Mr & Mrs S Brown

Moorfield House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out this unannounced comprehensive inspection on 01 and 02 March 2017. This inspection was undertaken to ensure improvements that were required to meet legal requirements had been implemented by the service following our last inspection on 03 June 2016.

At the previous inspection improvements were required to ensure medicines were managed safely and this was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with regards to safe care and treatment. At this comprehensive inspection on 01 and 02 March 2017 we found improvements had been made to meet the relevant requirements previously identified at the inspection on 03 June 2016.

There was a registered manager in post. 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.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

People who used the service and their relatives told us they felt the service was safe. There were appropriate risk assessments in place with guidance on how to minimise risk.

We observed good interactions between staff and people who used the service during the day. People felt staff were kind and considerate.

Recruitment of staff was robust and there were sufficient staff to attend to people's needs.

Medication policies were appropriate, comprehensive and medicines were administered, stored, ordered and disposed of safely. Safeguarding policies were in place and staff had an understanding of the issues and procedures.

People's nutrition and hydration needs were met appropriately and they were given choices with regard to food and drinks. Staff responded and supported people with dementia care needs appropriately. Care plans included appropriate personal and health information and were up to date.

People's health needs were responded to promptly and professionals contacted appropriately. Records included information about people's likes and dislikes and we observed that people had choices, for example, about when to get up, what to do and when and where to eat.

Staff were caring and kind with the people they supported. Throughout the inspection we observed staff

members to be kind, patient and caring whilst delivering care.

People and relatives told us they were involved in making decisions about their care and were listened to by the service.

We saw people being treated with kindness and respect and when support was provided, such as supporting people eating their lunch time meal.

We found the service aimed to embed equality and human rights through well-developed person-centred care planning which ensured that each person had a person-centred plan in their care files.

People were involved in developing their care plan and sensitive information was being handled carefully.

The service had a service user's handbook called Moorfield House Service User Guide which was given to each person who used the service in addition to the Statement of Purpose.

The service followed the Six Steps programme in end of life care and were supported by relevant community professionals.

People who used the service and their relatives spoke positively about how the service was managed.

Staff told us they felt there was an open, transparent and supportive culture within the home and would have no hesitation in approaching the manager about any concerns.

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards.

There was a business continuity plan in place that identified actions to be taken in the event of an unforeseen event.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff.

Residents and relatives meetings were undertaken approximately every three months and comments from people who used the service were positive.

The service worked alongside other professionals and agencies in order to meet people's care requirements where required.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People who used the service, their relatives and professionals told us they felt the service was safe.

There were appropriate risk assessments in place with guidance on how to minimise risk. Safeguarding policies were in place and staff had an
understanding of the issues and procedures.

Recruitment of staff was robust and there were sufficient staff to attend to people's needs.

Is the service effective?

Good

The service was effective.

People's nutrition and hydration needs were met appropriately and they were given a choice of food at meal times.

Care plans included appropriate personal and health information and were up to date.

The home worked within the legal requirements of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS).

Is the service caring?

Good

The service was caring.

People who used the service and their relatives told us the staff were caring and kind.

Staff interacted with people in a kind and considerate manner, ensuring people's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive.

People's care plans were person centred and contained information about their preferences and wishes.

There was an appropriate complaints procedure and complaints were
followed up appropriately.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in post.

People told us the management were approachable and supportive. Staff supervisions and appraisals were undertaken regularly.

A number of audits were carried out where issues were identified and action was taken.

Moorfield House

Detailed findings

Background to this inspection

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

This inspection took place on 01 and 02 March 2017and was unannounced. The inspection was undertaken by one adult social care inspector.

Before the inspection, we reviewed all the information we held about the home. We reviewed statutory notifications and safeguarding referrals. We also reviewed the action taken by the provider following our previous inspection, who wrote to us explaining what action the service had taken to meet legal requirements.

We looked at records held by the service, including policies and procedures, staffing rotas, four medication administration records (MAR) five care files and four staff personnel files.

At the time of the inspection there were 28 people using the service. During the inspection we spoke with the registered manager, the deputy manager, six care staff, three people who used the service, four visiting relatives and two visiting healthcare professionals.

We observed care within the home throughout the day including the lunch time medicines round and the breakfast and lunchtime meal. We walked around the premises and looked in various rooms. We also reviewed previous inspection reports and other information we held about the service.

Good

Is the service safe?

Our findings

People we spoke with living at Moorfield House and their relatives told us they felt the service was safe. One relative said, "[My relative] is totally safe here and I've never had any concerns." A second relative told us, "[My relative] feels safe and I feel they're safe; I've never had any issues with staff and never witnessed any abusive treatment of anyone living here." A third relative commented, "I feel [my relative] is absolutely safe and my stress levels have gone down since they've been living here."

A person who used the service told us, "I feel safe with all the staff; I end up making them laugh and we have a great time, " A second person said, "I feel safe living here; the environment is good and we have a joke now and again."

At our previous focussed inspection on 03 June 2016 we identified a continuing breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the safe management of medication. At this inspection we found the service had taken remedial action to rectify the issues we found and was now meeting the requirements of this regulation.

We observed the lunch time medicines round. We saw the staff member checked each person's medicine administration chart (MAR) before administering each medicine to ensure they were administering it correctly. The medicines round was not rushed or interrupted and when the medicine had been administered the staff member completed the MAR chart as required before moving on to the next medicine.

There was a medicines policy in place that included a range of guidance on self-medication; ordering, storing and disposing of medicines; PRN medication (which is medication taken as and when required); homely remedies; controlled drugs (CD); guidance on transfer and discharge; medication errors; safe disposal of medication; and arrangements for when people were going out of the home; covert medicines. A covert medicine is medication given without the person's knowledge when they are unable to make an informed decision and the medication is given in their best interests.

The systems for medicines management were robust and only trained staff were allowed to administer medication. Staff competency assessments in the administration of medicines had been undertaken which included a direct observation of practice. Medicines were stored safely, in two locked medicines trollies and these were chained securely to a wall. There was a lockable cupboard for controlled drugs which were in a lockable room. We checked the stock of controlled drugs for three people and found these to be correct and corresponded with entries in the controlled drugs register, which had two signatures from staff as required.

Body maps were in place for the administration of creams, which identified the areas of the body that required application of creams. At the time of the inspection no medicines were required to be stored in the fridge. A new fridge was being ordered and shortly after the date of the inspection the service informed us that the new medicines fridge was in place.

MAR charts had a photograph of the person attached to them which would help to ensure medicines were given to the right person. 'As required' (PRN) medicines were recorded correctly with times of administration on each person's individual MAR. Regular checks were made of staff competence with regard to medicines administration to ensure they continued to be able to administer medicines safely.

There was a safeguarding policy in place, which referenced legislation and local protocols. This was last reviewed in October 2016. The policy included details of the local authority safeguarding process, including contact numbers and also contact details for CQC. We spoke with care staff who demonstrated an awareness of safeguarding and were able to describe how they would make a safeguarding referral.

One staff member told us, "Abuse could be physical such as bruising or it could be through neglect or financial matters. I've done the training for this and would first speak to my manager but we also have other contact numbers like the local authority if need be." A second staff member said, "Safeguarding is about protecting people. If I thought a safeguarding alert was needed I would tell my manager first or if they weren't available I would tell the local authority; we have a process for this."

The home had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take of they had any concerns or if they had concerns about the manager and this included contact details for the whistleblowing helpline, the local authority, the NHS and the Care Quality Commission. Staff we spoke with had a good understanding of the actions to take if they had any concerns and told us they would contact the proprietor, the local authority or CQC.

We saw people had risk assessments in their care plans in relation to areas including falls, nutrition, moving and handling, pressure sores, continence. We looked at how the service managed accidents and incidents. There was an appropriate up to date accident/incident policy in place and addition to a serious injury notification policy. Accident/incident forms were completed correctly and included the action taken to resolve the issue and the corresponding statutory notification form required to be sent to the Care Quality Commission.

There was appropriate information regarding the maintenance of the premises. We looked at a building maintenance file, which included information about the maintenance, servicing and testing of the lift, hoisting equipment and fire equipment. All the records were complete and up to date. Up to date gas, electrical and legionella certificates were in place. There was a fire risk assessment and a fire policy and procedure in place. Care files included an initial assessment and a bedroom assessment to help ensure people's safety.

Fire call points were tested regularly and we saw there were monthly emergency lighting and fire door tests and weekly fire alarm tests. Fire drills were undertaken and there were personal emergency evacuation plans (PEEPS) for each person who used the service which identified their level of dependency and what assistance was required in the event of an evacuation of the building. Staff were also formally observed by the manager to ensure their competency in emergency evacuation situations. This would help ensure people received the required level of assistance in the event of any emergency

Building cleaning schedules were in place and these identified tasks to be carried out in various areas of the home. The cleaning schedule ensured that all bedrooms received a regular deep clean which would assist with reducing the potential for the spread of infections. Bathrooms and toilets were cleaned daily. Records regarding cleaning were completed and up to date.

Liquid soap and paper towels were provided in each of the toilets/bathrooms. There was instruction on

appropriate hand washing techniques which helped to minimise the risk of cross infection within the home. The premises were clean and tidy and there were no malodours in any areas. The service had achieved a score of 98% compliance following an external inspection carried out by Salford city council in October 2016.

Equipment, such as pressure mats which alert staff when someone has got out of bed, were in place to help keep people safe and these were identified in people's care plans.

Staffing levels were sufficient on the day of the inspection to meet the needs of the people who used the service. We looked at the staff rotas for February 2017 and these consistently demonstrated that there were sufficient care staff on duty to meet the needs of people using the service. There were four health care assistants (HCA's) on duty between 8.00am and 3.00pm, four HCA's between the hours of 3.00pm and 10.00pm plus one HCA on duty 3.00pm to 10.00pm. During the night three HCA's were on duty between 10.00pm and 8.00am. Each shift had a senior care staff member on duty and these were supported by the registered manager, domestic and kitchen staff.

When determining the level of staff required to meet people's needs the service took into account people's needs and their dependency level, using a formal dependency level tool which identified if people were independent or if they needed minimal, moderate or full staff assistance for various tasks such as washing/dressing/mobilising. The tool also took into account if the person was living with a dementia. A person who used the service told us, "There's generally enough staff on duty and I don't have to wait for long if I call them. I feel safe here and the environment is good."

We looked at four staff personnel files and there was evidence of robust recruitment procedures. The files included written application forms, an equal opportunities form, a medical history questionnaire, proof of identity and at least two references. There were Disclosure and Barring Service (DBS) checks undertaken for staff in the files we looked at. A DBS check helps a service to ensure the applicant's suitability to work with vulnerable people. This showed us staff were recruited safely.

Good

Is the service effective?

Our findings

A visiting healthcare professional told us, "The manager and deputy manager are always willing to engage and work with us. If there are any problems they always inform us and are on top of things in my opinion."

A visiting relative said, "It's such a nice place; we can speak to any staff at any time and we know things will be sorted. Communication is excellent and I feel I can come in anytime to the office; the district nurses are here regularly." Another relative commented, "All my questions have been answered by the service. Once [my relative] was becoming very anxious so the service called me and asked if I could visit. Later on the same day in the evening they called me back with an update and this was very reassuring to me." A third relative told us, "Staff are very knowledgeable about [my relative's] needs. It's like [my relative] is in the middle and all the staff are surrounding and supporting her."

A person who used the service told us, "Staff will do anything for me like tonight when I want to go to be they'll get my wheelchair and help me upstairs; I can go to bed and get up when I want each day. The food is great and there's two or three choices every day." A second person said, "My room is clean and the food is great; I have a good appetite and enjoy my food; I sleep very well."

We looked at the process of staff recruitment. Newly recruited staff followed a four week formal induction programme and undertook a range of basic mandatory training and were required to read and sign certain policies prior to starting their employment. An induction checklist booklet was completed for each new staff member and this was carried out until the staff member was deemed competent.

One staff member told us, "I had an induction when I first started and shadowed another member of staff for about a week and was assessed by the manager after this. I felt competent after the induction but I knew I could always go and ask somebody if I wasn't sure about something. I've done training in moving and handling, medicines, food hygiene and the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA/DoLS). I feel I'm getting the training I need and I've also done NVQ level two and three." A second staff member commented, "I've been here quite a few years but I remember having an induction at the start and doing some shadowing with other staff. I also had my own practice observed by the manager. We get a lot of training here, some of it is on-line and some is face-to-face practical like moving and handling."

We looked at staff training records which included details of training previously undertaken and dates for when training was due for renewal. For example 96% of all staff groups had competed moving and handling training, with 92% of all care staff having completed training in medication administration. 96% of all staff had completed hand washing training, 76% in basic food hygiene, 83% in continence care, 83% in communication, 70% in dementia care, 85% in safeguarding and 81% in first aid.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as

possible.
People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The MCA/DoLS require providers to submit applications to a 'supervisory body' for authority to do so and we saw that the service had made the appropriate applications as required.

There was a DoLS file in place which identified a range of information for each person including the person's name, the date the authorisation had been requested, the date of the local authority social worker best interest assessment, the date the DoLS was authorised, the date an assessment was undertaken with the person's doctor and if an advanced decision was in place.

There were appropriate MCA assessments in place, which were linked to screening tools, restrictive practice tools and applications for DoLS where the indication was that this was required. These were up to date and reviewed regularly to capture any changes in the person's capacity. We also saw that the conditions relating to DoLS authorisations related to what was recorded within the care plans about people's support. Appropriate supporting policies and procedures were in place, for example, the service had a policy on physical restraint.

A relative told us, "[My relative] has a DoLS in place and I was involved in discussions about this with the doctor, the social worker and the service. I feel the home is acting in [my relative's] best interests and I get contacted if there are any issues which is reassuring."

We checked whether the provider had properly trained and prepared their staff in understanding the requirements of the Mental Capacity Act in general, and (where relevant) the specific requirements of the DoLS and found that only 43% of all staff groups had undertaken this training. However we saw that additional training dates had been identified for June, August, October and November 2017 which would result in all staff having received this training.

Staff received regular supervision from their line manager in addition to an annual appraisal, and the documentation within staff files confirmed this. There was a supervision planner in place. One staff member said, "We get regular supervisions and I've just had one; they're very useful and we get a record of what was discussed and we check this before signing and agreeing to it." A second staff member told us, "I get regular supervision and had one last month; I sign to agree the minutes of what was said afterwards and I get good feedback about the things I do."

We looked in the kitchen and saw that it was clean. The fridges, freezers and cupboards were well stocked with food. There were plenty of frozen and tinned provisions as well as dry goods, fresh food and fruit.

People were eating breakfast when we arrived which was a choice of cereal, porridge, toast and jam or marmalade, and there also a cooked option available if requested. We saw snacks and drinks were offered throughout the day. There was a food hygiene policy and we saw that staff had completed training in food hygiene. There was a four week rolling menu which was posted on the wall of the dining room.

In the morning we saw the chef explaining to people what was for lunch and asking what they would like for lunch. At the lunchtime meal there was a relaxed unrushed atmosphere and we saw that staff interacted

with people in a respectful and dignified manner and encouraging their engagement. There was discussion and laughter between people who were dining. Staff provided assistance to people who required it and spoke politely to people confirming with them what they wanted to eat and drink before serving it.

Information on special diets was posted in the kitchen and there was also guidance around high calorie food for those who required extra calories. We saw evidence of diet and fluid charts for people who required monitoring in these areas, which were complete and up to date.

Information was available to staff which identified those people who could not have their breakfast until they had taken their alendronic acid medicine, once each week. This medicine must be taken on an empty stomach as food and drink can greatly reduce its effectiveness. A visiting relative told us, "[My relative] is on a special diet and she eats very well; sometimes we come in and help out at meal times. Even if [my relative] has a minor tummy upset the service will communicate it to me and I'm actively involved in care planning." A second relative commented, "I've looked at the menu and the food and there's lots of choices each day. I've seen the cook going round and asking people each day what they want and [my relative] says the food is fabulous."

We heard staff seeking verbal consent from people for all support provided, for example when moving between rooms. This ensured that people were happy with the care being offered before it was provided.

We found there were people living at Moorfield House who were living with dementia. We saw staff responded and supported people with dementia care needs appropriately. We saw people's bedroom doors had their photo and room number on it which would assist some people to orientate to their room. There was signage throughout the home identifying different areas such as the dining room and bathrooms/toilets which would assist some people to orientate around the building.

Different areas/units of the building had been given different names, for example one unit was called 'Ruby Road' and another was called 'Emerald Avenue.' These names had been chosen by people who used the service and each unit was decorated in different colours which would assist with recognition and orientation. There was a secure and pleasant garden area with a variety of different seating types to suit different needs and a seated conservatory area.

There were assisted bathrooms and walk-in showers which were easily accessible by anyone with mobility problems. Some toilets had frames on them which would assist some people to use the facility independently or in a safe manner.

People's health needs were recorded in their files and this included evidence of professional involvement such as GPs, podiatrists or opticians where appropriate. Relatives we spoke with told us they were kept informed of all events and incidents and that professionals were called when required.

Care files included appropriate health and personal information and appropriate risk assessments were in place and were up to date. People's health requirements and allergies were recorded and there was a dependency profile to assess the level of assistance required by each person who used the service. This was updated monthly to ensure recording of people's support needs was current. We saw evidence of professional visits and appointments.

Consent forms were kept within people's files, including consent to care and treatment and consent to have photographs taken and used. Within the care files we looked at there was evidence of appropriate and timely referrals to relevant professionals including opticians, chiropodists and doctors.

Good

Is the service caring?

Our findings

Staff were caring and kind with the people they supported. It was clear that staff knew the people they were supporting and had developed good relationships. We saw people smiling and enjoying the interaction that took place. We saw many instances where staff took the time to speak to people and enquire about their welfare or inform them of what was going on.

One relative told us, "Staff are really lovely and caring; they look after [my relative] really well; medicines are given correctly and nurses are called for when needed. I hear the way staff speak to people and they're always cheering people up and encouraging them to do things." A second relative said, "The staff here are really good, whenever you ask something they are wonderful and have the right attitude. Staff promote people's independence through encouragement and are building up a rapport with [my relative] and she can get in the bath now which she wasn't doing before she came here." A person who used the service told us, "It's very good here; staff work hard and are very respectful and we have a laugh and a joke together."

Throughout the inspection we observed staff members to be kind, patient and caring whilst delivering care. The home had a privacy and dignity policy in addition to policies on equality and diversity, supporting independence and anti-bullying. Staff were aware of these policies and how to follow them.

We asked staff how they ensured people's dignity was respected when delivering care, one staff member said, "If I was providing support for personal care I would first ask the person what they wanted and tell them what I was going to do, then I would shut the curtains and make sure the door is closed and secure and cover up any parts of the body not being washed." A second staff member told us, "When giving personal care I would close the door and curtains and talk with the person about what I was doing. It's important to take your time and don't rush things."

People and relatives told us they were involved in making decisions about their care and were listened to by the service. They told us they had been involved in determining the care they needed and had been consulted and involved when reviews of care had taken place. One relative told us, "I was involved in the initial assessment with the home, the social worker and the doctor. At first [my relative] came in for respite care but as their needs changed another assessment was done and a permanent placement was needed. I also got a service guide and statement of purpose at the beginning so I knew about the home." A second relative said, "I'm really involved in all aspects of care planning. I looked at other places and settled on this one. I've got a statement of purpose and a service user guide. I've made some suggestions to the manager about activities and they have taken these on board."

We saw people being treated with kindness and respect and when support was provided, such as supporting people eating their lunch time meal, this was done with sensitivity and compassion.
Staff appeared to know people well and there was a friendly atmosphere between staff and people living at the home. We observed laughing and joking between staff and people during a pampering activity session that took place during our visit. It was apparent the people involved in the activity were enjoying themselves. The sessions also included the option of seeing the hairdresser in the hairdressing salon and we saw several

people had their hair done on the day of the inspection.

During our inspection we looked to see how the service promoted equality, recognised diversity, and protected people's human rights. We found the service aimed to embed equality and human rights through well-developed person-centred care planning which ensured that each person had a person-centred plan in their care files. Support planning documentation used by the service enabled staff to capture information to ensure people from different cultural groups received the appropriate help and support they needed to lead fulfilling lives and meet their individual and cultural needs.

People were involved in developing their care plan. One person told us, "I'm involved in my care plan and I've had some professional visits to test my memory. Staff know what they are doing and are very competent."

People's sensitive information was being handled carefully. We saw that the provider had secure electronic systems for the storage of people's care records and we saw staff making sure that people's information was protected by 'locking' the computer or iPad they were using after they had entered a record. We heard staff share information about people in a discreet and sensitive way so that conversations were not overheard by others. We also saw that the provider had made confidentiality and data protection policies available to staff. This meant that people's privacy was being protected by a provider who had suitable procedures and by staff who knew about these.

We found that most people were receiving support from a small number of regular staff members. This enabled the development of positive long-standing and trusting relationships between people who used the service and the staff who supported them.

The service had a service user's handbook called Moorfield House Service User Guide which was given to each person who used the service in addition to the Statement of Purpose, which is a document that includes a standard required set of information about a service. These documents provided a wide range of information such as the care philosophy; principles and values that the service followed; the standards of care that people should expect; details of the registered manager and nominated individual; a description of the services and facilities provided; how to make a complaint, confidentiality and dignity and respect.

We spoke with the manager about how people were supported at the end of life. They told us the home endeavoured to support people according to their individual wishes and those of their family where appropriate. Where people did not wish to discuss end of life care, this was recorded in their care files and individual care plans were used to ensure people's wishes and needs were recorded and available to staff caring for them. The service followed the Six Steps programme in end of life care and were supported by relevant community professionals. We spoke with a visiting end of life care professional and they told us, "I've previously attended a meeting with relatives to discuss end of life care provision. Staff here are very skilled and up to date with end of life care and staff champions have been trained. The home is very good at identifying and planning for changing needs and getting the relevant professionals together." At the time of the inspection no person was in receipt of end of life care.

Good

Is the service responsive?

Our findings

A visiting relative told us, "I have information on how to make a complaint but I've never had to make one in the past. I've seen art classes, bingo and visiting singers when I've visited." A person who used the service said, "I was poorly when I first came here but the girls (staff) have got me going again and I'm better off here. I love doing activities and I've done some painting today and been to the hairdresser. I know how to make a complaint but I would just go to the office because it's always open." A second person commented, "There's an activity room that I can do art in or make baskets. We had a Christmas concert and there's bingo and dancing and singing and other activities going on." A third person told us, "We have a joke now and again and they have helped me to stand and walk again with my Zimmer so I feel a lot better now; the staff know what they are doing."

We looked at a sample of five care files of people who used the service. These were largely stored in electronic format on a system called CareDocs. CareDocs is computer-based care planning and home management system for residential and nursing homes, designed by care home owners. We found these records to be of a good standard and were easy to follow and included information on people's background and histories likes and dislikes. There were five iPads and three computers available for staff on duty to input information, which meant that every care staff member could instantly input information onto the electronic system rather than doing this later on in the day, which we observed staff doing during the course of the inspection. New Wi-Fi access points were being installed to ensure that a signal could be received in any part of the building, and this was completed during the inspection.

People who used the service had a care plan that was personal to them. This provided staff with guidance around how to meet their needs and what kinds of tasks they needed to perform when providing care. We found care plans included detail of whether people required support in making decisions, cognitive capacity, and whether a DoLS was in place. We saw that people's wishes were adhered to, for example, where they wished to take their meals and times of rising and retiring to or from bed.
Care plans were comprehensive and person centred and provided clear instructions to staff of the level of care and support required for each person. For example one care plan stated '[Person] needs assistance of one staff member with washing and dressing, she needs help with zips and fasteners,' and another stated [Person] requires two pillows at night.' This showed that the service took into account different people's individual needs and preferences.

Care plans also provided clear instructions on a number of areas including medication, personal care, continence needs, skin integrity, spirituality and sensory impairment and were regularly reviewed by the service.

Some people were still in bed when we arrived at the home and we saw that they got up at a time of their choice. We saw that people's choices about times of getting up and going to bed were recorded within their care files. All the people living at Moorfield House were dressed well and well-presented.

We looked at how complaints were managed. There was a complaints policy and procedure in place which

had contact numbers for CQC and the local authority and a copy was available in the entrance lobby to the home. People told us they had never had reason to make a complaint but would feel confident in doing so. We saw evidence within the complaints log that complaints had been followed up appropriately and in a timely manner. People who used the service and their relatives told us that they knew what to do if they had a complaint.

People were able to personalise their own room and were encouraged to bring personal family photographs and items relevant to the individual. People could use their own bedding if requested. We saw that rooms were personalised and all were clean and fresh.

During our inspection, we checked to see how people were supported with interests and social activities. We saw that people were involved in group activities and other individual activities that took place during our visit. There was an activities display board in the reception area that had photographs of activities previously undertaken. People's recreational interests were recorded in their care plans, for example one person who had previously been a typist in a former employment had been offered the use of a computer in order to maintain keyboard skills.

The service received support from Salford Community Volunteer Service and during the inspection we observed three accredited volunteers providing activities for people alongside care staff, including art and crafts, nail painting and pampering. This facilitated connection with the wider community. We spoke with two volunteers about the type of support they provided and one volunteer said, "When we first started the art class many people struggled with using pens and pencils but now people are doing really well. We also do bingo, quizzes, listen to music and recently made some pompons. We use old books and photographs as people like to talk about the past." A second volunteer said, "We got a certificate from the local authority to show we are trained and accredited volunteers and had to get this before we could do anything."

Good

Is the service well-led?

Our findings

People who used the service and their relatives spoke positively about how the service was managed. One relative told us, "Things have improved recently and I've attended meetings with families and friends and found these to be useful. The manager seems very busy and is always around and I have no concerns." A second relative commented, "I regularly get invited to meetings but can't always make them. If I can't go I get the notes of the meeting afterwards."

There was a registered manager in post. 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.

Staff told us they felt there was an open, transparent and supportive culture within the home and would have no hesitation in approaching the manager about any concerns. One staff member said, "The atmosphere is great here, I feel supported and would definitely be listened to if I raised an issue. We work very well as a staff team and I'm really happy here. We have staff meetings about every three months or so." A second staff member told us, "Things have got better since the new deputy manager has been in post. She has a new set of eyes and could see things we couldn't see. I feel I would be listened to if I asked for anything." A third staff member commented, "The managers are very fair and I've no problems there. Things are changing for the better, the managers suggest things then we trial them out and then give feedback. I feel I'm always listened to. The deputy manager once worked a night shift to see what things were like and from this we changed a process so that in the morning when people get up they must be offered a drink and something to eat straight away unless there is a reason why they couldn't."

The service undertook a range of audits of the service to ensure different aspects of the service were meeting the required standards. These included audits of medication, care plans, falls, hospital admissions and discharge, infection control, the environment, staff supervision, hand hygiene, equipment, staff meetings and resident meetings and training. A falls register analysis was completed including the action taken to reduce repeat incidents. Regular testing of fire safety equipment and alarms was undertaken together with fire drills. Regular reviews of care plans and risk assessments were also undertaken and a daily walk-around of the premises was completed by the manager or deputy manager.

There was a business continuity plan in place that identified actions to be taken in the event of an unforeseen event such as the loss of utilities supplies, catering disruption, flood and lift breakdown.

Staff had access to a wide range of policies and procedures. These included medication, nutrition, moving and handling, safeguarding, health and safety and infection control. These could be easily accessed and viewed by staff if they ever needed to seek advice or guidance in a particular area.

Throughout the course of the inspection we saw the registered manager walking around and observing and supporting staff. This meant that they were immediately aware of updates to people's circumstances. We

saw that the registered manager was very visible within the home and actively involved in the provision of care and support to people living at Moorfield House. A staff member commented, "The registered manager is great; she's always accessible and provides me with the support I need."

Staff told us that the deputy manager ensured they attended both the morning shift handover and the evening shift handover on different days of the week. This would assist management to keep in regular contact with staff members who could have already left their shift or not started their shift during the course of normal 'office' hours.

Residents and relatives meetings were undertaken approximately every three months. We looked at the minutes of the previous two meetings and saw that discussions included fund raising, a vintage tea party, DoLS issues, advanced care planning, activities and trips out, the remit of the Care Quality Commission and building redecoration.

People and their relatives told us they were aware of these meetings in advance and attended when possible or if they wished to. A visiting relative told us they had made suggestions about certain types of knitted bags and cuffs which they felt would be suitable for some people living with a dementia who were particularly tactile and who had been observed to regularly fold items of clothing and we saw that this had been recorded in the notes of the relatives meeting.

We looked at feedback comments that the service had previously received from satisfaction surveys given to people who used the service or sent to relatives. Comments from people who used the service included, 'very homely atmosphere,' and 'I'm always asked about what I want to do,' and 'staff are very much respectful.' Comments from relatives included, 'would recommend Moorfield House to anyone,' and 'I have found management to be happy and accommodating of people's needs; staff have been helpful when required, with a smile.'

Feedback was also sought from volunteers and included, 'I have been working at Moorfield House for over nine years now and I am very comfortable as a mobile hairdresser. Staff are very helpful when and if needed and they take good care of people. The managers are also good and caring people.'

The home submitted statutory notifications to CQC as required. Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications.

The service worked alongside other professionals and agencies in order to meet people's care requirements where required. Involvement with these services was recorded in care plans and included opticians, chiropodists, district nurses, psychiatrists and doctors.