Akari Care Limited

Moorfield House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Requires improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 25 and 26 November 2015 and was unannounced.

We last inspected this service in January 2014. At that inspection we found the service was meeting all the legal requirements in place at the time.

Moorfield House is a care home for older people, some of whom have a dementia-related condition. It provides nursing care. It has 35 beds and 27 people were living there at the time of this inspection.

The service had a registered manager who had been in post for seven months. 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 protected from abuse. Staff were fully aware of their responsibility to keep people safe and to report an actual or potential harm. People told us they felt safe

Summary of findings

in the home. Risks to people were regularly assessed and appropriate steps were taken to reduce such risks to a minimum. Frequent checks took place of the safety of the environment and all equipment used.

Accidents and incidents were recorded and analysed to see if lessons could be learned.

Staffing levels in the home were kept under constant review to ensure there were enough staff to meet people's needs safely and in the ways they wanted. Robust systems of recruitment and selection meant that only applicants suitable to work with vulnerable people were employed.

People's medicines were managed safely by trained staff whose competency was regularly re-assessed. People received their medicines at the times they were due and in the way they wanted.

The staff team was experienced and well-motivated. They demonstrated the knowledge and skills necessary to meet people's needs effectively. They were given appropriate support to carry out their roles by means of staff supervision and appraisal. However, staff had not been kept up to date with their training needs.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS are part of the Mental Capacity Act 2005. These safeguards aim to make sure people are looked after in a way that does not inappropriately restrict their freedom.

Appropriate assessments had been undertaken of people's capacity to make particular decisions. Where it was deemed that people did not have capacity, we saw that appropriate 'best interest' decisions had been taken, with the involvement of the person's family, and these were clearly recorded. People were asked for their consent before staff members carried out any care tasks or other interventions.

People's nutritional needs were assessed and specialist advice was taken, where necessary, to ensure those needs were met. People received a varied and nutritious diet and had choice of their meals. People told us they enjoyed their meals.

People's health needs were assessed and kept under regular review. Staff were alert to any deterioration in people's health and reported and monitored people's progress. Appropriate referrals were made to specialist services, where required. People had access to the full range of community health services such as GPs, dentists, opticians and podiatrists.

The staff team demonstrated a very caring, person-centred approach in their work. People and their relatives spoke highly of the sensitivity, care and commitment of the staff. Efforts were made to keep people fully informed about their care and about the running of the home, and there were regular meetings with people and their relatives to get their views about the service. People told us staff helped them do things for themselves and be as independent as they were able. They said they were treated with respect at all times and their privacy and dignity were protected by the staff team.

People were involved in identifying their needs and in describing how they wished those needs to be met. People's views and preferences were incorporated into their care plans, which were very detailed and informative. Regular reviews of people's care were undertaken and care plans were updated in line with people's changing needs and preferences.

Social activities were available and the registered manager demonstrated a commitment to widen the range of these and make them more individualised. Care was taken to avoid the risks of social isolation. People were encouraged to make all possible choices about their daily lives.

Any complaints or concerns were taken seriously and investigated thoroughly. The registered manager spoke with each person in the home daily and acted on people's feedback.

There was an open and reflective culture in the home, and new ideas and practices had been introduced to improve the service. Staff told us they were treated with respect and that their views were valued. Staff took an obvious pride in their work. Systems were in place to monitor the quality of the service, and to identify and address areas for improvement.

We found a breach of Regulations in relation to staff support (staff training). You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff had been trained to recognise the signs of abuse and to respond appropriately.

Risks to people were regularly assessed and control measures were in place to minimise harm.

Recruitment systems were robust and ensured only suitable persons were employed to work with vulnerable people.

There were enough staff to meet people's needs in a safe and timely way.

Is the service effective?

Requires improvement

The service was not fully effective. The staff team were experienced and skilled, but had not been given all the training they needed to meet the needs of people using the service.

People's rights under the Mental Capacity Act 2005 were protected and they were asked to give consent to their care.

Health needs were kept under review and any changes were responded to promptly. People were supported to enjoy a healthy and nutritious diet.

Is the service caring?

Good

The service was very caring. People and their relatives spoke highly of the caring nature of all the staff.

People were given information about the service and about their care, and were encouraged to be involved in the running of the home.

People's privacy and dignity were protected and they were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive. People and their relatives were involved in assessing their needs and planning how those needs would be met.

Care was delivered in a person-centred way that preserved people's individuality.

Complaints and concerns were taken seriously and resolved sensitively and professionally.

Summary of findings

Is the service well-led?

Good

The service was well-led. The new registered manager had brought about many improvements and ensured the whole staff team took responsibility for providing a high standard of care.

There was an open and reflective culture in the home, and staff took pride in their work.

Systems were in place for monitoring and improving the quality of the service provided.

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 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 25 and 26 November 2015. The first day of inspection was unannounced.

The inspection team was made up of an adult social care 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 care service.

We reviewed the information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries. The provider is legally obliged to send us these within required timescales.

We contacted other agencies such as local authorities and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we talked with 13 people, three relatives and a visitor. We spoke with 15 staff, including the registered manager; deputy manager; three senior care assistants; two registered general nurses; two senior care assistants; three care assistants; assistant chef; activities coordinator and housekeeper. We also spoke to one visiting professional. We looked at the care records of nine people. We 'pathway tracked' the care of four people by looking at their care records, talking with them and with staff about their care. We reviewed a sample of five staff personnel files; and other records relating to the management of the service, including medicines, recruitment, staff supervision and appraisal, accidents and quality monitoring systems.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe and well protected in the home. All the relatives we spoke with felt their relatives were safe, well protected and well cared for in the home.

The service had a clear policy on the safeguarding of people who used the service, which was displayed in the entrance to the home. The policy incorporated the local authority's guidance and included a flow chart for the reporting of safeguarding incidents. This facilitated the prompt notification of such events. We discussed the low number of safeguarding alerts (two in the past year) raised by the service with the registered manager. We were assured the registered manager was fully aware of their responsibilities and had been prompt in reporting all safeguarding issues. Staff we spoke with confirmed they had regular safeguarding training and were vigilant for signs of any potential abuse. They were aware of the need to report any bad practice (whistle blowing) they observed. The registered manager told us there had been no formal whistle blowers in the past year, but that staff had come forward with small examples of low level poor practice, which had been dealt with appropriately.

The service sought to protect people's rights under the Human Rights Act (1998). Each person had a personalised human rights care plan. These summarised the legislation for staff and described how people's rights might be inadvertently compromised. The registered manager was fully aware of his responsibility under the 'duty of candour' regulation to be open and honest with people about any notifiable safety incidents.

Clear records were kept of any monies held on behalf of people in the home, with evidence of regular auditing. Individual care plans stated the person's capacity regarding their finances, and included details of any person with legal authority, such as power of attorney, who were involved in handling their affairs. This meant people were protected from financial abuse.

Risks to people living in the home were assessed using both general and, where appropriate, specific risk assessments. Control measures were in place for risks identified. Examples included the provision of a soft diet for a person with swallowing difficulties and a low bed and a 'crash mat' for a person at risks of falls from bed.

All accidents and incidents were recorded. These were regularly analysed to see if steps could be taken, either individually or organisationally, to prevent any re-occurrence of the event. We saw no particular patterns of accidents or incidents had been identified. Response to individual accidents had been appropriate including, for example, a referral to the local falls team and the provision of a sensor mat to alert staff for a person prone to falls. Attention was also paid to the safety of staff, who were provided with the personal protective equipment they required to carry out their roles safely.

The registered manager told us staffing levels were set according to a monthly assessment of the dependency needs of people in the home. They told us this was used flexibly to reflect the layout of the building and said they were able to use extra staff at short notice, where necessary. The registered manager told us they felt the home was appropriately staffed to meet people's needs in a safe and timely manner. Our observations confirmed this. People's needs were attended to promptly and no-one seemed hurried or stressed. Staff we spoke with said staffing levels were appropriate. One told us, "We have time to sit and talk with people." A second staff member said, "We have enough staff. No-one's needs are neglected."

We looked at the recruitment of new workers. A clear and robust system of recruitment and selection was in place. This included checks on applicants regarding their identity, employment history, health and any previous convictions. References from current/previous employers were taken up and verified. Staff told us their induction had been thorough and had prepared them properly for their roles and responsibilities.

The service had a business continuity plan in place for responding to emergencies such as the failure of gas or electricity supply services, severe weather and the need to relocate from the building. This contained contact numbers of all essential stakeholders including the emergency services, local council and the Care Quality Commission. Arrangements were in place to safeguard people's health and wellbeing by the provision of items such as blankets and thermos flasks. Each person in the home had an individual personal emergency evacuation plan.

The safety of the premises was subject to regular audits. These included a daily walk around the building by the registered manager, noting any safety issues, monthly

Good

Is the service safe?

audits of infection control, the environment and staff hand hygiene. Fire safety systems and equipment were checked regularly. Maintenance and servicing contracts were in place and up to date.

We looked at the management of medicines. A robust system for the ordering of people's prescribed medicines was in place. Monthly orders were sent to the supplying Chemist who delivered the monthly medicines order promptly, and with plenty of time for staff to check the medicines and deal with any problems. Storage of medicines was managed safely, with the drug trolley secured to the wall in the locked treatment room when not in use.

We observed part of a medicines round and saw the administration of medicines was managed appropriately and professionally. The medicines administration record was completed accurately and contained no unexplained gaps. We looked at the methods in place for the safe administration of medicines, such as discarding spoilt medicines, covert medication, homely medications and self-administration. We spoke with the nurse administering medicines and with a senior care assistant who both demonstrated sound knowledge and good practice. All staff involved in the administration of medicines had been appropriately trained and had their competency checked regularly.

Prescribed creams for topical application were dated on opening and all were discarded every month. A topical administration chart was not available for creams so that the care staff could administer the creams to the correct area as prescription states. This was discussed with the nurse who undertook to ensure that clear instructions would be issued to care staff to ensure the correct application and recording of creams.

There was a clear audit trail for the ordering, receipt, administration and return of unwanted medicines. Medicines audits were carried out monthly on each person's records by the deputy manager and occasionally by a pharmacist from the supplying Chemist.

Requires improvement

Is the service effective?

Our findings

People told us they felt the staff had the skills and knowledge they needed to meet their needs. One person told us, "Staff have had the training 'to do the job'." A relative told us, "My (relative) was very poorly when she came in but the manager and the girls were marvellous. The care was excellent." All the care and nursing staff we spoke with were very knowledgeable about people's needs and demonstrated a caring attitude. A visiting health professional commented favourably on the knowledge and helpfulness of the staff team. The atmosphere in the home was calm and we saw effective care was delivered to people in an unrushed, professional way.

New staff members underwent an initial induction to the service and worked a probationary period, during which their suitability to work with vulnerable people was assessed. The registered manager told us the Care Certificate was being introduced. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. The registered manager had received training in its implementation and we were told staff had undertaken the required initial self-assessment prior to this. A new member of staff told us they had a good, informative induction.

We looked at the training staff were provided with to enable them to meet people's care and nursing needs. We saw, from the staff training matrix, that only 59% of the core training needs identified by the provider, and 43% of the specific training needs, had been met. Of particular concern was the fact that the majority of staff had not been trained, or had not been given required refresher training, in health and safety, safeguarding, tissue viability and food safety. Significant numbers of staff were also overdue training in areas including moving and handling, infection control and mental capacity. The registered manager told us they were aware of the training deficits and showed us a draft training plan. However, we noted this plan would not address some essential training areas such as safeguarding and restrictive practice for more than six months.

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

The registered manager told us that nurses were supported with their 'revalidation' process by the provision of revalidation packs and a bursary to allow them to study chosen topics to extend their knowledge and practice.

Staff received regular supervision from the registered manager. Supervisions took place approximately monthly, giving staff the opportunity to get feedback about their performance, set new goals and identify training needs. A staff member told us, "I've had a couple of supervisions recently. They were very professional."

Care plans were in place for improving verbal and non-verbal communication with people with short term memory loss. Care plans emphasised the need for staff to use active and empathic listening techniques. Staff told us that communication with people and within the staff team was good. Relatives we spoke with told us that they were contacted by Moorfield House if there were any issues with their relatives or if they were ill.

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 saw people's cognitive abilities were assessed before admission to the home, using a formal mental capacity assessment, where appropriate. This assessment also noted whether a DoLS was currently in place, or if one needed to be applied for. The registered manager was aware of their responsibilities under the MCA and had acted accordingly in submitting applications for DoLS to the authorising body. Clear records were kept of DoLS and capacity assessments. We saw that, where a person had made an 'advance decision' about their future care (for example, not to receive cardio-pulmonary resuscitation) the relevant documentation was placed prominently at the front of their care record, to inform all staff.

Requires improvement

Is the service effective?

Where a person displayed behaviours that distressed them or others around them, we saw specific care plans had been drawn up to minimise such distress. Care plans showed a holistic approach that recognised the many possible reasons for such behaviours, including uncommunicated pain, confusion, lack of awareness, anxiety and frustration. Clear records were kept of incidents of disturbed behaviours and the possible contributory factors and, where necessary, referrals were made to specialist resources such as the challenging behaviour team. The registered manager told us that sedative medicines were never used as a first line of treatment for such behaviours. We observed several incidents of disturbed behaviour during the inspection, and saw that staff dealt with them calmly and appropriately.

People we asked confirmed that staff sought their permission before carrying out any treatment or providing support. People or their representatives were also asked to sign a form giving their formal consent to all the staff actions contained in their individual care plans. We discussed with the registered manager whether such consent would be better informed if people were asked to read, agree and sign each individual care plan. A small number had not yet been signed. Formal consent was also requested for issues such as agreeing to receive influenza vaccinations and having photographs taken for identification purposes.

People's nutritional needs were regularly assessed using the Malnutrition Universal Screening Tool. This is a screening tool to identify adults, who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop a care plan. Eating and drinking/nutritional care plans, which included people's food and drink likes and dislikes, were in place. These were notified to the kitchen staff. Referrals were made to dieticians and speech and language therapists, where appropriate. People's weight was monitored at least monthly.

A 'dining protocol' was in place which aimed to enhance the dining experience. We observed residents having lunch in the dining room. All appeared to be enjoying their meals which were served with a range of cold and hot drinks. There was a choice of main course and dessert. Staff regularly asked people if they wanted more food or drinks or if they needed help as well as enquiring if they were enjoying their meal. Comments included, 'The food is very nice'; "It's smashing, I love the bread and butter pudding"; and, "It's lovely. It's always nice." Relatives agreed and told us people were well-nourished and hydrated. Adapted cutlery and crockery were available to assist people who had difficulty in eating independently.

People's health needs were assessed on admission and regularly thereafter. Areas covered included oral health, skin integrity and foot care. People and their relatives or friends confirmed that health professionals could be easily accessed as and when required by making a request via the staff or registered manager. Care records confirmed this. One person said, "They (staff) sort out whatever is needed medically." We noted evidence of appropriate referrals to health professionals and that their advice was incorporated into the person's care plan. Emergency healthcare plans were in place, recording people's wishes about their future care in the case of long term illness, stating whether or not a hospital admission was wanted.

We saw that, when a person's health began to deteriorate, the service used the National Early Warning Score (NEWS) to determine the seriousness of their condition. This is a system that records a range of basic physiological observations such as blood pressure, heart rate and temperature and is used to monitor the progress of their illness and provide essential information to other health professionals. Staff told us this had led to improvements in people's care and had given staff a better understanding of people's health needs.

Good

Is the service caring?

Our findings

People told us the staff were kind, caring and helpful**.** One person said, "The girls are all very caring and help me with most tasks. They are all very nice and the new manager is nice, too." Other comments included, "I enjoy it here, everyone is nice"; and, "It's okay here. I get ample attention from people and (named member of staff) is great." A relative of a person formerly living in the home told us, "Whenever I came in it always felt like it was a happy, comfortable place, the staff always seemed happy and happy to help." Another relative commented, "Lovely care home. The staff are welcoming and caring."

We observed staff had a caring approach to people. As a typical example, the nurse administering medicines spoke with every person to enquire about their wellbeing even though not all were on lunch time medication. The nurse had a very approachable and caring manner and spoke to people softly and with patience. A relatively new member of staff told us, "It's alright, here. It's not regimented and staff are meant to use common sense. Staff are very person centred and do lots of extra little things for the residents." We saw staff assisted three people with eating their lunch meal, and provided attentive, caring and sensitive support to meet their individual needs.

Relationships between people and staff were positive and affectionate. A care assistant told us, "We like to think they are all our grandads and grandmas." We saw each person had a named care assistant (keyworker) whose role was to get to know the person well, be involved in drawing up and evaluating their care plans and attending in-house and social worker reviews. They took a lead role in ensuring the person's room was clean and tidy and clothing suitably labelled, and acting as a link with the person's family. People told us the registered manager was always visible around the home. We saw part of the registered manager's daily walk round the home. He greeted each person by name and had a little chat, walking arm in arm with one person as they conversed.

Efforts were made to involve people and their relatives in the daily life of the home. People were aware of residents' meetings but said they did not attend. The relatives we spoke with were also aware of meetings but had only attended occasionally. They were aware they could use these meetings to express their views about the service. Minutes of these meetings were displayed. We saw, in the last meeting, "All relatives commented that the care was lovely and they expressed their thanks to the staff". Relatives told us they had been involved in their relative's care planning and reviews. Communication care plans included advice to staff such as, "(Name) appreciates all information regarding care to be explained fully and in an accessible format." A 'relative's communication sheet' was on each person's care record, to help keep relatives up to date with people's progress and to record relatives' comments. The availability of local advocacy services was advertised around the home, to assist people who did not have relatives or friends to speak for them.

We looked at how the service promoted people's well-being. The registered manager told us he felt all the staff were skilled at picking up and reporting changes in people's mood and demeanour that might indicate a concern or a health issue. As part of the named keyworker system, keyworkers were responsible for ensuring the 'personal touches' to people's care, including checking their toiletries and shopping for small items. Recent improvements to the décor and furnishings had improved people's morale, we were told, and people confirmed this. The daily 'Sparkle' newspaper, which is a professionally written reminiscence and activity tool for older people and people living with dementia, was used by staff to engage people.

We looked at how people's privacy and dignity were maintained. We saw, in every review meeting, people were asked to give specific comments regarding their choices, independence, fulfilment and rights. We saw examples in people's care plans of being given the choice of male or female care assistants for personal care, and the registered manager told us he was introducing 'do not disturb' signs for when personal care was being given in people's rooms. We saw that staff knocked on people's doors and waited to be invited in. People we spoke with confirmed that their privacy and dignity was respected. People's independence was enhanced by the provision of appropriate equipment such as mobility aids and powered wheelchairs. People were assisted by staff to use local shops and other community facilities.

No-one in the home was receiving end of life care but staff we spoke with were knowledgeable about the issues and spoke sensitively about the particular care and emotional needs of the person and their family members in their final days. When we looked at the care records of a person

Good

Is the service caring?

formerly resident in the home these showed careful attention to pain relief and that comprehensive documentation had been in place which confirmed involvement of all the appropriate people.

Good

Is the service responsive?

Our findings

People told us the staff team responded well to their changing needs. One person said, "I feel comfortable here and help is always there if you need it." People told us that call bells were responded to "Quickly or quite quickly." Our observations confirmed there was a timely response to call bells.

The registered manager told us they received copies of any current assessments carried out by health or social care professionals, as well as carrying out their own assessments of people's needs. These included the person's health needs, dependency needs, social and spiritual needs and preferences. Where people had made advance decisions regarding their future care, this was clearly documented. For example, 'Do Not Attempt Resuscitation' (DNAR) forms were kept prominently on the records of those who had made them.

Following this initial assessment, care plans were developed detailing the care and support needs, actions and responsibilities, to ensure appropriate care was provided to all people. Care plans covered areas such as nutrition, communication, personal hygiene, sleeping, pain, social needs, medication and environmental safety. Care plans showed a very comprehensive and personalised approach to people's care, centred on the individual and they were not task led. Care plans were up to date and reviewed monthly by the person's named keyworker. Where necessary, care plans were updated. For example, "(Name)'s care plan re-written to reflect changing needs." Regular reviews of people's care were held. People and their relatives were encouraged to take an active part in these reviews and their views were recorded and acted upon.

The service had recently employed a new activities co-ordinator, but we were not shown evidence of a fully developed social activities programme. However, there was evidence of regular celebrations of birthdays and other days of note; and of visiting entertainers such as Irish dancers and a choir. Other activities offered included karaoke, bingo, ball games and chair exercises. The service had recently converted a top floor lounge into a small cinema room, following consultation with people and families. This was proving popular with people, especially as it showed old black and white films.

The registered manager told us the staff team were supportive of social activities, with staff often coming in their own time to assist with, for example, activities and trips out and to put up Christmas decorations. People who preferred not to join in group activities were given extra one-to-one by staff, or had activities tailored to their individual interests, to avoid social isolation. For example, a person who used to work as a gardener was being supported to grow flowers and fruit in the garden. There was also a conservatory designated as a 'quiet lounge' for those who preferred less stimulation.

People's social and emotional needs were assessed. Areas addressed included the person's family tree; contact numbers for relatives and other significant people; life history; religious and spiritual needs; and hobbies and interests. People said staff respected their choice to stay in their room or to go to the communal lounges. They told us they could get up and go to bed when they chose, and had choices in all daily activities such as meals, social activities, movement around the home and when to bathe or shower. One person told us, "I can get up when I want to, wander around or sit in the lounge, I can please myself. If I need help, it's on hand and everyone is quite helpful."

A complaints log was kept. This showed three complaints had been received in the previous six months. These had been treated seriously, investigated properly, and appropriate actions taken to resolve the problem to the complainant's satisfaction. People were asked if they had any complaints or concerns in every residents/relatives' meeting. They were reminded of the registered manager's open door policy and that he had a weekly early evening surgery to allow relatives to raise any concerns. People told us they would talk to a member of staff or the manager if they had a concern or a complaint. Most people said they just told a member of staff if something was concerning them and it was quickly sorted out.

Documentation was in place to facilitate people's movement between services, such as an admission to hospital. We noted the standard transfer form did not include reference to issues such as the existence of, for example, DoLS and DNAR documents. The registered manager told us this would be rectified immediately. The registered manager told us people were always given a staff escort when being admitted to hospital.

Good

Is the service well-led?

Our findings

The service had a registered manager who had been in post since April 2015. The registered manager demonstrated a full awareness of the responsibilities that came with registration, including the notification of significant events to the Commission.

People and their relatives were generally positive about the care and provision of services at Moorfield House. They told us they were always made to feel welcome and the atmosphere was always friendly. They also confirmed that they could visit whenever they wished. One relative said "There's always a nice atmosphere, it's very comfortable here and staff seem happy in their work." The general view of people and relatives was that the service was well-led and staff were kind, caring, supportive and helpful. One person told us, "The manager is quite new, he seems okay, I'm giving him a chance before I decide how good he is."

We found an open, listening and caring culture in the service. The registered manager and his staff fully assisted the inspection process and were open and honest with us. All staff demonstrated an obvious enthusiasm for their work and staff told us they were happy working in the home. They said they felt respected and valued by the manager and the company.

There was a clear management structure and the registered manager told us they felt supported by their line manager and provider. They told us they were also supported by the registered managers of other local services operated by the provider, and this was demonstrated in the course of this inspection.

Staff told us they were happy with the current management of the service. We were told there was much less sickness and that staff now smiled at work. One staff member said, "I would say it's a well-managed service, yes. The manager treats us with respect and listens to us." A second staff member said, "(The registered manager) is very good. He's clear in what he wants and models good practice." Another staff member commented, "I love it here and things have got so much better with the new manager." A nurse told us, "The situation in the home is improving. We now have good routines, we are better organised and have better communication. The team work is much better and the team is more reliable." A visiting professional commented, "The manager manages staff well, firm but fair."

Staff had involvement in the way the service was run. Regular staff meetings were held. The minutes of these meetings showed staff were informed and consulted about developments in the service; and were asked for their views and ideas. They also demonstrated the registered manager was inclusive in his approach, stressing his 'open door' policy for staff and people in the home, and the importance of team work in improving the quality of the service delivered. There was also evidence of clear leadership, with nurses and seniors being given full delegated responsibility for the running of their units. Staff told us they felt able to question practices in the home, but felt there was little that needed challenging. One staff member told us, "I haven't seen anything I'd disagree with."

The registered manager told us he was keen to build links with the local community and gave examples. Local primary school children were visiting to sing to people in December. A number of secondary school students on health and social care courses had undertaken supervised work experience in the home. A local church held a regular prayer group in the home.

When assessing the vision and values of the service we took note of statements by the registered manager in the minutes of staff meetings, including, "We are all here for the sake of the residents" and, "All staff to make people feel welcome at Moorfield." The registered manager also told us of the 'Six C's of nursing care' which he said were integral to approach of all staff in the home: 'care, compassion, courage, competence, communication and commitment'.

A range of systems were in place to monitor the quality of the service being provided. The registered manager completed a daily walk round the home, talking to people and completing a daily audit that included the environment, clinical issues, infection control and meals. The registered manager told us this allowed him to keep in touch with people and issues, and to pick any small problems up before they escalated into complaints. There were monthly audits of staff hand hygiene, infection control, medicines, kitchen, care plans and people's dependency levels. The maintenance person completed a range of weekly and monthly checks of fire safety, water quality and temperature, environmental risks, equipment safety and décor. Various external audits were carried out by the line manager.

All issues for improvement identified in the various audits were fully recorded and areas for action were added to the

Good

Is the service well-led?

service's 'home development plan'. This was regularly updated, with details of progress and completion dates. We saw evidence of improvement across all areas of the service including care planning, infection control, recording of consent and capacity issues, assessing risks and staff induction. We noted, however, insufficient emphasis was placed on monitoring staff training needs. We discussed this with the manager who provided us with an updated training plan.

Surveys to capture the views of people, their relatives, staff and professionals were normally sent out annually by the provider. The 2015 surveys were overdue, but were sent out in the course of this inspection. However, a similar set of surveys, carried out by an independent polling company, had been sent out and the results were being collated by head office. The registered manager told us he made a point of using 'mini surveys, in-house, as a way of seeking the views of people on particular issues such as the proposed refurbishment of the dining rooms. People, visitors and professionals also had the option of using an iPad situated at the front door to give any comments about the service. Comments seen were uniformly positive, including, "The care and commitment I see from staff is brilliant and it's good to see happy residents"; "Lovely care home. Staff welcoming and caring and always try their best"; and, "Lovely home with friendly staff."

The registered manager held membership of various professional bodies including the Association for Coaching, the UK Resuscitation Council and the Anaphylaxis Campaign, and was a registered foot health practitioner. He was a qualified trainer in subjects including venepuncture, catherisation, anaphylaxis and basic life support. The registered manager told us of the plans in place for further improving the quality of the service. These included the introduction of new clinical measures such as infection pathways for chest and urinary infections, and the 'Situation-Background-Assessment-Recommendation' (SBAR) tool for improving clinical communication with health professionals.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The service provider had not ensured that persons employed in the provision of a regulated activity received appropriate training to enable them to carry out the duties for which they were employed.** **Regulation 18 (2)(a)**