Ashberry Healthcare Limited

MoorHouse Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This was an unannounced inspection which took place on 7 and 8 April 2016.

MoorHouse Nursing Home provides support and accommodation for a maximum of 38 older people who require residential or nursing care. Services offered at the home include nursing care, end of life care, respite care and short breaks. The rooms are arranged over three floors. There are stair lifts and a lift to each floor. On the ground floor there is a large dining room, two lounges and further sitting areas. At the time of the inspection there were 33 people living at the home. People had a range of needs. Some people were living with dementia; others required nursing care to manage pressure areas whilst other people required minimal assistance.

The home did not have a registered manager. The previous registered manager had not worked at the home since 10 March 2016. A new manager had been recruited and in post since 21 March 2016 and was present during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The manager was in the process of submitting an application to register with us.

MoorHouse Nursing Home was last inspected on 12 October 2015 where it was rated as 'Requires Improvement'. Four breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. These related to personalised care, risk management, recruitment procedures and quality monitoring. Requirement actions were set in relation to these and the registered provider sent us a report that detailed steps that would be taken to make the required improvements. At this inspection we found that although initially the registered provider had taken steps to address the requirement actions these had not been sustained and issues remained in three areas. In addition, new areas of concern were identified.

There had been changes in senior management and of management of the home. These had not been managed well by the registered provider and had impacted on the quality and safety of service people received. The registered provider had not ensured the quality and safety of service was monitored or that action was taken to improve service delivery.

The numbers and deployment of staff on duty did not meet people's needs. People told us that staffing levels impacted on their bathing and personal care preferences. People did not receive their medicines on time and some people did not have all the medicines they had been prescribed. People did not get the care and support they needed or wanted at the times they required this.

People with specific nursing needs did not receive care and treatment safely. Assessment and care planning was not robust and did not ensure that people's needs were managed effectively. There were not enough nurses on duty to meet the nursing needs of people.

Staff did not receive sufficient supervision to understand their roles and to undertake their responsibilities. Some training had been provided but knowledge gained from this was not reflected in practice.

Although staff sought peoples consent when delivering care, formal consent processes were not being used. Staff were not following the requirements of the Mental Capacity Act 2005 for people who used bed rails and were not able to consent to the use of this equipment. Formal systems were not being used consistently to support people to be involved in making decisions about their care and support.

People told us they felt safe. However staff did not recognise that neglect was a form of abuse. Up to date information was not available for staff to refer to about definitions of abuse and how to report concerns.

Despite the concerns about staff levels people told us that staff were kind and caring. We observed that care was given with respect and kindness but it was clear that some people had to wait for too long for the help they required.

In the main, people said that they were happy with the meals provided at the home and we saw that people who chose to eat in the dining room had a positive experience. Activities were offered and people expressed satisfaction with these. People were aware of how to raise complaints. There were no restrictions on visitors and relatives told us they were always made welcome.

There had been an improvement in the recruitment records maintained for staff. These showed that suitable checks had been completed to help ensure staff were safe to care for people.

People had access to health care professionals such as a GP and when accidents and incidents occurred action was taken to ensure people received appropriate medical advice.

During the inspection 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 the report.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely. People did not receive all their medicines. Medicines were not given at the times they should have been and as a result people' health was compromised.

Risk assessment processes were not being followed and changes in people's needs were not responded to safely.

Staff levels impacted on the care people received and people did not always receive care and support when they wanted or required it.

People told us they felt safe. Staff did not understand all forms of abuse and did not have access to up to date information about abuse and reporting this.

Recruitment procedures were followed to ensure staff were safe to care for people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff were not sufficiently skilled and experienced to care and support people to have a good quality of life. They were not provided with sufficient support to fulfil their roles and responsibilities.

MoorHouse Nursing Home was not meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005.

People, on the whole were satisfied with the dining and meal arrangements.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Formal systems were not being used consistently to support people to be involved in making decisions about their care and support.

People said that the staff were kind and caring and that they were treated with dignity and respect. Staff were able to explain how they promoted people's dignity and privacy. However this was not always applied when care was delivered.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were not assessed appropriately and care and treatment was not provided in response to their individual needs and preferences. People were not consistently supported to manage specific health, nutritional and care needs.

An activity programme was in place and people expressed satisfaction with the range of activities available.

People felt able to raise concerns and were aware of the complaints procedure.

Is the service well-led?

Inadequate

The service was not well-led.

The home lacked a clear, imbedded management structure. Changes in organisational structure and management had not been managed well. This had resulted in a decline in the quality of service that people received and low staff morale.

Quality monitoring systems were not being used to identify and take action to reduce risks to people and to monitor the quality of service they received.

MoorHouse Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 8 April 2016 and was unannounced. The inspection team consisted of three inspectors who had experience of older people and nursing needs.

We did not ask the provider to complete a Provider Information Return (PIR) as the inspection was brought forward due to information of concern that we had received. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before the inspection, we reviewed information that we held about the home and the registered provider. This included statutory notifications sent to us by the registered provider, previous inspection reports and information of concern. A notification is information about important events which the provider is required to tell us about by law. We used all this information to decide which areas to focus on during our inspection.

We spoke with 10 people, two relatives and two external professionals who were present at the home during our inspection. We also spoke with three registered nurses, two care staff, the manager and an external quality consultant engaged by the registered provider. In addition, on the second day of our inspection we spoke with the registered provider and the managing director who came to the home to discuss our inspection findings.

We observed care and support being provided in the lounge and dining areas and we also spent time observing the lunchtime experience. We also observed part of the medicines round that was being completed.

We reviewed a range of records about people's care and how the home was managed. These included eight people's care and medicine records, staff training, support and employment records, quality assurance audits, minutes of meetings with staff, menus, policies and procedures, complaint records and accident and incident reports.

MoorHouse Nursing Home was last inspected on 12 October 2015 where it was rated as 'Requires Improvement'. Four breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. Requirement actions were set in relation to these and the registered provider sent us a report that detailed steps that would be taken to make the required improvements.

Inadequate

Is the service safe?

Our findings

The medicine management in the home was unsafe. One person who lived at the home told us, "I always get them (medicines) late."

We observed people were not given their morning medicines until midday. The nurse who gave the medicines signed the Medication Administration Record (MAR) but did not record the actual time the medicines were given. This meant that people might not have had a suitable time gap between medicines which could affect their wellbeing. One of the medicines that was given late was for the management of epilepsy that was required to be given at specific times. As the person was given this late and not in line with the GP instructions this meant that this could lead to risk of seizure. We also found that the same person was not given their morning medicines prescribed to help them breath which meant that their wellbeing was compromised. Other medicines given late were one to manage a person's diabetes and analgesics to manage people's pain. The timing of the medicine rounds meant people were not receiving their prescribed medicine in a timely way thus reducing the effectiveness of the medicine prescribed.

We looked at people's MAR charts and noted errors in medicine administration. Four people's records did not confirm that they had been given all of their required medicines at the times and days required. For example, one person's records showed they had not received a medicine for management of epilepsy in the afternoon on three consecutive days. Another person should have received medicine for management of diabetes. On one day they only received one tablet instead of two and then none of the required dosage at night. This meant that staff had not ensured people received their medicines as prescribed and placed them at risk of harm.

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

A pharmacist from the supplying chemist was undertaking an audit of medicines at the request of the home manager during our inspection. They also found significant errors. We asked the manager to make a safeguarding referral to the local authority during our visit regarding unsafe medication administration which they did immediately. In addition they put measures in place to ensure people received their medicines safely. These included the manager checking daily that each person received their medicines as prescribed.

Medicines were stored appropriately in trolleys that were kept in the hallway secured to the wall opposite the medicine room. There was a designated medicines room located on the first floor which contained stock medicines and external preparations such as creams and lotions. There was also a fridge in this room to store medicines that needed to be stored below room temperature. Each person had a preferred care plan relating to their medicine management which outlined how they liked to take their medicine. This included if they liked to take medicine before or after food, what drink they liked and if they wished to take tablets singly or together. However, this did not always happen due to the length of time it took the medicine round to be completed.

We observed the nurse undertaking medicine administration in line with the Nursing and Midwifery Council's (NMC) Code of Professional Conduct. They administered the medicines safely, signed when the person had taken their medicines and disposed of any equipment and washed their hands before moving on to the next person.

People who lived at the home told us that there were not enough staff on duty to support them at the times they wanted or needed. One person who lived at the home said, "You have to wait for such a long time if you want anything". Another person said, "It's quite difficult to find any staff from 3 o'clock onwards." This person gave us an example of how they had been left on a commode for over half an hour. A fourth person told us that they had to wait for three hours to get up on the morning of our inspection. They explained that they had asked to get up at 7 am and eventually got up at 10am when there was a member of staff available to support them. This person told us this was a frequent occurrence and they often had to wait over forty minutes for help when they rang their call bell. This person's relative also confirmed this to us. Call bell records and discussions with staff confirmed that people waited unacceptable lengths of time to receive assistance.

One person who resided on the top floor of the home told us that there were no staff permanently deployed to that part of the home and that, "You have to wait for such a long time if you want anything". Our observations confirmed that dedicated staff were not deployed to this part of the home and that for up to half an hour no staff, apart from a housekeeper, were present. People who resided on the top floor of the home did not receive their morning medicines until midday or later.

One person had to wait nearly an hour for their meal from the time lunch was served and staff brought them a meal which they had not requested and would not eat. The person requested an alternative which was not provided for another 35 minutes. Another person was given a tray with their lunch and pudding on it in their room. This person was drowsy and they were still sitting with their meal in front of them 30 minutes later without touching this or being offered help.

We saw staff were very busy and attending to people's personal care and still getting people up at midday. Staff confirmed that that this was the norm and that at times people did not receive assistance to get up and to get dressed until midday or later. One relative said, "I have been sitting here with X (family member) and not seen any staff for two hours." We read that another relative had raised concerns with the manager during March that their family member had not been assisted by staff despite them calling for help. We discussed this with the manager who informed us that she had raised this with staff during a staff meeting. Although the manager had taken steps to address this by talking to staff she had not considered reviewing staffing levels as part of this process.

Staff also told us that staffing levels impacted on the service that people received. One said, "It was feasible for one nurse on shift to do everything when resident levels were lower. Now it's almost full it's hard to give medicines in a timely manner and we don't have time to update care plans. We have many residents at high dependency. You have to have the resources". Another said, "Residents have to wait for an hour or more at times".

The manager told us that staffing levels were decided on occupancy and individual dependency assessments. She said there were 18 people in the home requiring nursing input however we identified that the majority of people were funded for nursing care. The manager told us that staffing levels consisted of two nurses and six care staff during the morning, one nurse and five care staff during the afternoon and one nurse and four care staff during the night. Discussions with people who lived at the home, staff and the manager and examination of records confirmed that staffing levels had not always been maintained at all

times during the past four weeks.

We found that there was not sufficient management oversight of staffing levels and that this impacted on the care that people received. On the first day of our inspection there was only one nurse on duty. However, for the second day three nurses were allocated. The manager informed us that changes to allocated shifts had been made by nurses without her prior approval. Also, arrangements for a second nurse to be on shift on the first day of our inspection had not been made. The home had been using agency staff to cover some vacancies and shifts. The manager was unable to tell us how many vacancies there were.

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

Other staff employed at MoorHouse Nursing Home included housekeepers, activity staff, catering staff, maintenance and administration. Activity staff were not on duty on the first day of our inspection. The manager informed us that she had identified the need to review the deployment of activity staff. She had held a meeting with them to review shift patterns in order to ensure a better distribution of activity staff.

At our previous inspection a requirement action was set because we found that potential risks to people were not always assessed or planned for in order to keep them safe. At this inspection we found that the same issues remained.

We saw that one person had a skin tear to their leg. They told us that it occurred when staff were lifting their legs in bed. They said of staff, "They don't realise my skin is so fragile". We checked the incident and accident log and could not find a record of this being investigated. The daily notes for the day of incident in April mentioned the wound however stated it was unwitnessed. There was a body map showing the wound but no wound care plan as to when, why or how the dressing should be changed. The same person had an assessment in place that identified them as being at high risk of developing pressure areas. We observed the person sat in the same position for six hours with no alternative positioning offered by staff. This meant that risks to the persons were not being adequately assessed, planned or managed.

Another person had had been admitted to the home with two pressure wounds. There were assessment and care management documents in place for one of the wounds but not for the other. We spoke to the nurse on duty about the second pressure wound and lack of documentation. They were not aware that the person had a second pressure wound. They stated, "Oh I didn't know, they (the person) haven't said anything". The same person had an assessment which stated they were at very high risk of skin breakdown. This did not include a description of equipment such as pressure mattress or cushions that needed to be used to prevent skin deterioration. This meant that the person was at risk of receiving inappropriate or unsafe wound care.

A third person was having dressings undertaken for a wound on their leg caused by a skin tear. A wound management plan had been commenced which recorded dressings were undertaken during February and March. The person was still having their wound dressed on the day of our inspection which was confirmed by the nurse on duty but had no records on the frequency of the dressings or how this was improving or deteriorating. This put the person at risk of cellulitis or other infections as there was nothing recorded. Staff were not provided with clear wound management instructions on how to provide safe and effective care for this person.

One person had been assessed by the Speech and Language Therapy team as requiring a pureed diet. They had a fluid chart which had not been completed since 26 March 2016 and a food intake chart that had not

been completed since 1 April 2016. The food intake chart also included one entry that described a meal they were given that was not pureed. They were weighed twice in February 2016 where it was found they had lost weight. This person had not been weighed since and there was no further evidence of action taken to support the person in this area. This meant that the person was not supported to manage their nutritional needs safely.

When spending time with people in their bedrooms we observed six people had bed rails in place. No documented risk assessments were in place for the use of this equipment. Also, we saw that for one person the protective bedrail covers were not in place. This meant that they were at risk of entrapment. We immediately drew this to the attention of the nurse on duty who directed staff to put this in place, which they did immediately. The lack of assessment meant that potential risks associated with bedrails were not assessed.

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

People said that they felt safe from harm. Staff spoken to were able to describe what different types of abuse were apart from neglect and acts of omission. They did not recognise that if care was not provided to meet people's assessed health and welfare needs this could potentially be neglect. Two of the five staff spoken with said that they would not be confident in raising alerts with the local safeguarding teams and did not know how to contact them. Both these members of staff said that they had not received safeguarding training since being employed at the home. We saw that information in the home available for staff to refer to regarding safeguarding was out of date and did not meet the requirements of the Care Act 2014. This meant that robust systems and processes were not in place to protect people from harm and abuse.

The above evidence was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection a requirement action was set as robust recruitment checks were not always completed to ensure staff were safe to support people. At this inspection we found that steps had been taken and that the requirement action was met.

Staff files included evidence that references had been obtained and proof of identity, checks had been undertaken with regard to criminal records, eligibility to work in the United Kingdom and completed applications forms. Therefore, appropriate checks had been completed to ensure staff were safe to work with people.

The manager was able to explain her role and responsibilities in relation to safeguarding people from harm. As she had only recently been recruited she had not yet had the opportunity to share her knowledge with staff.

Personal emergency evacuation plans were in place for people which would help them move safely from the home if needed, in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

Staff said they had not been receiving sufficient support to understand their roles and to undertake their responsibilities. Care staff and nurses told us, and records confirmed they had not received a formal induction or supervision since November 2015. Only one nurse had received a supervision which was in February 2016. Nurses informed us that they had shadowed other staff at the start of their employment and familiarised themselves with records and procedures but they had not had structured support or clinical supervision. There had been no consistent clinical lead in post for over six months. There had been a clinical lead during December 2015 and January 2016 however the nurses informed us that even then they had not received any clinical supervision.

Some training had been provided to staff since our last inspection but this was not consistent. For example, two staff told us that they had not received or been offered Mental Capacity training. Nurses had completed medicine training since our last inspection and their competency had been assessed. However, medicine concerns identified during our inspection indicated that the training provided had not equipped them with the necessary skills in this area. They had also completed wound and pressure care training but again evidence from our inspection indicated shortfalls in practice. This meant that people received support from staff that did not have sufficient knowledge to care for people effectively.

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

A training programme was in place that included training for staff for the forthcoming year. This included training in equality and diversity, pressure care, food safety and health and safety. Since our last inspection training had also been provided to some staff in areas that included safeguarding, moving and handling, falls prevention and dementia awareness. Fire safety training was planned for the end of the month. The planning and provision of training would help equip staff with the skills and knowledge to support and care for people effectively. After our inspection we were sent documentary evidence by the registered provider that Mental Capacity training had been arranged for staff.

We checked whether the home was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The 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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager told us that no one who currently lived at the home was subject to a DoLS application or authorisation. We observed that some people who had a formal diagnosis of dementia had bedrails in place

which had the potential to restrict their movements. There were no individual assessments in place that included consideration of people's ability to consent to this equipment. Staff told us that decisions were made in people's best interests if they lacked capacity but again this was not recorded. This meant that people may have had their freedom of movement unnecessarily restricted without due consideration to their abilities to consent. This was not in line with the MCA Code of Conduct.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite formal consent processes not being followed in full, we did observe instances when staff checked that people were happy with the support being provided and attempted to gain their consent. For example, before undertaking personal care. We also observed that people were freely able to access other areas of the home or the gardens. The front door was unlocked and people could leave the home of their own free will.

Some staff had an understanding of the MCA. For example, one member of staff told us, "Always assume they have capacity unless evidenced that they do not. So if going to give personal care and they say no, unless structure in place for best interest you have to stop what you are doing. Or offer alternatives like someone else to support them to trying later."

Tissue viability support was not always in place when required. We saw that a referral had been made to the Tissue Viability Team by nurses at the home for one person. The nurses had sent the referral to the wrong department and management of the home had not identified this. We pointed this out during our inspection and gave the nurses the correct contact details so that the delay could be rectified. Action was taken to address this by the end of our inspection.

People expressed mixed views regarding the food provided at the home. Some people told us they enjoyed the food and that they were consulted about the menu. Other people said the food was okay or, "So, so". One person said, "My lunch was very nice today." Another person said, "The food is good here and I have no complaints."

People were able to eat their meals where they chose. Some people chose to eat their meals in the communal dining rooms whilst others preferred to eat their meals in their own rooms. We saw staff support people in the dining room who required help to eat. One person told us they did not want to go to the dining room and we saw a member of staff bring them a tray, and ensured they had a table at the correct height, with cutlery and a napkin before they left the room.

Lunch consisted of beef stew and dumplings, cabbage, green beans and potatoes, or vegetable ravioli. Desert was custard tart, fresh fruit, yogurt and cheese and biscuits. One person told us, "This was the worst meal I have ever had here. The dumplings were hard and the potatoes were uncooked." This person was offered an alternative meal of corned beef and mashed potatoes.

The atmosphere in the dining room was relaxed and people sat at well-laid dining tables in groups they were relaxed with. There was plenty of chatter throughout their meal. There was a choice of fruit juices and water and people were offered plenty of fluids with their lunch. The staff in the dining room at lunch time were aware of people's dietary needs and knew who was having special diets for example, diabetic, or soft.

In the main, people were supported to have access to health care professionals. They were registered with a GP who visited regularly. People also had access to chiropody, dental care, physiotherapy and a dietician. Palliative care was being offered to one person with the support of the Macmillan Nursing Team.

Requires Improvement

Is the service caring?

Our findings

Formal systems were not being used consistently to support people to be involved in making decisions about their care and support. Monthly residents/relatives meeting were held where people's views on aspects of the service and home were obtained such as activities. However, we found no evidence that people or their representatives had regular and formal involvement in care planning or risk assessment after the initial admission assessment stage. Consequently, there was no opportunity to alter the care plans if the person did not feel they reflected their care needs accurately.

One person and their relative told us that they had been involved in the planning of their care when first admitted to the home and it was agreed the person could have a daily bath. This did not happen. Their care plan was reviewed during January 2016 and again the person requested a daily bath which was still not happening. The person's relative visited during April and asked staff to bath their relative in the afternoon as they did not smell clean. On the first day of our inspection the relative told us, "I came in today and X (family member) is still wearing the same clothes for six days, this is not good enough." The person themselves also confirmed this. They also said that they would rather have a female carer to attend to their personal care but this was not possible due to the staffing levels and, "It's a matter of having to put up with it." This person was not treated with respect because they did not receive care and support in the way they wished.

Another person told us how staff levels impacted on their preferences. They told us, "Staff want us to go to bed by 8pm as most of them leave after supper." We discussed this further with the person concerned and they said it was not their choice to go to bed at this time but, "I have to. I don't want to be an inconvenience."

The above evidence meant that people were not receiving care and support that reflected their preferences and were not supported to be involved in make choices about their care. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people told us that the staff were kind and caring. One person said, "I love it here, it's marvellous. The care is good. The staff are wonderful." Another person told us, "The staff are superb; they are very kind and caring." A third person said, "The staff are all very good but are too busy it's not fair on them." A fourth person said, "Staff seem to do their best and are usually kind."

We were able to see from observations and from our short interactions with people that some people were content within the home and some people were not. We saw some staff treat people with kindness and respect. However we saw that on occasion's staff did not interact with people effectively or treat them with dignity and respect at all times. Staff were task orientated and did not show an ability to freely converse with people. People who resided on the top floor of the home had commodes in their rooms. People told us that staff did not offer them the opportunity to use the main toilet when they wanted to. This practice did not show respect for people.

Although we observed that staff appeared busy and rushed we saw no signs of deliberate impatience with

people. When people needed assistance with personal care we observed that staff did this behind closed doors in bedrooms and bathrooms. Attention to detail had been given with people's appearance with many ladies wearing items of jewellery that complemented their co-ordinated outfits and gentlemen were freshly shaved.

Care was given with kindness but it was clear that some people had to wait for too long for the help they required. Staff were able to explain how they treated people with dignity and respect and promoted privacy; however, they did say that staffing levels sometimes affected this. One explained, "If I have got time I go in every room and say hello, ask how they are. If I am too busy to respond to call bells I explain the reason why. When helping them I always ask if they want their door open or closed. If I say I will come back later I always make sure that happens."

Since being in post the manager had held a residents and relatives meeting to inform them of changes that had taken place at the home and to allow them the opportunity to share their views. People had commented on staffing and the manager had offered assurances that this would improve.

There were no restrictions when relatives or friends could visit the home. Relatives said they could visit whenever they wished and that they were made welcome by staff. One relative told us, "The staff are very welcoming to us as visitors. We are always welcomed with a smile and the offer of a cup of tea." People were able to stay with their loved ones during end of life care.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection a requirement action was set as we found that some people did not receive responsive care or support based on their individual needs. At this inspection we found that although initial action had been taken by the provider this had not been sustained and issues remained.

One person was seen by a GP on 4 April 2016 who directed staff to check the person's temperature every four hours. This was not carried out with only one check taking place on each of the two days following the GP visit. Another person's care plan stated that they needed to be assessed by an audiologist as their hearing had deteriorated. Arrangement for this to take place had not been made. A third person's records directed staff to encourage a person to stand for 10 seconds, two or three times a day. We checked the daily logs for this person and these did not evidence this had happened and we did not see staff support the person to do this during our inspection. This meant that people had not received care and support based on their individual needs.

One person was receiving palliative care and was being support by the Macmillan nurses who visited the home to manage pain relief using a syringe driver. The Macmillan nurses kept their own records for this. The person was being nursed in bed but there was no care plan for personal care, oral hygiene or continence management. There were no records or charts in place to demonstrate the frequency of when this person was repositioned, how their pressure areas care was being managed, and how their fluid intake was being monitored. Therefore, this person's needs were not being effectively assessed, planned for and managed.

Another person who was diabetic did not have a care plan in place or recorded actions for staff to follow in order to support the person to manage their diabetes. As a result staff did not have information to follow in order to consistently and effectively meet this person's needs.

The above evidence meant that people were not receiving responsive care and support. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people's records contained sufficient information to ensure they received responsive care and treatment. For example, one person had been admitted to the home from hospital with a pressure sore. We looked at this person's care plan and noted staff had photographed and documented evidence of the wound on admission to the home. Staff had involved external agencies, such as the person's GP and the NHS Tissue Viability Nurse at an early stage, had followed advice and guidance given and documented relevant information in the care plan.

For another person the home had involved the MacMillan Nurses to support someone who was reaching the end of their life. A McMillian Nurse visiting the home during our inspection told us that the home made prompt referrals to them when needed.

A third person was referred to a physiotherapist promptly for assessment after falling and provided with equipment to aid their mobility.

People expressed satisfaction with the range of activities available to them. One person said, "They are very good in that respect [providing activities]. The activities' people are brilliant. There are always things we can join in if we want to." A second person said, "When they do take place they are very good." On the first day of our inspection a quiz was supposed to take place but this did not occur. However a church service did take place during the afternoon.

An activity programme was in place that included a mixture of events provided by either external entertainers or one of the activity staff employed at the home. Activities included visiting musicians, hand massage and nail treatments, quizzes, crosswords and reminiscence activities. Information about forthcoming events was displayed on a notice board in order to make people aware of choices available to them. A newsletter also informed people as to what was occurring in the week ahead and also included photographs of previous activities.

Since our last inspection a mobile library had been introduced which we were informed had been well received by people.

People told us they would feel comfortable making a complaint if they needed to and were confident that any concerns they raised would be addressed. One person told us, "Standards are generally excellent but if I wasn't happy with something, I would certainly make a complaint." A copy of the providers complaints policy was on display in the home for people to refer to if they needed to. In addition to this a suggestions box was located at the entrance of the home in order that people could raise concerns or make suggestions for improvements at the home.

A record was in place of complaints received and included a record of actions taken to investigate the complaint and outcome. We noted that concerns had been raised in March 2016 by a person regarding staff levels and how these had impacted on the care people received. The manager had responded to the individual and offered assurances that the issues would be resolved. However, evidence from this inspection demonstrated that issues remained.

Inadequate

Is the service well-led?

Our findings

Changes in management had not been managed well and as a result there had been a decline in the quality of service people received. The manager had been in post since 21 March 2016. However during this time she had been on two days training and annual leave. As a result her knowledge of the service was limited. At the start of our inspection when asking about staff on duty and the needs of people who lived at the home the manager was unable to supply this information. The nurse on duty gave us information about people who lived at the home. For example, people with pressure areas or nursing needs. However, our inspection evidence found that this was not accurate and did not reflect the numbers of people with needs in these areas.

There was no designated clinical lead at the home and the evidence from our inspection demonstrated that there has been a lack of management oversight of clinical practices. We were informed that a clinical lead had been recruited and was due to commence employment at the home. Nurses employed at the home had not received clinical supervision and there had been a lack of support by the registered provider. One nurse told us they learnt new things from looking on the internet and that is how they had found different ways to manage dressings for wound care.

People said that it was too soon for them to give a view on the new manager. One person said they had, "Just met the new manager, and hope things improve." Regarding management of the home another person said, "It doesn't seem very well organised here at the moment". A member of staff said, "First impression she is determined to get things right. I am confident I could take issues to her if need be".

We spoke with the manager about steps that had been taken to meet the requirement actions set as a result of our previous inspection. She stated that she had only had a short handover with the outgoing manager. She stated she had looked at the previous manager's action plan from the last inspection and felt some actions had been achieved. The manager told us that since being in post she had completed some audits but that care plans were not up to date. She said, "I think you are going to find concerns, and quite a lot." The manager told us that she was confident of being able to make the required improvements and that she was, "An experienced manager and I have a good understanding of the new regulations".

Since our last inspection, in addition to the change of manager at the home there had been changes to the registered provider's senior management structure. These had not been managed well by the registered provider and as a result three of the four requirement actions had not been met and new concerns were identified at this inspection.

At our previous inspection concerns were identified regarding response times when people activated the call bell system. In response, the provider sent us an action plan that detailed steps that would be taken to make improvements in this area. At this inspection we found that improvements had been made in responding and auditing of call bell response times until the beginning of January 2016 when changes in the organisational structure took place. After this time there had been a decline and no further auditing had taken place. We looked at the call bell log for January and February. This detailed instances when call bells

had not been responded to for up to an hour. The manager told us that they had not had the chance to audit response times yet and the registered provider had undertaken any work in this area.

We also found this to be the same in relation to auditing and monitoring of accidents, incidents and falls. An analysis of events occurred on a monthly basis until the end of February with none having been completed since.

Where audits had been completed these were not always accurate. For example, medication audits had been completed by nurses at the home. These had not identified any concerns despite the concerns we and the chemist identifying during this inspection. We did note that one nurse had raised concerns about nurse levels and the impact on medication practices at the home during a supervision in February 2016. Nurse levels had not been reflected in any audit or taken forward as an area that might require further investigation.

The registered provider had sourced an external quality assurance consultant who visited the home and completed a detailed audit in February 2016. The report highlighted shortfalls in areas that included care planning and delivery, medicines management, staffing, training and support, quality assurance and management. An action plan detailed steps that should be taken with timescales for achievement. These had not been achieved. For example, care plans and risk assessments had not been updated despite the action plan stating this was completed week ending 4 March 2016. Medicines compliance had not been achieved despite the action plan stating this was completed week ending 18 March 2016.

At this inspection we found that there had been a deterioration in the quality of records maintained in the home. Records were not accurate, up to date or at times easily accessible. This included incomplete or inaccurate care records, staff rotas and staff training documentation.

There was a list of staff signatures in the front of the MAR folder which identified the staff authorised to undertake medicine administration. This needed to be updated as most of the signatures in place were for staff who no longer worked in the home.

We were unable to determine staff who had been on duty during the previous two months by looking at the staff rotas as these were not accurate. The manager told us that we would need to cross reference the rotas with staff timesheets to find out who was on duty. On the first day of inspection the staff rota did not reflect the people who were on duty at the home. We used the staff signing in book to determine this along with talking to staff and the manager.

A training matrix was in place which was used to monitor training undertaken and required. This was not up to date or accurate. A certificate of registration was on display in the home that contained the details of a manager who no longer worked at the home.

When giving feedback to the manager about our concerns she confirmed that she was already aware of these areas that required improvement.

The lack of robust and sustained auditing meant that effective systems and processes were not in place to assess, monitor and improve the quality and safety of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we gave feedback to the registered provider at the end of our inspection he assured us that steps would be taken to make the required improvements. Within 24 hours of our inspection we were supplied

with an action plan that described steps that had and would be taken. These included additional support for the manager from two external quality assurance consultants who had been sourced, further training for staff and a review of the staffing levels.

The changes in management and organisational structure had impacted on the morale of staff at the home. One member of staff said, "It's gone downhill slowly since I've been here. It's a nice care home; the residents get good treatment but delayed. Staff levels and training needs sorting. Staff have left and rumours are flying around." The new manager was aware of this and for the need to create a positive culture at MoorHouse Nursing Home but had yet to implement changes in this area. The manager said that she was supported by senior management and that she had regular contact with them via telephone. She told us that she had declined a formal induction by the registered provider as she felt confident to manage the home.

Since being in post the manager had held a meeting with staff so they were kept informed of events and changes at the home. A member of staff confirmed that the manager had spoken to them and informed staff she wanted their feedback on the service. This showed a commitment by the manager to involve staff and to use their views to drive improvements.

There were clear whistle blowing procedures in place which staff were aware of when we spoke with them. For example, one member of staff said, "You can share information with X (director). If you think things are not right you can report to other organisations such as CQC and social services." Information that guided staff how to report concerns and bad practice was displayed on the staff noticeboard so that information was easily accessible.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured people received care and treatment that was appropriate, meet their needs and reflected their preferences. They had not enabled and supported people to participate in making decisions about their care and treatment. 9(1)(a)(b)(c)(3)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered provider had not ensured care and treatment of people was provided with the consent of the relevant person. 11(1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured systems and processes were established and operated effectively to prevent abuse of people or to ensure restrictions on people's liberty of movement only occurred with lawful authority. 13(1)(2)(5)(7)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 18 HSCA RA Regulations 2014 Staffing

personal care Treatment of disease, disorder or injury	The registered provider had not ensured sufficient numbers of suitably, qualified, competent, skilled and experienced staff were deployed to meet people's needs. The registered provider had not ensured staff received appropriate support, training, professional development and supervision in order to enable them to carry out their duties. 18(1)(2)(a).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The registered provider had not ensure care and treatment was provided in a safe way to people. They had not assessed risks to the health and safety of people and done all that is reasonably practicable to mitigate any such risks. They had not ensured the safe and proper management of medicines. 12(1)(2)(a)(b)(g).

The enforcement action we took:

Warning notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The registered provider had not ensured systems and processes were operated effectively to assess, monitor and improve the quality and safety of services provided to people and to reduce risks. Records had not been maintained that were accurate and complete. 17(1)(2)(a)(b)(c)(d).

The enforcement action we took:

Warning notice