Gorselands in the Forest Limited

Gorselands Nursing Home

Inspection report

Coach Hill Lane
Burley Street
Ringwood
Hampshire
BH24 4HN

Tel: 01425402316
Website: www.gorselandsnursinghome.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Gorselands Nursing Home is a residential care home providing personal and nursing care to 39 people aged 65 and over at the time of the inspection. The service can support up to 39 people.

Gorselands Nursing Home accommodates 39 people in one adapted building. The property has additional activity and office space in log cabins in the extensive grounds.

People's experience of using this service and what we found
Medicines were safely administered. Available audits were unclear; however, we saw that registered nurses would reconcile stock and ensure that documentation was completed. A new medicines audit had been introduced and would be completed from August onwards. Topical medicines were not well recorded, and we have made a recommendation about this in our report.
There were limited records available to indicate how safeguarding concerns and accidents and incidents had been dealt with. New documentation had recently been added and there was now a clear process to deal with concerns.
Improvements were immediately made to the premises when we identified concerns. Premises safety checks were current and thorough and additional new, more detailed checks had been set up for wheelchairs, walking aids and other equipment.
Staff were safely recruited. Some staff records lacked a full employment history however these were obtained by the manager before we finished our inspection. Staff told us there were sufficient staff.
A new infection control champion had been identified and had begun to complete audits of hand washing. We saw that some staff wore wrist watches and there was a communal nail brush in the staff bathroom. We have made a recommendation about infection control.
New audits of accidents, incidents and falls had been completed in July 2019 and were accompanied by thorough incident reports.

An electronic care record was in place which generated risk assessments as people's needs were added to the system. Care plans had been personalised however some significant information was missing. We have made a recommendation about care plans.
Staff had not received regular planned supervisions, these had been on an ad hoc basis. A new supervision arrangement was in place and some responsibilities delegated to registered nurses and senior care staff.
Training had been reviewed and a new provider would be used for online training. Additional face to face training had been identified.
People were generally very happy with the food provided and meals were prepared according to people's needs and wishes. One relative was unhappy with food provision, so this would be discussed at the next residents and relatives meeting.
Staff worked with health care professionals to maintain people's health and well-being, and care plans reflected people's specific requirements.
The premises were a converted country house in a large garden. The grounds were monitored by CCTV and

a keypad entry system was being added to secure the building.
Décor was plain and lacked dementia friendly signage.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Care was person centred and reflected people's diverse needs. People felt cared for and we saw appropriate, caring interactions.
When possible, people were included in care planning and there had been a resident and relatives meeting introduced.
Staff were respectful of people and told us how they maintained people's dignity when delivering care.
Confidential information was securely stored.

People's needs were assessed before admission into the home and information was gathered about life histories to enable staff to have relevant conversations with them.
Communications needs were identified and met, and consideration was given as to how people liked to receive information.
An activities coordinator and a well-being coordinator supported people with activities and there were regular trips out using the services minibus.
There was a complaints procedure and recent complaints had been dealt with accordingly.
There was no one receiving end of life care when we inspected. The service had discussed this with some people and some care records showed end of life plans.

For more details, please see the full report which is on the CQC website at
Rating at last inspection
The last rating for this service was good (published 6 January 2017).

Why we inspected
This was a planned inspection based on the previous rating.
Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

Gorselands Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by one inspector, a specialist advisor who was a registered nurse 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.

Service and service type
Gorselands Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager had given notice and a new manager was in place, their application to become registered had been submitted.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with 25 members of staff including the nominated individual, directors, manager, registered nurses, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider
We reviewed a range of records. This included nine people's care records. We looked at eight staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
The manager provided all requested information.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
• The provider had a safeguarding policy and procedure. Limited records were available to view during the inspection however the manager had set up new forms and there was a clear process for dealing with future concerns.
• Staff were familiar with signs and symptoms of abuse and would not hesitate to report any concerns. Staff had been trained in safeguarding however the manager had identified that the training could be improved so staff would be completing additional training.
• People told us they felt safe. One person told us, "I feel safe because I have my call bell and I don't wait too long. The longest I've waited is 10 minutes". Another person told us, "I feel moderately safe, there's nothing I feel unsafe about".

Assessing risk, safety monitoring and management
• On the first day of the inspection we identified some areas in the premises that needed improvements made in order to be safe. These included a sluice room which was heavily soiled in areas and had an unsealed work surface, two shower rooms had unsuitable light fittings and a sloped floor had split flooring and was uneven. We found that both the lights and two sluice rooms had been refitted the day after we informed the provider about them and a builder had assessed the sloped floor and was booked to rebuild it to a higher safety standard.
• Water safety had been managed effectively, there had been regular testing of water and flushing and temperature checks were completed. We found that in one area a shower hose hung in a way that would hold standing water when not in use. The provider addressed this and added a wall bracket to reduce this risk.
• New records had been introduced to ensure completed safety checks were fully documented. For example, existing records showed that wheelchairs and walking aids had been checked each month, one tick box against one check, new records showed that wheels, footrests, brakes and other areas had been checked. Each wheelchair and walking aid had been discreetly numbered so checks were easily identifiable and there would be no confusion should one need repair.
• Risks concerning for example, care tasks, the environment and fire had been assessed and all actions identified to mitigate residual risks had been completed.

Staffing and recruitment
• Staff were safely recruited however this had not been the case for all staff. The most recent staff files for

staff recruited by the current manager had, as required, full employment histories. Longer serving staff members staff files did not all hold full employment histories. The manager, who had been recruited shortly before our inspection, had supplied a full employment history however this was not on their staff record. Providers are required to obtain full employment histories to assist them to make safe recruitment decisions. We bought this to the attention of the manager and they immediately issued a form to all staff and at the end of the inspection they had full employment histories for most staff with the rest in process.
• We bought the inspection forward by a short time following a concern raised in part about staffing. The concern was that there were often several staff on breaks at the same time leaving the service with no staff and in particular there was frequently no staff on the first floor of the home. We spoke with the manager about staff breaks and they had identified this when they commenced in post. Staff were now restricted to only two people on break at the same time and annual leave bookings had also been restricted to two staff and not unlimited as it had previously been. We noted that at times there were no visible staff on the first floor however most people spent the day on the ground floor in the communal areas and those people remaining in their rooms had regular well-being checks and a floor sensor mat was in use for one person who often felt lost if they left their room. Staff, on hearing the sensor alarm, would support the person where they wished to go to reduce their anxiety.
• Staff told us that there had been periods when staffing had not been sufficient but there had been an improvement. One staff member told us, "[Staffing] has been low, we were short over the summer. It's definitely been sorted, you can see it getting better".

Using medicines safely
• Medicines were administered by registered nurses. We saw a medicines round which was completed safely. Records were in the form of electronic medicines record sheets, EMARS. The electronic system had been designed to minimise the possibility of medicines errors and only the medicines due at the time of administration were available to access on the system and staff could not move to the next persons medicines until they had completed all recording on the last person.
• There were no useable medicines audits. Registered nurses completed daily medicines counts and reconciled any differences between their count and the amount on the system. The discrepancies would be due to medicines being dropped or omitted due to someone refusing to take them for instance. Medicines amounts were correct and there were no visible errors on EMARS.
• The medicine audits we saw were not named and lacked details. For example, one record from September 2018 stated next to a heading of 'stock tallies with records', partially met. The comments box was empty. There was no indication of which medicine did not tally, the amount of the discrepancy and why it did not tally. The new manager had implemented use of a Clinical Commissioning Group medicines audit from August 2019. They and the registered nurses would complete weekly audits to ensure the safe management of medicines.
• Topical medicines when prescribed were applied by registered nurses and signed for on the EMAR. Non-prescription topical medicines were applied by care staff and should be signed for on a paper topical medicines administration record, TMAR. We saw TMAR's that had been signed on the day of our inspection however the record referred to three different topical medicines and it was unclear as to whether one, two or all three had been applied. There were also two days not signed and no record as to whether the medicines were refused or not needed. We saw two different peoples TMAR's, both with similar omissions. There should be a TMAR for each topical medicine with clear information about the location it should be applied, how much to apply, how often and what it is for, ideally showing a skin map with shaded locations.

We recommend that the procedures around topical medicines are reviewed, and TMAR's updated to reflect best practice.

• Fluid thickening products were not stored safely, and we saw that one container of thickener was used on

the tea trolley for everyone that needed thickened fluids. Fluid thickening granules are prescribed, and each person's individually prescribed granules should be used for them. We saw that in one person's room, they had thickening granules belonging to another person in use. We discussed this with the manager and they immediately acted, thickening granules for each person were placed in a locked cupboard for use by staff making drinks, these were not put on the tea trolley and drinks that required thickening were made in the kitchen. Granules in people's rooms were checked and locked away between uses.
• Registered nurses told us they had received two medicines competency checks since the new manager had commenced. Additional medicines training had been booked with the supplying pharmacy and senior care assistants were also booked to attend as they were to undergo training to take on additional responsibilities.
• Medicines were safely stored, temperatures of storage areas were taken and were within safe limits and controlled medicines were stored as required. Medicines were disposed of when no longer required and controlled medicines were destroyed in a denaturing kit prior to return to the pharmacy.
• Medicines were reviewed by the GP and people who were taking anti-psychotic medicines were additionally reviewed every six months by the pharmacist who flagged any concerns to the GP.

Preventing and controlling infection
• The service was clean and free from odours. The sluice room we had identified as being unhygienic had already been noted by the new manager and there were housekeeping staff cleaning the premises throughout our inspection.
• The provider had a 'resident of the day' procedure which had recently been formalised. Registered nurses, care assistants and housekeepers had been allocated specific duties and this included a deep clean of the persons room and decontamination of bedrails, bumpers, crash mats and any other items of equipment. This was completed in addition to day to day cleaning.
• We noted that slings were hung over hoists. We checked slings and saw they were not named. People should have their own slings to reduce the risks of infection being transferred between people.
• We saw that a staff toilet had a communal nailbrush. This is an infection control risk. There were no hand hygiene reminders or guides for staff.
• We saw several staff members wearing wrist watches and not observing the good practice guidance of 'bare below the elbow'. One registered nurse was wearing long sleeves when we inspected, we asked if this was usual and they advised they were office based that day, and when they worked with people they would remove the long-sleeved item.
• An infection control champion had been identified and commenced their duties during our inspection. They had completed an infection control audit which would be completed monthly and had observed staff members hand hygiene, assessing it against a hand decontamination tool. If staff were only 80% competent they would be advised on their errors and retested however below that level, training would be given before retesting.
• Gloves and aprons were readily available around the service and consideration had been given to the risks associated with having them accessible. At the time we inspected there was no-one living at the service that accessible gloves could pose a risk to, the manager would review this risk assessment following each new admission and if a person had behaviours that may cause them to ingest gloves, they would be removed to a safer location.
• Anti-bacterial hand gel was used by registered nurses in between giving medicines to people. There were additional bottles of the gel around the premises. We advised the manager that wall mounted dispensers would be a safer option as people would be unable to drink the gel from those. The manager advised us that, apart from use during medicines rounds and outbreaks of infections, use of the gel would be phased out as good hand washing practice negated the need for its use.

We recommend reviewing infection control practice and training to ensure all staff are current with best

practice guidance and techniques.

Learning lessons when things go wrong
• There were few records available for us to ascertain if the provider had reflected on practice and learned from it. However, we saw records for July 2019 of six falls that had occurred, detailed accident forms had been completed and the information from these had been audited to see if there were themes or actions that could be taken to minimise future risks.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were assessed before moving to the service. The previous registered manager assessed people and shared their needs with registered nurses who wrote their care plans.
• The provider used an electronic care record. Once assessments were added to the system it would generate specific care plan and risk assessments to be completed relevant to the person's needs. We saw some generic risk assessments however care plans were person-centred and fully personalised to each individual.
• Some care plans lacked important details. We saw that one person liked to have three pillows, three pillows were on their bed. The same persons moving and assisting care plan stated to use a stand aid. The type of stand aid and size of sling were not recorded. The same person had a catheter and needed incontinence pads. Neither type of bag or size and style of incontinence pads were recorded.
• Another person had a care plan stating they needed to be repositioned every four hours. There was a paper copy of a turning chart available. The chart had only one date on for the last entry and appeared to show repositioning for several days. Recorded times showed that the person was being repositioned at varying intervals from two hours to seven hours. The person had also refused to reposition on two entries meaning they remained lying on their back for nine and a half hours on one occasion. The impact on the person was minimal as when we inspected their skin was intact and there were no pressure wounds.

We recommend that care plans are reviewed, missing information is added, and a process is developed to manage time sensitive tasks such as repositioning.

• Daily recordings had been made however staff had to complete records on only two terminals which meant records were not always contemporaneous increasing the risk of errors. We spoke with the manager about this, staff had told us that tablets had previously been used. At the time of our inspection the Wi-Fi did not effectively support use of tablets however improvements had been planned and trials of tablets were planned for the near future.

Staff support: induction, training, skills and experience
• Staff had not received regular supervisions prior to the new manager commencing in post. We were able to find two supervision records and one appraisal in the eight staff files we reviewed. The manager believed there may be additional electronic records however we did not see these.
• The manager had delegated some of the supervision responsibilities to registered nurses and senior carers.

A clear structure of who would be supervising which staff had been issued and staff who were new to supervision of staff would receive training and guidance from the manager before commencing this task.
• Training had been reviewed and the fully online system had been replaced with a more in-depth online system and face-to-face training. Moving and assisting, fire and medicines face-to-face training had been booked and the new training provider offered a broader range of courses.
• A new induction had been introduced and newly recruited care staff would commence on this when they started in post. The new induction allocated a mentor and focussed on the learner becoming familiar with practical tasks such as providing different types of care, supporting people's well-being and health and safety.

Supporting people to eat and drink enough to maintain a balanced diet
• We spoke with the two chefs and were impressed with their commitment to ensuring people received good quality foods they enjoyed. They recognised the importance of nutrition in people's overall well-being. On admission to the home, people would sit with a chef and the registered nurses so that a list of their favourite foods as well as likes and dislikes and nutritional needs could be made.
• All meals were cooked from scratch, most cakes and snacks as well, and a five-week menu was in use and available for people to review. Staff asked people what they wanted for lunch during the morning and if they did not want the choices offered there were several other options including sandwiches, jacket potatoes, fish, soups, baguettes and omelettes, the chefs told us they would be open to making anything for people assuming they had the ingredients.
• The chefs were aware when people needed to have additional nutrition to maintain or gain weight. One person ate a small breakfast and lunch but tended not to eat much afterwards. They were offered homemade cakes with cream for extra calories and would often have a milkshake made with full cream milk. These 'treats' were boosting their calorie intake and helping to reduce weight loss. Other people were encouraged to eat by the provision of things they may have mentioned in activity sessions. For example, there were eight different choices of biscuit available on the tea trolley as during chat sessions people had expressed a wish to have biscuits they had particularly liked.
• Special diets such as pureed meals were prepared. The provider had purchased plates with three separate sections so that the proteins, carbohydrates and vegetables did not mix together and become an unpleasant colour. The plates were age appropriate and stylish and well suited to the purpose they were used for.
• People were supported to eat their meals where they wanted to have them. The dining room was not large enough to seat everyone however some people liked to remain in their rooms and others ate in the two lounges. We were concerned that a few people appeared to remain in certain seats in a lounge all day and did not move even for lunch. Staff told us they had tried very hard to involve these individuals in lunch in the dining room, but they chose to remain where they were.
• We received mixed feedback from people and their relatives about the food. One person told us, "The food is nice. It's good. There is no menu, but I always have the same for breakfast, a full English. Lunch is nice, and I never turn it away". A menu was displayed in a communal area and people were asked what they would like to eat the following day by staff.
• A second resident told us, "I like the food on the whole, but there is lots of gravy and I don't like too much gravy. They have asked me what I like and don't like. They have also changed my food to soft food because of my cough. They looked into the type of food I could have".
• A friend of a person told us, "The food is excellent, we've not noticed that it is ever served cool. We chose Gorselands because of the food, they make cakes and there is always plenty of fresh fruit, we asked them to add fruit to the tea trolley which they did."
• However, a relative said, "'I saw the way a carer feeds the residents. For example, I saw a carer force a whole roast potato into a resident's mouth, even when the resident said it was too big. I didn't like it, so I decided I would come in the morning and stay until after lunch to feed my husband". We observed people

being supported with their meals both in their rooms and in the dining areas. We saw people being supported at their own pace and with bite sized amounts. The provider had not been informed about the person being given a whole roast potato and if they had been made aware would have acted to ensure that people received more appropriate support.
• Another relative told us they were concerned about the type of meals prepared, they felt that a sweet and sour chicken dish that they had seen served was not appropriate or appetising and that jacket potatoes had been served cold. The manager had arranged a relatives meeting, one of the items on the agenda was to discuss the menu, day by day and to implement any changes that the relatives or people in the home felt necessary.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• People were able to access healthcare services such as chiropodists. Registered nurses referred to specialist services such as tissue viability nurses and GP's attended the service when needed.
• People were supported to attend hospital appointments using the services minibus. Staff remained with them and could supply relevant information to health care professionals.
• Care plans held very specific details about healthcare needs. One person in particular had a temperature lower than normal. If their temperature were to read that of an average person's temperature they may already have an infection and, waiting until it read that of a normal high temperature would be potentially very dangerous for them. Having this specific information meant that the person was referred to the GP early to minimise possible harm.

Adapting service, design, decoration to meet people's needs
• The premises were a converted country house which had been extended and made accessible by the addition of two passenger lifts and ramps. Stairways were kept safe by the addition of bolted wooden gates at the top to prevent people accessing them unaccompanied. When we inspected, both gates had dropped slightly and were difficult to operate.
• The front door and the grounds were monitored using CCTV cameras to minimise risks of people leaving the premises unattended. The provider was also fitting a keypad entry system to the main entrance and visitor's car park.
• Décor was plain and lacked dementia friendly signage, some carpets were frayed and could become a trip hazard if not replaced.
• The service had extensive accessible gardens and an activities cabin was situated close to the building so people could enjoy sessions in a different environment. The gardens were surrounded by trees and one person, who had been a naturalist, particularly loved watching the wildlife surrounding them.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.
In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).
We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

• Care files had evidence of capacity assessments and there were two DoLS authorisations in place with new applications submitted for those people unable to consent to living at the home.
• Staff consistently offered people choices of day to day things such as what to eat or drink or whether to join activities.
• The service was compliant with the MCA and DoLS.

Good

Is the service caring?

Our findings

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

At the last inspection this key question was rated as outstanding. At this inspection this key question has now deteriorated to good.

This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
• People told us staff were kind and caring towards them. One person told us, "The staff are good to me and my [spouse] is in a room two doors down [from me]". Another person said, "Without exception, the staff are lovely and delightful". A relative told us, "The care is outstanding, for care and kindness you can't beat Gorselands".
• We saw staff speaking to people with respect and all staff knew people by their names and used their preferred names when speaking with them.
• Staff told us they would often sit with people after they had finished their shift as they were fond of people and liked to spend quality time sharing news with them.
• We heard lots of laughter throughout our inspection, staff and people joked together and enjoyed relaxed 'banter'. This was appropriate, and people laughed with each other.
• The provider spent time in the service most days and until recently had been there every day. They knew everyone living in the service by name and often spent time chatting with them. A staff member told us, "I've seen some changes over the years and they went through a sticky time, but things are improving. The manager and the owner are willing to put money into supporting residents. For example, when a resident's pet bird died, they paid for another, including a trolley to put the cage on. They also replaced a resident's electric organ and ensured another resident who had a stroke received appropriate speech therapy".

Supporting people to express their views and be involved in making decisions about their care
• 'Resident and relative' meetings had commenced at Gorselands, there had been one since the new manager commenced in post and a second was planned shortly after our inspection. These had not previously taken place as the registered manager had an 'open door' policy and thought meetings not necessary.
• We saw the minutes of the meetings and saw people and their relatives were being encouraged to be involved more fully in their care plans. The minutes read, 'Families are welcome and encouraged to look at the care plans with the resident's permission, or if applicable with a power of attorney in place'. People were also encouraged each month to comment on the care they received and to suggest changes.
• We asked people if they felt included and involved in the service. One person told us, "There have been a lot of changes lately, staff have changed, and I've been wondering what's going on. There have been a lot of new staff over the last three years. They do talk to me about the changes". Another person told us, "I do let them know if I have anything to say and my Daughter talks to them".

Respecting and promoting people's privacy, dignity and independence

• Staff told us how they would maintain peoples dignity when supporting them with personal care tasks, closing doors, keeping people covered and speaking with them about what they would be doing. We saw staff knock bedroom doors and ask if it were OK to enter.

• One relative had made a complaint about the way her family member was treated. They had been assisted with their meal by an agency staff member, while seated on the commode. This was wholly inappropriate however; the previous manager had not responded to the concerns. It was not clear if an investigation had taken place as the new manager had found no evidence of the incident being reported. They would not condone support being provided in this manner and welcomed comments from people and their families with regard to care provided.

• The same relative also needed to raise concerns that their family member felt they had been roughly handled when being moved, again it was not clear if this had been investigated.

• Confidential information was securely stored, and we did not over hear any conversations about people.

Good

Is the service responsive?

Our findings

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

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

This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences
• Peoples care plans held information about their life histories and had clearly been written with or following discussion with people and their relatives.
• Staff told us, "We assess new residents and currently use 'This is Me'. This gives me an idea of who they are, where they are from, their family, and their likes and dislikes".
• Monthly reviews took place so that people and their relatives could speak about their care with a registered nurse or senior carer. One staff member told us, "I should do reviews but haven't been able to, because recently we have been short staffed. I'm hoping [manager] will pull us together".
• People, their relatives and staff members all spoke with us about the positive changes that had happened since the new manager commenced in post.
• We noted that for one person, information shown on the handover sheet did not match their care plan. The handover sheet referred to them being cared for on an air mattress while this was not mentioned in their care plan and in fact they had a soft form mattress. Staff were familiar with people's care needs however a new agency staff member may be confused by the discrepancy.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• People's communication needs were identified as were factors such as their cognitive ability, eyesight, preferred language and comprehension levels. The care plan also stated, 'How do they prefer to receive information'. Information would then be provided as needed however when we inspected, larger print and reading information aloud to people were the only necessary aides to receiving information.
• If necessary, the provider would seek translations of information or use pictures to aide communication.
• The provider was compliant with the Accessible Information Standard.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
• An activities programme was in place and a variety of sessions including physical exercise, mental stimulation and entertainment were organised each day.
• An activities coordinator and a well-being coordinator worked together to provide activities. The newly

appointed well-being coordinator had been tasked with more individual work with people, particularly those who opted out of group sessions and spent extended periods in their rooms.
• An activities cabin was in the garden for small group activities and well-being sessions. Each month there was a different theme for reminiscence, crafts and music.
• The provider had installed a 'smart speaker' in the communal areas which enabled anyone to ask for music to be played or for information on subjects they were talking about.
• People had enjoyed a visit to another care home for tea, and the providers minibus was to be used to collect people from the other care home to come for a return visit to Gorselands.
• Other activities had included a summer fete, boat trips, outings to the beach and into the forest, visiting alpacas, horses and chickens and monthly tea parties. People had frequent outings as the provider had its own minibus.
• A hairdresser attended the service each week, a chiropractor visited and there were manicures and massages to boost people's well-being. Plans were in place to become more involved in the local community and to set up a gardening club.
• A pastoral volunteer attended from a local church. They told us, "I visit 2-3 times a week. I read, pray and talk to residents. One resident is blind, and their relatives live abroad, and they send [person's name] emails which I read out to them".
• There were two dogs, one belonging to a person living in the home and a 'family pet'. There was also a cat who had belonged to a previous resident of the home who had remained after their death and who had been adopted by subsequent residents of their owners' room. People loved having the pets around the home, they were popular with people who were seen to fuss the animals and enjoy spending time with them.

Improving care quality in response to complaints or concerns
• There was a complaints procedure however there was little evidence of its use. Complaints that had been dealt with by the new manager had been dealt with as per the procedures, in a timely way. They had been thoroughly investigated and learning taken from outcomes.

End of life care and support
• When we inspected, no one was receiving end of life care. People had been asked about end of life care plans however one person had no plans when they were admitted to the home and this had not been revisited with them.
• One person's care record showed clear plans including whether they wanted to be treated for minor and major health issues, what should happen if they had a terminal diagnosis and where they wanted to remain. The plan was not complete however had clear information on some of the persons significant wishes.
• The provider had attended training in a care pathway for people at the end of their life to ensure that care was delivered well and as planned.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• During our inspection the manager was available, visible, approachable and happy to help where they could. They led by example, working with people alongside team members as well as providing support through supervisions. There was also an 'open door policy', the manager was available to staff and people when they wished to speak with them.
• We received positive feedback about the care provided to people and we saw people being cared for in a person-centred way.
• Staff were empowered to fulfil their roles. Since commencing in post, senior care staff had been allocated roles as champions in various areas of the service and both nurses and senior carers would be providing supervisory support to team members.
• Staff were happy in their roles and were complimentary of the nominated individual and of the new manager. One staff member told us, "It has been really tough here, but now we have a new manager, things are better, things are improving". All staff we spoke with told us that there had been a positive change to the service recently.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The manager was keen to meet with people and their relatives. One relative told us they had arranged a meeting with the manager to discuss their family member as they had quite specific care needs. They were also intending to be at the next resident and relatives meeting.
• The manager had significant experience as a registered manager in previous roles and was aware of their legal responsibilities. At the time of our inspection there had been no requirement under the duty of candour however the manager would not hesitate to inform, people when things went wrong. They had tackled issues apparent in the service in an open manner and did not shy away from dealing with issues that could appear controversial.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care
• There had been a new manager in post for four weeks when we inspected Gorselands Nursing Home. They had immediately commenced in setting up new procedures to ensure that the service was providing quality

care and that they had clear oversight of processes.
• The manager was aware of their regulatory responsibilities. They had submitted notifications of significant events to CQC and we saw that the previous rating of the service was displayed.
• The nominated individual had, due to unavoidable circumstances, needed to step back from their role which had been a very proactive one within the service. This had meant there was less oversight and the service, prior to the new manager commencing had not been monitoring quality and safety or providing support to staff members. An additional director has become closely involved in the service and was available to provide support to staff and the manager.
• Audits had been introduced and commenced from July or August 2019. Audits reviewed personnel files including supervision and appraisals, health and safety, infection control, including hand hygiene, cleaning and laundry and accidents and incidents. We saw completed audits of accidents and incidents. Falls had been looked at in one audit, causes and themes had been considered and actions including a review of risk assessments taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Meetings had happened with the service since the new manager commenced. Staff, people and their relatives had been involved in meetings with additional meetings already planned. One relative told us, "Previously, concerns were not dealt with. If we raise concerns now, the new manager listens and is trying very hard to turn things around. The first family/residents meeting was held last week, and they plan to hold one every 3 weeks initially".
• We saw minutes from the first people and relatives meeting, areas covered included staffing and staff breaks, catheter bags and call bell response times. Staff breaks had already been dealt with, only two staff able to take a break at the same time, catheter bags would be discussed with the GP surgery and single use ones to be used instead of the current supply and call bell responses would be monitored once a new control system had been added to the current call bell.

Working in partnership with others
• The manager had sourced new training opportunities for staff, some of which would involve attending and lining with other providers. A new medicines audit had been introduced which had been developed by the local health service, the manager utilised existing resources from local providers.
• There were plans to integrate the service into village life. The service was on the outskirts of a busy village where many events were held, and the manager was keen to enable people to attend or to host events.
• Positive working relationships were in place with local health and social care professionals.