action had been taken and improvements had been made though some improvements were still required to ensure that findings of audits and analysis were acted upon to drive improvement. The registered manager had completed an analysis of falls in the home and identified trends. However, suitable actions had not been taken following this analysis to reduce the risk of similar incidents, this included a review of staffing levels.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found there were not always enough staff to ensure that people's needs and risks were monitored in line with their care plans. The provider had not reviewed staffing levels following the last inspection or listened to feedback from staff to ensure that there were adequate staff to meet the needs of people who used the service. This was a breach of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

People were not consistently protected from avoidable harm and abuse because we saw that an incident had taken place and concerns had not been reported to the local authority in line with local safeguarding adult's procedures. No plans had been put into place to reduce the risk of a similar incident occurring again.

People's risk were mostly assessed and monitored though some people did not have plans in place to manage specific risks.

People were asked for consent before care was provided though people's mental capacity to make their own decisions had not been assessed when required which meant that the service could not be sure they were acting in accordance with the Mental Capacity Act (2005).

People's care plans were not always reviewed regularly to ensure that plans in place met their current needs. People and their representatives were encouraged to be involved in creating their care plans to ensure they reflected people's preferences.

People were provided with enough food and drink to maintain a healthy diet. People had choices about their food and drinks though records in relation to people's nutrition were not always accurate.

Medicines were safely managed, stored and administered to ensure that people got their medicines as prescribed. Staff were suitably trained to meet people's needs and were supported and supervised by the registered manager.

People's health was monitored and access to healthcare professionals was arranged when required.

People were treated with kindness and compassion and they were happy with the care they received. People were encouraged to make choices about their care and their privacy and dignity was respected.

People were offered opportunities to participate in activities that interested them and could choose how to spend their time. People knew how to complain if they needed to. A complaints procedure was in place though no formal complaints had been received.

People, relatives and staff felt that the registered manager was visible in the home and felt they were approachable.

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 consistently safe.

There was not always enough staff to keep people safe and manage their risks. People were not consistently protected from avoidable harm and abuse though staff knew how to recognise and report abuse. People did not always have specific risk management plans in place. Medicines were stored, administered and managed safely to ensure people received their medicines when required.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's mental capacity to make their own decisions had not been assessed when required which meant the service could not be sure they were acting in accordance with the Mental Capacity Act (2005). People had enough to eat and drink but records in relation to people's nutrition was not always accurate to ensure they received the correct support. People were supported to maintain good health and has access to professionals when required. People were asked for consent before they supported by staff who were suitably skilled to support them effectively.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion and were encouraged to make choices about their care and treatment. People's privacy was respected and staff provided care in a dignified way.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans were not always reviewed regularly and did not always reflect people's current needs. People were given opportunities to participate in activities that interested them and could choose how to spend their time. People knew how to

complain though no formal complaints had been received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Improvements had been made to ensure that systems were in place to monitor the quality and safety of the service provided. However, further improvements were required to ensure that findings of analyses were acted upon in order to drive improvements. The registered manager was visible and people and staff felt supported by them.

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

This inspection took place on 4 April 2016 and was unannounced.

The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We looked at the information we held about the service. This included looking at notifications. A notification is information about important events which the provider is required to send us by law. We also looked at information we had received from the local authority. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used the information in the PIR completed by the provider to help plan our inspection.

We spoke with six people who used the service and five relatives. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with four members of care staff, the cook, the registered manager and one of the providers.

We looked at three people's care records to see if they were accurate and up to date.

We also looked at records relating to the management of the service. These included quality checks, three staff recruitment files and other documents to help us to see how care was being delivered, monitored and

maintained.

Requires Improvement

Is the service safe?

Our findings

We found that sufficient numbers of staff were not always deployed in order to meet the needs of people who used the service. We observed that lounges were left unsupervised for periods of up to 15 minutes throughout the day when staff were busy supporting people with tasks in other areas of the home. During these times, we saw that people mobilised unsupervised despite a number of people's care plans stating that they required support and supervision whilst mobilising to keep them safe. We saw that people who were experiencing confusion became upset with each other and we saw that one person was making their fingers bleed by picking their skin. There were no staff available to manage these risks which meant that people's safety and wellbeing was compromised as they did not have the support and supervision they required.

The registered manager told us there would usually be an additional care assistant on duty in order to safely and effective meet the needs of the people who used the service. However, we were told that the additional staff member was not working due to sickness and would not be working for a number of weeks. No cover for the care assistant had been sought other than the registered manager stating they would be expected to provide the care and support alongside their management duties. We were also told that the additional staff did not work during weekends. There was no rationale for this decision. There was no formal assessment of people's dependency and we could see no reason why mornings, evenings and weekends warranted less staff to keep people safe from harm. The provider told us that the additional staff member was not required at weekends because more relatives visited the home and some liked to provide support for their own relatives. However, we saw that some relatives had commented about the lack of staff during weekends in the comments book but no action had been taken to address this. This meant that staffing numbers had not been assessed or reviewed to ensure that people's care needs could be met at all times.

We found that a number of people were assessed as being at high risk of falls and required supervision to ensure their safety. We saw that one person started to mobilise unsupervised without using their frame. When a member of staff noticed them, they asked them to stop whilst they fetched their frame, which they needed to mobilise safely. We looked at falls records that showed four out of the five falls that occurred in 2016, occurred when only two care staff were on duty and the additional staff was not present. We saw that an analysis of falls had taken place though no action had been taken to review staffing levels to reduce the risk of further similar incidents occurring. This meant that staffing numbers had not been reviewed or amended to ensure that people's falls risk could be managed.

All of the staff we spoke with told us there were not enough staff to safely meet people's needs. One staff member said, "Mornings and evenings are still a problem even when we have the additional staff from 10.30-17.30. There are only two of us and you don't know which way to turn." Another staff member said, "All the people here are dependent on us, we are supposed to supervise the lounges but we can't do that if we are supporting people to the toilet and other things." Staff said they have raised their concern with the registered manager but nothing had changed. The registered manager told us they shared their concern with the provider but were told that additional staff would not be provided. This meant that staffing numbers had not been reviewed or amended following feedback from staff, to ensure that people's needs

could be met.

The Provider Information Return (PIR) completed by the provider prior to the inspection told us that staffing had been increased and this, "allows the manager of the home to be predominantly super numary to caring staff." However, we looked at staff rosters and we saw that the registered manager was often included in staffing numbers, usually completing three early shifts per week and two office shifts per week, during which time they were expected to complete all management tasks in additional to providing hands on care to people.

At the last inspection in November 2014, improvements were required to staffing levels and we saw that improvements had not been made.

There was not always sufficient numbers of staff deployed to meet people's needs. All of the evidence above constitutes a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Plans were not always in place to ensure that people were consistently protected from harm and abuse. We saw an incident had been recorded when one person who used the service grabbed and slapped the arm of another person who used the service. The registered manager had reviewed this incident form but no action had been taken to reduce of the risk of a similar incident occurring again. The incident had not been considered as potential abuse and had not been reported to the local authority in line with local safeguarding adult's procedures. When we asked the registered manager about this they told us that they did not feel it met the threshold to be reported to the local authority as no harm had occurred. However, they had not put plans in plans to reduce the risk of a similar incident occurring again. This meant that we could not be sure that people were consistently protected from harm or abuse. Staff we spoke with were able to explain the types of abuse that may occur and how they would recognise them. One staff member said, "I'd report it, I'd tell the manager, if they weren't around I'd call the provider."

The registered manager told us that one person could be verbally aggressive towards people, visitors and staff. We looked at their care records and saw that they had no specific risk management plan in relation to this. We heard the person being verbally aggressive to staff and we heard that staff responded appropriately in order to deescalate the situation. We spoke with other staff who described how they would suitably manage the risks. However, the person was at risk of receiving inconsistent care and support because clear plans and direction were not in place.

People's risks were mostly assessed and monitored and we saw that people's risks in relation to falls and developing pressure areas had been assessed. However, we saw that two people were sat on specialist cushions to reduce the risk of them developing pressure areas though this was not documented in their risk management plans which meant that their plans were not accurate and up to date. We saw that one person had a detailed plan in place to manage their risk of developing pressure sores and this had been co-written with the district nurse who was involved in the person's care. We also saw that they had a detailed plan in place in relation to catheter care and this gave staff guidance on how to manage the risks associated with catheter care.

People told us they felt safe. One person said, "I always feel safe here." Family members told us, "I get peace of mind. My relative is safe and content. I've no worries or concerns" and "My relative is safe here, they would not be here if we did not feel they were safe." Relatives told us and we saw that assessments were completed prior to a person moving into the home to ensure that the service could safely meet their needs.

People told us they were confident they got the right medicines at the right time. We saw that trained staff administered medicines and gave people explanations to help them understand what they were given. We observed that people were given the time they needed to take their medicines and were offered pain relief medication in line with their care plans. Systems were in place to ensure that medication was stored, administered and disposed of safely and we saw that these were effective.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. When there was doubt about whether people were able to make their own decisions, no assessment of their mental capacity had been completed. For example, one person, who had Dementia, had not signed a consent form for staff to administer their medication. There was no assessment of their mental capacity so it was unclear whether they were able to make their own decision or whether a decision needed to be taken in their best interests. This meant the service could not be sure they were acting within the principles of the MCA to ensure that people's legal and human rights were respected.

We saw that people were asked for consent before they were supported. For example, we saw staff ask, "Are you going to take your tablet now?" We saw that people had signed forms detailing their consent to care when they were able to.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked and saw that applications for DoLS authorisations had been completed when required.

People told us the food at the home was good and they got plenty to drink. One person said, "I like to drink tea all day long" and we saw that they were provided with hot cups of tea throughout the day. People told us and we saw that they were offered a choice at meal times. One person said, "They're good with meals, if there's something you don't like, they will fix you up with something else. There's a menu up on the board you can look at." We saw that some people chose to have salads or sandwiches instead of the hot lunch options provided. People were able to choose where to eat their meals, we saw that some people chose to sit in the dining rooms and others preferred to have their lunch in the lounges.

Some people needed support to eat their meals. We saw that staff helped one person to cut their meat. We saw that one person was supported by staff to eat and drink to ensure they were able to take adequate amounts. When we looked at their care plan, it did not specify that the person required support to eat, despite having been recently reviewed with no changes made. This meant that their care plan did not adequately reflect their needs in relation to eating and drinking. We saw that the person's weight was monitored because there were concerns about their eating and drinking. Records showed they had lost weight and that staff had identified this and referred to the doctor who prescribed nutritional supplements and we saw the person was given these to help increase their weight. We looked at food and fluid monitoring charts which were in place for people when there were concerns about their eating and drinking. We saw that the amount that people had consumed was not accurately recorded which could mean that it was difficult to know whether people had consumed enough. For example, one person's continence care plan advised staff to monitor fluid intake. However, it was not accurately recorded in millilitres so it would

be difficult for professionals to accurately review the person's intake and take necessary actions.

People were supported to maintain good health and had access to healthcare professionals when they needed them. A relative said, "They're very good in calling the doctor if anything is wrong." Another relative told us that staff had arranged for their family member to see the doctor when staff had noticed a rash and this had helped to, "nip the problem in the bud." Records showed that people had access to a range of healthcare professionals including doctors, district nurses, continence specialists and chiropody.

People told us and we saw that staff were suitably skilled to support people. One person said, "They're very capable." Staff told us and records showed they had completed training to help equip them with the skills and knowledge to support people effectively. Staff were able to demonstrate how training had helped them to better support the people who used the service. One staff member said, "The training I've done helped me to understand the people we support a lot better. I encourage people to make their own choices and spend time to get to know them better." Staff told us and records confirmed they had supervision with the registered manager. One staff member said, "We have regular supervision which is useful. We are supported and get a chance to air our views."

Good

Is the service caring?

Our findings

People told us and we saw that staff treated them with kindness and compassion. One person said, "They're very nice. I love them all." Another person said, "All the staff are so good to me here, I never regretted coming here even though I was apprehensive about moving to a care home at first." We saw that staff knew people well and showed people affection when people wanted this. For example we saw that one person asked the registered manager for a hug and they were given a hug. The person was smiling and said, "Oh I do like that." A relative told us, "All the staff are very good."

People and their family representatives were involved in decisions about their care. A family member said, "My relative can make choices and the staff encourage them to." We saw that people were given choices about which music they would like to listen to and where they would like to sit. People's care plans gave staff direction to encourage people to make their own choices and we saw that people and relatives were involved in creating their care plans. One relative told us detailed information about the care their relative received and told us they were fully involved in creating and the reviewing the plan of care.

People told us and we saw that their privacy and dignity was respected. One person who needed support with washing and dressing said, "They are helpful and respectful." A relative told us their family member needed a lot of support with their personal care and liked to look nice. They said their relative was, "always properly turned out." We saw that people were able to access their bedrooms to have some privacy whenever they chose to. This was considered in people's care plans and records showed that one person liked to have private time in their room to say their prayers. People were encouraged to be as independent as they could be. Care plans included information about what people were able to do for themselves and encouraged staff to prompt and remind people, we saw that they did this.

There was a homely atmosphere and relatives were encouraged to visit. One person said, "My son visits me whenever he likes." We saw that relatives were welcomed by staff and one relative told us, "You are always apprehensive when you go to a place for the first time but as soon as we came here they made us feel welcome. It's a real home, there's a welcoming feel." Another relative told us they were able to bring in their family member's dog to visit them which made the person happy. People were happy the care they received and one person said, "I like living here, it's great."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection the provider was not meeting the regulations because people were not supported to receive person centred care that met their preferences. They were not supported to access activities or follow their interests. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that improvements had been made in this area though improvements were still required in relation to people's care planning.

Regular reviews of care plans were not always completed and changes were not always made as required to ensure people received care that met their needs and preferences. For example, some people's care plans relating to nutrition, skin and behaviour did not reflect their current needs. People and their relatives were involved in the planning and review of their care. A relative said, "We were involved in the assessments, [Person who used the service] and us. The manager came and spoke with [Person who used the service]." We saw in people's records that they were involved in developing their care plans and their relatives were asked for information when people were unable to do this.

People told us they were offered the opportunity to take part in activities that interested them. One person said, "There are plenty of things to do. We play games, bingo and we have painted some mugs." Another person said, "I like to do some painting." We saw that people were offered the opportunity to take part in activities. We observed a game of skittles where people were encouraged and enabled to take part. We saw the staff member engaged each person and included them, we heard people chatting and laughing together whilst playing the game. We also heard people enjoying a singing session, supported by a staff member. People were singing, dancing and laughing which showed that they enjoyed the activity on offer.

People told us and we saw that they received personalised care to meet their needs and could spend their time how they chose. One person said, "We don't have to go to bed at a certain time or anything like that but we keep a bit of a routine, which I like." One person told us they were going out to the shops, which they did regularly. They told us they liked to spend as much time outside as possible and we saw that they freely accessed the garden and spent time outside whenever they chose to. One person told us they were enabled to have Communion once a month in the home and that they were supported to keep in touch with all the news from the Church they previously attended. Another person told us they were part of a group of friends who liked to stay up late and watch television most nights. This showed that the service was person-centred and people were not restricted by routine.

People and relatives told us they knew how to complain if they needed to and they would feel able to do this if required. One person said, "The staff are very approachable but I've never had a situation where I needed to complain." A relative said, "I know how to make a complaint, I would speak to the manager." There was a complaints procedure in place as well as a comments book. No formal complaints had been received by the service. Records showed that regular residents meetings were held and that feedback was encouraged and responded to. Records of a recent residents meeting showed that people were enjoying the new activities on offer and were enjoying having fresh fruit daily. Some residents requested that they would like to try potato wedges with lunch and we saw these were included in the menu.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection the provider was not meeting the regulations because effective systems were not in place to assess, monitor and improve the quality and safety of the service provided. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we saw that improvements had been made in this area though some improvements were still required to ensure that findings of audits and analysis were acted upon to drive improvement.

Systems were in place to monitor the quality and safety of the care provided. The registered manager completed a number of audits including health and safety, medicines and care plans. We saw that action had mostly been taken when required. For example, we saw that the first aid box had been replenished following the health and safety audit and we saw that that one member of staff had been given additional training regarding medication when a medicines audit identified that they had incorrectly managed the stock of a particular medicine.

We saw that the registered manager completed an analysis of accidents and incidents which allowed them to identify any trends which may give cause of concern. However, we saw that the findings of these analyses were not always acted upon to ensure improvements were made. An analysis of falls showed that falls had occurred in the lounges and a number of falls were unwitnessed. The actions recorded stated that staff should be present in the lounges. However, there was not enough staff to be able to complete this action. The falls analyses were completed every six months and we saw that the same actions were recorded on consecutive analyses' though staffing levels had not been reviewed following this. This meant that findings of audits and analysis were not always acted upon to drive improvements to the safety and quality of the service provided.

There was a registered manager. The registered manager did not fully understand all of their responsibilities of registration with us as they had not notified us that they had been authorised to deprive five people of their liberty in their best interests under the MCA. This is a requirement of registration with us. However, we were notified of other significant events in line with registration requirements. Staff knew about and understood whistleblowing procedures and said they would feel confident to use these procedures if required.

People told us and we saw that the registered manager was visible within the service. People who used the service spoke positively about the registered manager by name and knew that she was the manager. We saw that the registered manager knew people well and had good relationships with people as we heard them chatting about things that people liked and laughing together. Relatives and staff told us that the registered manager was approachable and they would feel comfortable to speak to her about any concerns. A staff member said, "If we get stuck, we go to the manager, she's very supportive." We saw records that showed that the registered manager held regular meetings with people who used the service and staff to gather their feedback and involve people in the development of the service.

The registered manager told us they were supported by the providers and had meetings with them 'as and

when required'. However, the registered manager told us that they had informed the provider that more staff were required to meet people's needs though this request had not been acted upon. Records of staff meetings showed that staff informed the registered manager that they did not feel valued by the provider despite them completing extra shifts to cover sickness and annual leave. The registered manager said they had given feedback to the provider following staff meetings but staff had not received a response. One staff member said, "This is a fantastic home but the manager needs more help. They can only work with what they have got." This did not provide an open and inclusive environment in the service.