Moreland House Care Home Limited

Moreland House Care Home

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This unannounced inspection took place over two days on 6 and 7 September 2017.

Moreland House is a purpose built 50 bed care home providing accommodation and nursing care for older people, including people living with dementia. The service is accessible throughout for people with mobility difficulties and has specialist equipment to support those who need it. For example, hoists and adapted baths are available. When we visited 45 people were using the service.

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

At the last inspection on 7and 8 September 2016, we found one breach of the Health and Social Care Act 2014. Medicines were not safely managed and we asked the provider to take action to make improvements to ensure that people who received their medicines without their knowing (covertly) or who had their medicines crushed were appropriately managed. The provider sent us an action plan detailing the action they were taking to meet these requirements. At this inspection we found that the actions had been completed and that people who received their medicines without their knowing (covertly) or who had their medicines crushed were now appropriately managed. People received their medicines safely.

Staff knew people and their needs well but some care plans were not sufficiently detailed or person centred. This was an area of ongoing development.

An activities worker was employed and social and recreational activities and events were available.

Systems were in place to safeguard people from abuse and staff were aware of how to identify and report any concerns about people's safety and welfare.

Staff received the training and support they needed to carry out their duties. They provided people with the support they needed and wanted.

People were supported to receive the healthcare that they needed. They told us they felt safe at Moreland House and were supported by kind and caring staff.

We saw that staff supported people patiently, with care and encouraged them to do things for themselves. Staff provided care in a respectful way that promoted people's dignity.

The provider's recruitment process ensured staff were suitable to work with people who needed support.

Systems were in place to ensure that equipment was safe to use and fit for purpose. People lived in a clean, safe environment that was suitable for their needs.

Complaints were taken seriously and action was taken to address any concerns.

Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People's nutritional needs were met and if there were concerns about their eating, drinking or their weight, this was discussed with the GP. Support and advice were sought from the relevant healthcare professional, for example, a dietitian.

Staff provided caring support to people at the end of their life and to their families. This was in conjunction with the GP and the local hospice.

The provider had systems in place to monitor the service provided and people were asked for their feedback about the quality of service provided.

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 received their prescribed medicines safely.

Risks were identified and systems put in place to minimise risk in order to ensure that people were supported as safely as possible.

Staff were trained to identify and report any concerns about abuse and neglect. They felt able to do this.

There were sufficient numbers of staff on duty to meet people's needs.

The provider's recruitment process ensured that staff were suitable to work with people who need support.

Is the service effective?

Good

The service was effective. People were provided with a choice of food and drink. They were kindly encouraged and supported to eat and drink.

Systems were in place to ensure that people received care and support in line with the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The staff team had the training they needed to ensure that they supported people safely and competently.

People's healthcare needs were identified and monitored and referrals made to other healthcare professionals when needed.

Is the service caring?

Good

The service was caring. People were treated with kindness and their privacy and dignity were respected.

Staff supported people in a kind and gentle manner and responded to them in a friendly and patient way.

Staff provided caring support to people at the end of their life.

Is the service responsive?

Requires Improvement

Not all aspects of the care provided were responsive. Not all care plans were detailed or personalised.

Activities and entertainment were available and an activity worker was in post to support this.

Complaints were taken on board and any required action taken.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for.

Is the service well-led?

Good

The service was well-led. Systems were in place to monitor the quality of service provided. Actions identified were recorded and followed.

Staff told us that the manager was accessible and approachable and that they felt well supported.

People were consulted about changes to the service and the provider sought their feedback on the quality of service provided. Their comments were listened to and addressed.

Moreland House Care 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 unannounced inspection took place on 6 and 7 September 2016. The inspection team consisted of one inspector, a specialist nurse advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Before our inspection, we received feedback from the local authority quality monitoring team. We also reviewed the information we held about the service. This included notifications of incidents that the provider had sent us since the last inspection.

During our inspection, we spent time observing care and support provided to people in the communal areas of the service. We spoke with ten people who used the service, the registered manager, the provider, six members of staff, six relatives and a health care professional. We looked at eight people's care records and other records relating to the management of the service. This included four staff recruitment records, staff rotas, accident and incidents, complaints, health and safety, maintenance, quality monitoring and medicines records.

Good

Is the service safe?

Our findings

People told us Moreland House was a safe place to live. Comments included, "I do feel very safe here, yes," "Yes I feel safe because of the staff around me" and "Yes I feel safe. There is always other people around, they are really good carers." In a thank you letter a relative had written, "We felt we could trust you to take care of [family member] and we were not disappointed."

At the last inspection on 7 and 8 September 2016 we found the systems in place to ensure people received their prescribed medicines safely and appropriately were not robust. During this inspection we found improvements had been made and that people received their prescribed medicines safely.

Some people needed to have their medicines without their knowledge (covertly). At the last inspection, we found that the process for doing this was not appropriately managed. At this inspection, we found that this was no longer the case. 'Covert Medication Care Pathway' documentation had been introduced and completed when necessary. These showed that meetings had taken place between care home staff, the health professional prescribing the medicine(s), the pharmacist and a family member to agree that administering medicines covertly was in the person's best interest. For some medicines, the pharmacist had signed that they could be crushed and for others liquid alternatives had been prescribed.

Individual guidelines were in place for the administration of 'when required' (PRN) medicines. These had been updated since the last inspection to include the necessary information to ensure people received these medicines appropriately and effectively.

We saw medicines were safely and securely stored in appropriate locked medicines trolleys in the nurse stations on each of the three units. The people responsible for the administration of medicines kept the keys with them during their shift. When not in use, medicines trolleys were secured to the wall. Controlled drugs (CD) were stored safely and securely in an appropriate CD cupboard. Medicines requiring cold storage were kept within a locked fridge in the treatment room. Minimum and maximum temperatures of the medicines fridge were checked and logged every day, providing evidence that these medicines were kept at safe temperatures to remain effective. However, in some units, the treatment rooms were very warm and the provider was looking into how this could be addressed to ensure that all medicines were stored at appropriate temperatures.

Staff who administered medicines had received medicines training and been assessed as competent to do this. Medicines training and competency assessments took place before staff began to administer medicines and then yearly. Appropriate arrangements were in place in relation to the recording of medicines. Medication Administration Record (MAR) charts were appropriately completed and were easy to follow. They included people's photographs to check that medicines were given to the correct person. People's allergies were also indicated where required. In line with good practice opening dates were recorded on liquid medicines, drops and creams to ensure that they were not used after the expiry period from the date of opening.

Systems were in place to safeguard people from abuse. Staff were aware of different types of abuse and knew what to do if they suspected or saw any signs of abuse or neglect. They told us they had received safeguarding adults training and felt confident to report poor practice. The provider had notified us about safeguarding incidents and had worked with the local authority and taken action to make sure people living at the service were protected from risk of harm or abuse.

We found that risks were identified and systems put in place to minimise risk and to ensure people were supported as safely as possible. People's files contained risk assessments relevant to their individual needs and gave guidance to staff on how to maximise safety. For example, we saw risk assessments on falls, moving and handling, pressure areas and nutrition.

The premises and equipment were appropriately maintained and systems were in place to ensure equipment was safe to use and fit for purpose. Records showed that equipment was available, serviced and checked in line with the manufacturer's guidance. Gas, electric and water services were maintained and checked by qualified professionals to ensure that they were functioning appropriately and were safe to use. The records confirmed that weekly checks were carried out on fire alarms and call points to ensure they were in good working order. A fire risk assessment was in place and staff were aware of what to do in the event of an emergency. Each person had an individual personal emergency evacuation plan. Systems were in place to keep people as safe as possible in the event of an emergency.

People were protected by the recruitment process, which ensured staff were suitable to work with people who needed support. This included prospective staff completing an application form and attending an interview. We looked at four staff files and found the necessary checks had been carried out before staff began to work with people. This included proof of identity and two references. There was evidence of checks to find out if the person had any criminal convictions or were on any list that barred them from working with people who need support. Nurse's registration with the Nursing and Midwifery Council was also checked to ensure that they were allowed to practise in the United Kingdom. There was evidence in staff records to confirm they were legally entitled to work in the United Kingdom.

Staffing levels were sufficient to safely meet people's needs. The registered manager told us staffing levels were dependent on people's needs and we saw that there was a system in place to calculate this. This meant that staffing levels were not the same in each of the three units. Agency staff were rarely used with shifts covered by bank or permanent staff and therefore a more consistent service was provided. One person told us, "I can't say that I have ever suffered by a lack of staff." Another said, "They are busy but they find time to chat." A member of staff said, "The number of staff on the rota is fine and the manager does get cover." Another told us, "Staffing levels are sufficient in this unit and people's needs are met."

We saw that all areas were clean and that people were cared for in a hygienic environment. People told us they were happy with the cleanliness of the service. One person said, "They come twice a day to clean. More intensive in the morning, sometimes they come around in the evenings too." A visiting healthcare professional told us the service was, "Clean, neat, tidy and had no smells." At the last inspection we found that corridor floors were very wet as a result of mopping and were very slippery. This was not the case during this visit as the way in which the floors were cleaned had been altered and there were not any slippery areas that presented a risk to people.

Good

Is the service effective?

Our findings

People told us they were well cared for. One person said, "They look after me well."

People were provided with a choice of suitable nutritious food and drink and told us they were happy with the quality of food and the choices available. One person said, "Nine out of ten. I like the food. If I don't they give me a choice of something else." Another commented, "The food is very good, no complaints." A relative told us, "[Family member] eats it and never seems hungry."

There was a four weekly rotating menu that included details of potential allergens. The service was able to cater for a variety of dietary needs. At the time of the visit, this included diabetic, vegetarian, soft and pureed diet. People's dietary needs were indicated on the menu request form which was sent to the kitchen each day with people's meal requests for the following day. The chef made some desserts suitable for people with diabetes and a range of diabetic foods were available. We saw that for pureed diets, each food was pureed and served separately to enable people to enjoy the different tastes.

We saw that people were offered drinks and biscuits throughout the day. A relative told us, "There are a lot of fluids, which is good." When there were concerns about a person's weight or dietary intake we saw that advice was sought from the relevant healthcare professionals.

We observed lunch time on each of the three units and saw that some people ate independently and others needed assistance from staff. We saw good interactions between staff and people. For example, at lunch time one person was being assisted to eat and the staff member sat with them chatting and at one point they were singing together. Another person had not started eating and a staff member moved the food towards them, talked about the food and gave them a fork and they started eating. People were encouraged to eat and this was done in a kindly manner.

People were supported to access healthcare services and their healthcare needs were met. We saw that appropriate requests were made for input from specialists such as a speech and language therapist, dietitian and palliative care practitioners. People's healthcare needs were monitored and addressed to ensure they remained as healthy as possible. Medical visit forms were completed each time a person was seen by a healthcare professional. This meant there was a record of people's healthcare needs and any recommended action or treatment. A healthcare professional told us that staff took any follow up actions that were required.

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

Records showed that staff had received MCA and DoLS training. For people with DoLS in place, the relevant supervisory body had agreed these. The manager was aware of how to obtain a best interests decision or when to make a referral to the supervisory body to obtain a Deprivation of Liberty Safeguard (DoLS). Records confirmed that when necessary, applications for DoLS were made to ensure that people were not being unnecessarily or unlawfully deprived of their liberty.

People told us that staff asked for their consent before providing support. One person responded, "Yes they do. They are really caring." Another said, "Oh yes unless they know I would consent anyway." A relative told us, "They always talk to [family member] about what they are going to do, they never just do it."

People were supported by staff who received the necessary training to enable them to provide an effective service that met their needs. Staff told us they received an induction when they first started working at Moreland House and received ongoing training. Training included manual handling, fire safety, infection control, safeguarding, dementia awareness, Deprivation of Liberty Safeguards and the Mental Capacity Act. They told us it was the right training for the job they did. One member of staff said, "I have had all of the mandatory training. It's the right training especially the dementia and best interest training." Another said, "All my training is up to date and it's very good." A third said, "Training is useful and the trainer is good. They explain things. It's the right training." Nurses had been trained to carry out more complex tasks that people needed. For example, to manage the care of people who had nasogastric tubes (tubes going into the stomach via the nose) inserted for the administration of fluid, nutrition and medication.

Staff told us that the manager was approachable and supportive. Staff received supervision, which are one-to-one meetings with their line manager to discuss work practice and any issues affecting people who used the service. They received these approximately every three months. One member of staff said, "I get very good supervision and support. The manager is open and you can speak to them about anything." Systems were in place to share information with staff including handovers between shifts and staff meetings. Therefore people were cared for by staff who received support and guidance to enable them to meet their assessed needs.

The service was provided in a large purpose built building in a residential area. We saw that the environment was designed to meet the needs of the people who used the service and was accessible throughout for people with mobility difficulties. It was also designed to be 'dementia friendly'. The person responsible for the design and building of the service had attended a dementia design course and had used this knowledge when planning the new building. Adapted baths and showers were available on all floors and specialised equipment such as hoists were available and used when needed. The environment was clean, bright and light. There were some contrasting colours on walls and rails and some coloured toilet seats and hand rails in bathrooms which were suitable for people living with dementia. However, the doors all looked the same and there were no tactile items around and no personalised memory boxes or similar. Although the overall building was designed to support people with dementia, further work was needed to make the signage more dementia friendly. This had been taken on board by the service and the activity worker told us that they had started to work on memory boxes with people.

Good

Is the service caring?

Our findings

People said staff were kind and caring. Comments included, "Yes very kind" and "Very good. No qualms about recommending this place. I can't impress on you enough that this is a nice place." One relative told us that the staff were kind and caring and took the time to take their family member out to the garden and read to them. Another said, "We notice how [parents] face lights up more when they [staff] come into the room, than when we do." We saw that a bereaved relative had written, "Thank you for the kindness and understanding given to us during the difficult moments. A kind word or action at those times was very helpful and greatly appreciated."

People told us that staff treated them with dignity and respect and that they were consulted if a member of staff was about to assist them with a task. Their privacy and dignity were maintained. One person said, "Yes they always close the door and don't allow anyone else in with me when they are showering me." Another told us, "They don't come into my bedroom unless I ask them too."

People's personal information was kept securely and their confidentiality and privacy was maintained. We saw that individual files were kept in the nurses' station, which was a small room next to the lounge area. In addition, a system was in place to ensure that relatives could receive information about their family member by telephone without compromising confidentiality. Relevant family members had provided a code or password that they used when telephoning the service for updates or to discuss their family member.

'Residents' and relatives' meetings were held every three months. This was an opportunity for people to be given information and explanations about what was happening at the service and for them to voice their opinions about these issues. At the most recent meeting, in August 2017 end-of-life care, Christmas plans, food and staffing had been discussed.

People were encouraged to remain as independent as possible and to do as much as they could for themselves. For example, we saw that a person who had recently used the service had written, "Thank everyone for taking a very weak resident on entry and helping me to regain in a very short time my original level of independence." A member of staff told us, "We want people to be independent and encourage them to do things for themselves, even if it's only to dry their face. If you just get on with it you're not helping them."

When needed the service provided care and support to people at the end of their life and to their families. This was in conjunction with the local hospice and the GP. We saw letters from bereaved relatives thanking staff for the care, love and compassion shown to their family members. One relative had written, "Thank you all for the great care you gave [family member]. We know they were happy and you made their last few months a pleasant and comfortable time." Another had written, "I need to express my thanks for the kindness shown to me at the time of [parent] passing." The service had made links with the local end of life care coordinator and staff were working towards accreditation for the Gold Standards Framework. This is an independent accreditation framework to support people as they near the end of their lives.

Requires Improvement

Is the service responsive?

Our findings

Most people who used the service and their relatives were positive about the way staff responded to their needs. One person told us, "I am quite happy. If I want anything they get it for me. I am really well looked after." A relative said, "It is a good home. [Family member] is well cared for. We are happy that they are not left on their own." Another relative commented, "Staff are helpful and it's nice here." Two people felt their needs were not always met in a timely fashion. However, records showed their needs were complex and meetings had been held with relevant professionals and relatives and plans were in place to resolve the situation.

People's individual records showed that a pre-admission assessment was carried out before they moved to the service. Information was also obtained from other professionals and relatives. The assessments indicated the person's needs and gave staff initial information to enable them to support people when they started to use the service.

Each person had an individual care plan that set out their care and support needs. Staff knew people well and were able to tell us about individual needs, likes and preferences. However, this was not always reflected in their care plans. A healthcare professional told us, "Staff are focused on patients and know the patients." In some files we saw appropriate, individual and person centred plans. This included one for a person who was hoarding food and the actions suggested were suitable and aimed at maintaining the person's dignity. However, this was not always the case. Other care plans were generic and contained information that was inaccurate or not relevant to the individual. For example, for a person who could not eat anything orally their plan said, "I will be given a choice of what meals I want to eat." Some care plans said, "Use the incontinence products that best suit me" but did not specify what these were. Other care plans stated the size and type of incontinence pad needed.

Since the last inspection, there had been ongoing work to improve the quality and detail of care plans but further work was needed to ensure they were clear, detailed and individualised. The registered manager was aware of this as a result of their ongoing care plan audits and senior staff had been allocated dedicated time to make the necessary changes to the care plans.

People were not always aware of their care plans, in some cases possibly due to their living with dementia. For example, one person said, "I have not heard of a care plan, but [relative] would know about it." However, we saw evidence that people's wishes had been discussed with them and their relatives. For example, some people had 'do not attempt resuscitation' decisions in place. These were appropriately completed including the reason for the decision and details of the discussions with the person and their relatives. Since the last inspection people had been allocated a keyworker (a named member of staff who acts as a focal point for the person and their relatives or visitors.) This meant that people had someone to approach with queries or concerns they might have.

Feedback about activities was mixed. For example, one person said, "We always seem to be doing things, yes" and another, "Not a lot goes on in here, but I choose not to participate." A relative told us, "We have

seen some of the dancing and games but [family member] does not want to participate." Following on from discussions with people and their relatives, the activity worker did activities in two of the three units each weekday as opposed to doing something in all three. They told us that for the unit they were not going to work on they provided activities such as films and colouring for people to do. We saw that the activity worker was proactive in encouraging people to join in activities. For example, one person was quite restless and did not engage with the activity but when the activity worker said they needed some help, the person agreed to help and happily joined in. Another person told us they were the bingo caller. We also saw staff spending time talking to people in the garden and in one unit a member of staff was painting a person's nails. However, this was not always the case and in another unit we saw little interaction or activity. Although a range of activities were provided, we recommend this is developed further to ensure that people's social and recreational needs are met when the activity worker is not present.

People were encouraged to make choices and to have as much control as possible over what they did and how they were cared for. Staff supported people to make daily decisions about their care. We saw that people made choices about what they did, where they spent their time, what they ate and when they got up. For example, about getting up, people said, "The average time is about eight. I call out to say I am awake. They come in and if I want a cup of tea, they get one for me. Then I get up and they help me shower and get dressed," "They get me up at six as I want and they shower and dress me" and "About nine which is the time I want to get up."

We saw that the service's complaints procedure was displayed on notice boards in communal areas. Complaints were logged and actioned by the registered manager and a response was given to the complainant. Records showed that the registered manager contacted people to review and follow-up if the action taken had been effective and if they were satisfied. People told us they knew who to complain to. One person said, "I would complain to the manager, but I haven't had to." Another person who used the service told us that following on from a complaint they kept a daily record about the issues they had raised. The registered manager had arranged for a member of staff to review the record so that the situation could be monitored. The person added that there had been an improvement. A relative told us, "Anything is rectified straightaway." People used a service where their concerns or complaints were listened to and addressed.

Arrangements were in place to meet people's social and recreational needs. A full time activity worker was in post to support this. They arranged activities such as games, art and crafts, exercises, films, quizzes and music. They also organised celebrations such as a summer BBQ and a Christmas party that family and friends were invited to. External entertainers were booked and 'Pets for Therapy' visited each month. There was a large garden with a covered veranda and during the day we saw that people spent time out there.

Good

Is the service well-led?

Our findings

People, their relatives and staff were positive about the service provided. They thought that Moreland House was a good place to be. One person had written, "Thank you all for making my stay a complete and rewarding experience. Any misgivings I had, evaporated after the first few hours during which I was made aware of your expert care given with humour." A healthcare professional told us, "The service is run properly and well managed."

There were clear management and reporting structures. There was a registered manager in overall charge of the service and in addition to care staff, there were nurses who led each shift and were responsible for the service when the registered manager was not there. People informed us they felt comfortable raising any concerns when they arose.

Staff spoke positively about the management of the service. One member of staff commented, "The management is good and I feel comfortable here." Another said, "I get a lot of support. The manager says if you need anything ask." A third said, "[Registered manager] is approachable and you can get in touch with them when they are not here. They deal with things as soon as possible. [Registered manager] says to give the best care as if it was to your relative."

The registered manager monitored the quality of the service provided which ensured people received the care and support they needed and wanted. They spent time each day talking to people, observing care provided and supporting staff. They also carried out audits in different areas. For example, care plans, infection control, falls and pressure ulcers. We saw from these audits that issues were identified and action taken to address them.

The provider had systems to monitor the quality of service provided. The manager was required to complete a monthly computerised quality report, completed audits, accident reports, complaints and other issues were recorded on a shared drive and senior managers of the organisation monitored these. Provider monitoring visits were carried out and a report written indicating what they had looked at and their findings, the action required and the date for completion. These were followed up at future visits to ensure that action had been taken.

The provider also sought feedback from people who used the service and stakeholders by means of an annual quality assurance questionnaire. Responses from this were analysed and plans put in place to respond to any issues that had arisen. People were consulted about what happened in the service. They were asked for their opinions and ideas. The provider visited the service most weeks and spent time talking to people about any issues or concerns they might have. People used a service that sought and valued their opinions, which were listened to and acted on to improve and develop the service. For example, after the last survey a revised menu was put in place, new laundry staff were recruited and new plants were purchased for the garden.