St Matthews (Moreton Centre) Limited

The Moreton Centre

Inspection report

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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**

Overall summary

The Moreton Centre provides nursing and personal care for up to 64 people who live with dementia and people who live with a mental health diagnosis. The home is purpose-built over two floors and divided in to four units. The home was laid out in a style that meant people who liked to walk around could do so without encountering barriers. The corridors were wide enough to allow and encourage this and provided quiet areas for people to sit if they wished to. There were 54 people living at the home at the time of the inspection with a range of complex mental health and health care needs. This included people who have had a stroke, acquired brain injuries, who live with diabetes and for those approaching end of life. Two units, Maple and Ash provided accommodation for both male and female people living with dementia. Maple unit accommodated younger people. A further two units, Willow and Oak provided single sex accommodation for those with a mental health diagnosis and behaviours that were challenging. People required varying levels of help and support in relation to their mobility and personal care needs.

There is a registered manager at the home. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was known as matron and will be referred to as matron throughout this report.

This was an unannounced inspection. The inspection took place on 26 and 28 August 2015.

People's safety was being compromised in a number of areas. Whilst people's medicines were stored safely and in line with legal regulations, we found discrepancies in the management of controlled medicines and in the medicine administration records (MARs). We also found poor recording of skin creams and dietary supplements. A recent audit undertaken by the clinical lead had identified poor recording on MAR records and had addressed this with the staff concerned with supervision, further training and competency.

Staff deployment over the past three months had been an issue recognised by the organisation. This was because two registered nurses (RN's) had left and a third was on maternity leave. This meant that the service operating with one RN on day duty instead of the two registered mental health nurse (RMN) identified as required when registered by the CQC. There were times when there was no RMN on duty. The units at this time were overseen by senior care staff whilst one registered nurse had overall responsibility for care to the people who lived in The Moreton Centre. Senior care staff administered medicines and ran the units whilst the RN undertook wound care, dressings and insulin management. The RN was not able to monitor and ensure that all units were running effectively and staff were delivering safe care.

We found that whilst risk assessments had been undertaken and risks for one person with complex needs identified, the care plan for this person was not in place and therefore staff lacked the information and guidance required to promote the person's health and well-being. Specialist equipment such as pressure relieving mattresses to prevent pressure damage was in place when identified as required, but not all was being used in a safe way. For example, mattresses were set on incorrect settings recommended by the manufacturer. This may contra indicate the specific reasons for use. There was also no evidence that that the settings of equipment were being checked regularly.

Whilst there were quality assurance systems in place, they had not identified the shortfalls we found. We found that people's safety was potentially at risk from poor medication practices and care plans were lacking in specific information that had the potential to cause harm to the individual. The registered manager acknowledged they had identified some medication and poor leadership skills through the audits and addressed them through supervision. The audit systems had failed to protect all people from harm.

People were looked after by staff who knew and understood them well. Staff treated people with kindness and compassion and supported them to maintain their independence. They showed respect and maintained people's dignity. Care plans were personalised and reflected people's individual needs and preferences. These were regularly reviewed.

There was enough staff to look after people. They had been safely recruited and were safe to work with people. Staff were well supported by the managers and colleagues. They received appropriate training to enable them to meet people's individual needs.

People were supported to take part in a range of activities, maintain their own friendships and relationships.

People had their nutritional needs assessed and monitored and were supported to enjoy a range of food and drink throughout the day. Mealtimes appeared to be pleasant and relaxed occasions.

There was an open culture at the home and this was promoted by the manager and deputy manager who were visible and approachable. People and staff spoke positively of the management structure at The Moreton Centre.

We found a number of breaches 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 this report.

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 Moreton Centre was not consistently safe.

Whilst medicines were stored safely, inconsistent recording of administered medicines and anomalies in recording of stock levels including controlled medicines placed people at risk from medicine errors.

The deployment of staff within the home had not ensured the safety and well-being of people.

Not everybody was protected from potential harm as care plans to provide safe care had not been put in place despite risks being identified.

Staff had a clear understanding of the procedures in place to safeguard people from abuse.

Risk assessments were in place and staff had a good understanding of the risks associated with the people they cared for.

Recruitment records demonstrated there were systems in place that helped ensure staff were suitable to work at the home.

Is the service effective?

Good

The Moreton Centre was effective.

Staff were trained and supported to meet people's individual needs.

Staff understood their responsibility in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were offered choices about the food they ate and staff supported them to enjoy relaxed and pleasurable meals.

People were supported to maintain good health and had access to on-going healthcare support.

Is the service caring?

Good

The Moreton Centre was caring.

Staff knew people well and had developed trusting relationships with people. This enabled them to provide good, person-centred care.

People's privacy and dignity were respected.

People were involved in day to day decisions about their care.

Is the service responsive?

Good

The Moreton Centre was responsive.

Summary of findings

People's care was planned in a way that reflected their individual needs and wishes.

People were supported to take part in activities that they enjoyed.

There was a complaints procedure in place and people felt comfortable raising any concerns or making a complaint.

Is the service well-led?

The Moreton Centre was not consistently well-led.

People were put at risk because systems for monitoring quality were not effective at this time.

The registered manager was seen as approachable and supportive and took an active role in the day to day running of the home.

Staff and people spoke positively of the management team's leadership.

Requires improvement

The Moreton Centre

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 was an unannounced inspection on 26 and 28 August 2015. It was undertaken by two inspectors, a specialist dementia 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.

Some people were unable to speak with us and share their experience with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning on the dementia unit. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we reviewed the records of the home. These included staff training records and procedures, audits, four staff files along with information in regards to the upkeep of the premises. We also looked at ten care plans and risk assessments along with other relevant documentation to support our findings. We also 'pathway tracked' people living at the home. This is when we looked at their care documentation in depth and obtained their views on their life at the home. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care.

During the inspection, we spoke with 18 people who lived at the home, four visiting relatives, ten staff members, the registered manager and deputy manager.

Requires improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe at the home. One person said, "Everything makes me feel safe," another said, "The staff make me feel safe," and "Yes of course I'm safe." One relative said, "Oh yes, he is safe." Another visitor told us, "Dad is absolutely safe here" and "Safety is very good here, doors are locked so people can't get lost. People and visitors told us there were enough staff. One person said, "I get the staff when I need them." One visitor told us there were enough staff but on occasions people may have to wait a bit longer to be attended to. They said, "There's nearly always adequate staff, you'll always get the odd time when it seems really hectic." Our observations during the inspection showed us that people reacted positively to staff and approached them with confidence for support and assistance.

Staff deployment over the past three months had been an issue recognised by the organisation. This was because two registered nurses (RN's) had left and a third was on maternity leave. Following meetings with staff and problems with not being able to secure appropriately trained consistent agency staff, a decision was made to have one nurse supported by senior care staff. This meant that the service only had one RN on day duty instead of the two registered mental health nurses (RMN) identified as required when registered for 64 beds by the CQC in 2014. On the day of the inspection there was an agency RN with no mental health training. This was a concern as the majority of people living in the home had a mental health diagnosis. The registered manager is a RMN and said that she was always available when required, but was not situated on the units.

The units at this time were overseen by senior care staff whilst one registered nurse had overall responsibility for the safe delivery of care to the people who lived in The Moreton Centre. We were told that senior care staff administered medicines and ran the units whilst the RN undertook wound care, dressings and insulin management. On the dementia unit we observed that care was not always delivered in a safe way. This was mainly due to the inexperience of the senior care staff member, who was in need of development and support. For example, documentation was not up to date and pressure mattresses and pressure cushions were not set at the correct setting for individuals the settings had not been checked by staff. We found discrepancies in medicine administration and recording. We also saw some people were left isolated and did not receive support in way that met their individual needs. The RN was not able to monitor, supervise and ensure that all units were running effectively and that staff were delivering safe care. The RN told us that it was extremely hard to be the only RN on duty as 'There was so much to keep on top of.' She also told us there was a handover system but that it was not possible to attend the handovers on each unit and so relied on feedback from the senior care staff, which was variable in depth and quality of information. This meant that the RN was not kept fully informed of changes to people's health and well-being. The RN was complimentary about the staff and support she received from the management team, but admitted it was, 'Overwhelming at times.' We shared our concerns about the delegation and experience of staff with the registered manager. This was acknowledged and we received confirmation on the second day of the inspection that two registered mental health nurses had been recruited from another home in the organisation and would be commencing work in the near future. We were also informed that one experienced senior care staff member who was a RMN from overseas awaiting their registration had been placed on the dementia unit to strengthen the team.

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

Whilst people's medicines were stored safely and in line with legal regulations, we found discrepancies in the management of controlled medicines and in the medicine administration records (MARs). Controlled medicines for two people had a running total that was different to the amount of medicine actually in the controlled medicines cupboard. The supporting documentation in the MAR sheets was not clear as to where the discrepancies occurred. Regular checking of controlled and daily medicine had not identified these discrepancies. This was raised with the management team and a safeguarding alert raised by the manager. We found another anomaly on the records concerning another medicine. The medicine notes stated 12 given on one record, the rolling count on the MAR was 28 and the blister pack for the medication contained just five tablets.

Medications that were to be given as required (PRN) such as pain relief tablets, however, there was a lack of detail of

Is the service safe?

how much was given and some had no time of administration. For example, one medicine was prescribed for one or two tablets - No more that 240mg per 24 hrs. These were signed for, but it was not documented whether one or two tablets had been administered and another medicine was prescribed one or two for times a day had no time against their administration. These identified shortfalls did not ensure safe administration of medicines.

A recent audit undertaken by the clinical lead had identified poor recording on MAR records and had addressed this with the staff concerned with supervision and further training and competency checks. Management of medicines is an area that requires improvement.

Whilst risks assessments were in place to help keep people safe, we found that one person who had complex medical, mobility and mental health needs did not have any care plans in place to guide staff. For example diabetes, mobility and peripheral circulatory problems. This person had problems settling into the home and this had not been reflected or appropriately risk assessed in their care plans. There had also been an incident that impacted on this person's safety since admission and this had not been recorded within the risk assessments or care documentation.

People that had been identified at risk from dehydration and weight loss (malnutrition) had been put on a food and fluid intake chart. We found that these were not being consistently completed. For example the care plan for one person stated fluids to be encouraged up to 1500mls in 24 hours however their fluid chart identified only 300mls in 24 hours had been taken on the 25 August 2015. There had been no fluids recorded after 5pm and none overnight until 11 am on the 26 August 2015 when this person got up. Other days the fluid intake for this person was around 500mls. Output was not recorded and the charts were not totalled to give a balance for staff to identify a balance of output against input. This potentially placed the person at risk from dehydration. This issue was found on all four units. Food charts were not completed in full and staff had not identified this as an area of concern. We were told people were weighed monthly however one person had not been weighed since June 2015 and two people showed steady weight loss over the last 6 months and it was not apparent in daily notes or care plans that particular attention has been paid to this. Monthly weighing was not always timely and therefore went over the required period. This placed people at risk of health problems associated with weight loss, such as skin damage.

Risk assessments had identified that there were people who required pressure relieving equipment to prevent pressure damage. On one unit we found that air flow mattresses and cushions were set incorrectly for their weight and had not been checked daily as the organisational procedure stated. One person's mattress was on twice the recommended setting and there was no check list in place. Staff could not find it and could not find what the correct setting should be. This placed people at increased risk of developing pressure damage.

These issues are a breach of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care plans within the MAR files contained detailed information and guidance for staff to ensure people received the appropriate treatment. For example some people had health needs which required varying doses of medicine related to the specific test results. People had an individual care plan for prescribed medicines which identified the reason for being prescribed, possible side effects and what would happen if they missed a dose.

Generic health risk assessments were in place for everybody. These included, pressure areas, falls and moving and handling and were personalised to reflect people's risks. Where people had individual risks, for example people who smoked, risk assessments were in place. Information from the risk assessments was used in care plans to provide guidance for staff. Some people displayed behaviour that may challenge others. We saw risk assessments which identified possible causes of the behaviour, for example one person found being with others a challenge as they like to sit quietly. This was managed by staff ensuring a quiet area was available.

Staff had received safeguarding training and had a good understanding of their responsibilities in relation to safeguarding people in order to protect them from the risk of abuse. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. Staff told us they would report to the most senior person on duty at the time. If this was not

Requires improvement

Is the service safe?

appropriate they would report to the relevant external organisations. They told us they would always report concerns to make sure people were safe. Staff were able to tell us how they were able to keep people safe for example, ensuring fall mats were in place and appropriate pressure area support was provided.

Systems were in place for the monitoring of health and safety to ensure the safety of people, visitors and staff. The home was clean and tidy throughout and maintained to a high standard. Regular environmental and health and safety risk assessments and checks had been completed for example a fire safety inspection and call bell tests. There were regular servicing contracts in place for example, lifts and hoists.

There were procedures in place to deal with an emergency which meant people would be protected. There was guidance for staff on what action to take and there were personal evacuation and emergency plans in place.

The home was staffed 24 hours a day with an on-call system for management and maintenance. Staff were aware of these rotas and who to contact if required. This ensured that risks to people were managed in a way that promoted their safety.

Staff recruitment records showed appropriate checks were undertaken before staff began work. This ensured as far as possible only suitable people worked at the home. Staff files showed there was appropriate recruitment and appointment information. This included references and police checks. Nursing and Midwifery Council pin checks for registered nurses had been recorded and demonstrated they had the appropriate qualifications for their job.

Good

Is the service effective?

Our findings

People had confidence in the skills and abilities of the staff at The Moreton Centre and visitors felt that they were well trained. Their comments included, "The staff are nice and seem very capable." One person said, "They do a really good job here, I wouldn't knock them. The general level of care is exceptional. I was awful before but the staff have made me well." "The nursing staff are good here, they know what they're doing," and, "Their training means they attain a pretty good level overall." People told us food was good and they could choose what they ate. One person said, "The food is ideal for me. I don't eat a lot, small portions. I ask for small portions and that's what I get." Another told us, "I've put on weight since I've been here." Visitors told us their relatives ate well at the home. People told us they were able to see their doctor whenever they needed to. One person said, "The doctors get called out if we need them."

Staff were aware of their roles and responsibilities and had the skills, knowledge and experience to support people. When they commenced work at the home staff received a comprehensive induction programme. This included a workbook of competencies which they were required to complete within 12 weeks. These were checked by their mentor or a member of the management team at six weeks and support provided where required. Staff were shadowed during their first six weeks and once completed their competencies were signed off by the registered manager and completed in the induction workbook. In addition they received taught sessions related to essential training for example moving and handling and fire safety. This meant staff had a comprehensive understanding of their work and the policies, procedures and work practices expected of them.

All staff received essential training updates and these included adult protection, infection control and nurses and senior care staff received annual updates in relation to medicines. The training was documented in staff files training with accompanying checklists showing understanding of the training received. Staff confirmed they received ongoing training and told us in addition to essential training there was extra they could choose to attend. Some staff had recently commenced training in relation to end of life and dementia. Nurses received ongoing clinical skills training for example diabetes, catheter care and wound care. Staff spoken with told us if they required training they, "Only had to ask" and it was provided. Care staff told us they were able to undertake further development for example the diploma in health and social care. The training programme showed specific training tailored to meet the needs of the people they supported. Staff we spoke with told us of their dementia training which was a 30 minute video followed by a quiz. They said that it gave them an initial introduction in to dementia but felt they needed a more interactive and in-depth training to fully be able to care for people who lived with dementia. This had been recognised by the management team and further training was being organised. Staff received training in managing behaviours that were challenging. Staff told us that the training was 'Interesting' and 'Gives us information to look after our residents well.'

There was an on-going programme of supervision. Supervision was delegated with managers, nurses and staff responsible for supervising a number of other staff. The registered manager had identified to us that some staff had received increased recent supervision due to some concerns found in the last audits. We spoke with one member of staff who told us, "I've had regular supervision and plenty of support, I am always talking to registered manager to discuss things. We have handovers and meetings, we communicate well."

Staff understood the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They had a clear understanding of DoLS and what may constitute a deprivation of liberty. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decision-making. The Deprivation of Liberty Safeguards concern decisions about depriving people of their liberty, so that they get the care and treatment they need, where there is no less restrictive way of achieving this.

The Care Quality Commission has a legal duty to monitor activity under DoLS. This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make an application to the local authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm.

Good

Is the service effective?

The manager understood the principles of DoLS and how to keep people safe from being restricted unlawfully. They also knew how to make an application for consideration to deprive a person of their liberty. The registered manager took full responsibility for DoLS applications and kept a folder detailing dates and responses. This had ensured that the provider was meeting the requirements of DoLS.

Staff asked people's consent before offering them help and made sure the person was happy with what had been provided. Where people were less able to communicate verbally or had varying capacity staff understood from people's body language and facial expressions whether people had agreed to the help offered.

People were supported to eat and drink a nutritious and varied diet, their nutritional needs had been assessed and regularly reviewed. The mealtime appeared to be a pleasurable occasion on the different units. Staff enabled people to eat at their own pace. People were talking to each other and engaging with staff.

We have already identified that food and fluid charts were not accurate and therefore had little value to assessing people's intake of food and fluids. We did see that nutritional risk assessments were in place and followed. For example, fortified food supplements and referral to the GP and dietician. The registered manager kept a spreadsheet of people's weights and we saw that 97% of people were weighed regularly. We saw evidence that where concerns had been identified the GP had been informed for further advice.

There was a dining room on each unit of the home and people were able to choose whether they wished to eat their meals in their bedroom or in the dining room. Some people required a range of support with their meals. This included, prompting and encouraging, support with cutting food or full support. Staff were attentive and encouraging and there were enough of them to ensure people received their meals in a timely way. People were provided with the meal of their choice. One person had changed their mind and an alternative was provided. We observed one member of staff supporting a person to eat in their own room. Although the person did not want to eat, the staff member offered very gentle encouragement and spoke kindly and warmly to the person. Staff told us although some people may not remember what they had ordered they had chosen, with staff knowledge and support, a meal they liked. A staff member added, "If they change their mind, we'll get them something else anyway." The chef delivered meals to each unit and ensured that there were enough meals.

Staff had a good knowledge of people's dietary choices and needs. For example some people required a soft diet and others a diabetic diet. There was information in the kitchen about people's dietary choices and needs. We spoke with the chef. They were passionate about providing good quality, nutritious food for people. The chef spoke about pureed vegetables and said, "People enjoy the food, we work to a weekly menu and change it according to peoples tastes. We found that a rolling four week menu becomes boring and we want people to enjoy a varied diet." People had two main choices of meal at lunchtime but many alternatives were also available including omelettes and sandwiches." There was also a 'grazing' fridge where staff could access snacks for people at any time. We observed staff offering people a choice of hot and cold drinks and snacks throughout the day. Even though staff knew what people liked to drink they continued to offer choices.

People were supported to have access to healthcare services and maintain good health.

People's health and wellbeing was monitored on a day to day basis and staff were pro-active in identifying when people were unwell or need medical attention. We observed staff informing the nurse when someone was unwell and the nurse contacted the doctor for further advice. We saw from the care files other external healthcare professionals were involved in people's care. This included, speech and language therapist, dietician and tissue viability nurses. People therefore received healthcare support from appropriate professionals. Visitors we spoke with told us their relatives received the healthcare the needed. One visitor said, "There's no problem whatsoever in getting to see a doctor." Another visitor told us their relative had been poorly and added, "They called in the GP to advise them."

A clinical lead was responsible for ensuring staff were aware of appointments people were due to attend. This included liaising with the hospital, GP, dentist and optician. This helped to ensure people did not miss appointments and staff were available to accompany people when required. There were regular health professionals who visited the home including chiropodist, dentist, and

Good

Is the service effective?

optician. People were able to use these services if they chose to. Communication within the home was seen as vital in supporting people to maintain their health and wellbeing.

Good

Is the service caring?

Our findings

People said that the staff at The Moreton Centre were warm, caring and friendly. Comments included, "The staff are OK. No complaints," "They are very friendly and helpful," "The level of patience and tolerance is unbelievable. They do a marvellous job," and "They are caring people. Basically they are very nice."

Throughout the inspection we observed staff treated people with kindness and understanding. We saw many occasions where there were positive interactions, conversations and activities between people and staff. The interaction on the dementia unit was more sporadic and was centred to specific people which meant others were left alone with little interaction. We mentioned this to the staff member in charge who admitted this had not been noted and they immediately made changes to how staff were deployed. The difference to people was immediate, people were more alert and responsive and the atmosphere lifted. Staff sat with people whilst they had lunch and chatted easily together.

When people required support this was observed to be provided appropriately and with care and compassion. It was clear from our observations that staff were able to engage effectively with people who were less able to communicate verbally. Staff spoke with people calmly and patiently and gave them the time they needed and when appropriate spoke with them discretely about their personal care needs. One person on Ash Unit was screaming, shouting and distressed. One particular care staff member was very good with the person. The staff member's tone and language was appropriate. Other people were given consideration to leave if they were distressed by the person's behaviour. Within a short time, the situation was managed well and was soon settled.

Although the home was busy the atmosphere was calm and relaxed. People were getting up and spending their day in a manner that suited them. We observed one person had decided to spend the day in bed as they wanted to rest. Staff supported them to do this and ensured they received appropriate support and attention when they required it. We observed that staff returned regularly to check on people throughout the day. On another unit people were observed to get up when they wanted to and having a late breakfast then spend time where they wished to. We saw some people enjoyed table games and we observed staff sitting with people socialising and chatting whilst clearly enjoying themselves, whilst others spent time watching television or going out with staff.

Staff knew people well and treated them as individuals and people were involved in decisions about their day to day care and support. Staff were able to tell us about people's choices, personal histories and interests. Care plans contained information about people's choices, likes and dislikes but staff continued to offer people choices. We observed one staff member asking a person what they would like to drink. They said, "I know you usually have tea, but just to remind you, you can have something different if you like." People told us staff knew what they liked. One person said, "They know what I like." A visitor said, "The staff know him as a person, they know his likes and dislikes and how to keep him calm."

As part of their induction staff covered privacy and dignity, and the provider had policies and resources available for staff which provided guidance and advice. Staff had a clear understanding of privacy and dignity and these were embedded into everyday care practice. One member of staff told us, When providing personal care, they made sure the door was closed and the person was covered up." A member of staff told us, "We always knock and await an answer before we go into people's rooms." People confirmed staff upheld their privacy and dignity. Throughout the inspection, people were called by their preferred name. Staff gave us examples of how people liked to be addressed. Some people liked to be called by a chosen name rather than a given name, other people preferred their full title. People were dressed in clothes that were well presented, some ladies have been supported with their make-up. Staff supported the choices of clothes that people had made for themselves.

People were supported to maintain their independence as far as possible and care plans informed staff to encourage and prompt people to undertake daily tasks for themselves. One person said, "Now I'm doing quite a bit for myself, they leave me and then come back. I had a shower this morning, all I do is tell them and they arrange it." Visitors told us how they had seen their relatives encouraged to become more independent. One visitor told us how staff had supported their relative to practice their walking to regain their strength and confidence.

Good

Is the service caring?

People's rooms were personalised with their belongings and memorabilia. People showed us their photographs and other items that were important to them.

Good

Is the service responsive?

Our findings

People were involved as much as possible in deciding how their care was to be provided and received care that was responsive to their needs and personalised to their wishes and preferences. People told us there was a range of activities available and they were encouraged to join in. One person told us, "There's enough going on, I'm quite happy, I join in when I want." Visitors told us there were a lot of activities and their relatives joined in if they chose to.

Before people moved into the home the registered manager carried out an assessment to make sure they could provide them with the care and support they needed. Care plans included information about people's likes and dislikes and how they would like their care provided. Where people were less able to express themselves verbally the registered manager ensured the person's next of kin or advocate was involved. This meant people's views and choices were taken into account when care was planned.

Care plans were personalised and reflected the individualised care and support staff provided to people. We saw some people had complex care needs in relation to their mental health needs and behaviours that distress. We asked staff about the care some of these people required and saw care plans reflected the care people received. People had their care reviewed regularly this included any changes that related to their health, care, support and risk assessments. There was evidence that people and, where appropriate, their relatives were involved in the reviews.

People and visitors we spoke with confirmed they were involved in care planning decisions. Visitors, told us they were updated with any changes in their loved ones health or care needs. They said, "If anything happens I'm contacted, they tell me what happened and what they are going to do about it, they really do everything they can."

People were able to maintain relationships with those who mattered to them. We saw visitors were welcomed to the home. They told us they were always made to feel welcome and felt involved with their relatives care. We observed that staff knew the regular visitors well and there was an open, professional relationship between them.

Information was available on people's life history, their daily routine and important facts about the person. This included their food likes and dislikes and what remained important to them but the quality of these varied. The registered manager explained this had been identified also activities, staff were working with people to develop and improve these. One staff member told us, "Initially, the information we have is dependant of what relatives tell us."

It is important that older people in care homes have the opportunity to take part in activity, including activities of daily living that helps to maintain or improve their health and mental wellbeing. There was a dedicated activities team. There was a wide range of activities taking place throughout the day. This included 1-1, trips out, games and music. There was also a well-equipped day centre which has external staff with an art a crafts room, quiet room and kitchen. Unfortunately this facility will soon be closing due to lack of clients from outside attending. Information about people's social needs were recorded in their care plans. For example one person did not like being in a noisy environment and staff ensured a quiet area was available. Another enjoyed gardening and staff sat and looked at gardening books and chatted about the gardens.

In response to peoples need to walk around staff were seen enabling them to be as independent as possible, whilst ensuring their safety. Each floor was a 'racetrack' formation with bedrooms, lounges, staffing areas off the corridors. Due to the layout people were able to walk around the floor safely without encountering barriers. A key pad system meant that people living in The Moreton Centre and subject to DoLS authorisations could not leave unless accompanied. The corridors were wide and included seating areas. People were able to walk around, spend time in the lounges or sit in the corridors as they chose. There was a selection of pictures and paintings some of which were bright and others were reminiscent. People were seen looking at the pictures and commenting on them. We observed people sitting in seating areas observing and engaging with staff and other people as they passed.

Staff had recognised that although there was a varied activity programme in place there were limited activities for people who remained in their rooms or didn't chose to participate. Staff told us they were reviewing and introducing more one-to-one and reminiscence type activities. Some staff showed a depth of understanding of what constituted an activity and explained how each interaction should be meaningful for people. For example one person didn't participate in group activities or one-to-one activities. The staff member said, "We can make

Good

Is the service responsive?

sure they still receive the one-to-one experience. When we provide support with personal care or at mealtimes we make sure we talk with this person and they will engage with us. It's about making every contact meaningful."

There was a complaints policy at the home and this was seen to be followed. People and visitors said they did not have any complaints at the time but they were happy to speak to the registered manager or other staff. A visitor told us, "There have been one or two issues but when it's brought to the attention of (registered manager or deputy) they are sorted out." Another visitor told us about a complaint they had made and said, "I got a response in writing. I'm happy to tell them about any problems."

Requires improvement

Is the service well-led?

Our findings

People and visitors knew the registered manager of the home and recognised familiar staff. People, visitors and staff were positive about leadership at the home. One person said, "I think it is really well run." Another person told us, "I think the staff are happy working here because they seem to like being with us." One visitor said, "What holds it together is good leadership." Another told us, "I think it is well run." Staff told us they enjoyed working at the home, one said, "This place is very well run and the residents are very happy." Another said "The night shift will help the day shift, the day shift help the night shift, teamwork that works well here." Staff told us the registered manager was, "Very supportive" and, "The management team are approachable, we can ask anything and will get an answer." The atmosphere at The Moreton Centre was busy calm and relaxed, with good relationships between the people living there and the staff.

Whilst there were quality assurance systems in place, they had not identified all the shortfalls we found. We found that people's safety was potentially at risk from poor medication practices and care plans for some people were lacking in specific information to manage the potential to cause harm to the individual. Food and fluid charts were not being completed or followed up to ensure people were eating and drinking enough to sustain their health and well-being. This placed people at risk from dehydration and weight loss.

The registered manager acknowledged they had identified some medication and poor leadership skills of senior staff through the audits and addressed them through supervision. However these had not at this time protected people from potential risks to their health and well-being. Insufficient support had been put in place at this time to manage the risk to people effectively.

This was a breach of Regulation 17 of the Health and Social Care Act 2014.

Regular audits were carried out in the service including health and safety, environment and care documentation. The registered manager had identified areas for improvement. This included a more robust medicine audit and care plan audit, a room chart audit and the introduction of a topical medicine chart to ensure there was a record people received their creams as prescribed.

We were told these audits had recently been put in place. Where shortfalls or concerns had been identified action had been taken to rectify. For example, further training and competency assessments for medicine management. As identified above these were not fully embedded and at this time had not ensured people's health and well-being. To help drive improvement and continually improve care delivery a clinical lead role had been developed for an experienced registered mental health nurse to provide support and guidance for staff. This demonstrated the registered manager and deputy manager were continually working to improve and develop the service for the benefit of people who lived at the Moreton Centre.

There was an open culture at the home and this was promoted by the registered manager and deputy manager who were visible and approachable. The manager was on duty five days a week and the registered manager ensured she met regularly with night staff to ensure all staff teams had access to management support. The registered manager knew people well and had a good understanding of their needs and choices. She told us her goal was to provide good quality person-centred care. She had worked hard to develop an open and welcoming home for people, their relatives and staff.

There was a clear management structure at The Moreton Centre. Staff were aware of the line of accountability and who to contact in the event of any emergency or concerns. Staff said they felt well supported within their roles and said they could talk to the registered manager or deputy manager at any time. The registered manager was seen as approachable and supportive and took an active role in the day to day running of the home. Both the manager and deputy manager knew the people who lived in the Moreton centre well.

Staff told us The Moreton Centre was a good place to work, they felt supported and encouraged in their roles. One said, "It's a good place to work, it's hard work but I feel we do a good job here. We have a good management team and good staff, everyone's supportive."

People, their relatives and the staff were involved in developing and improving the service. We saw a recent survey which had been sent to people and their relatives. Feedback was very positive with people and relatives commenting on the good standard of care and the caring attitude of staff. We saw minutes of a staff meeting which complimented the staff on the positive feedback received

Requires improvement

Is the service well-led?

in the surveys. There was also information for staff about upcoming training and a reminder about correct safeguarding procedures to follow if they identified any concerns.

There was some feedback about the laundry service and people and visitors felt more care was needed with clothing as some went missing and they found that sometimes their mother was wearing clothes that weren't hers. The registered manager told us this had already been identified and was being addressed with new laundry facilities and procedures.

There were various systems in place to monitor or analyse the quality of the service provided. The registered manager identified the work that had commenced in activities had started to enhance people's lives at the home. She also told us that due to staffing concerns staff were now allocated a unit to work on for six months. This decision was to ensure people and staff got to know each other and provide continuity of care. This had led to a better understanding of individual responsibilities and improved the delivery of care.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.** **The provider had not ensured the proper and safe management and administration of medicines including as required medicines.** **The provider had not ensured that the equipment used by the service provider for providing care or treatment to a service user is used in a safe way.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (1) (2) (a) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

This section is primarily information for the provider

Action we have told the provider to take

The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs.