Ashberry Healthcare Limited

Moorhouse Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Moorhouse Nursing Home (Moorhouse) is a nursing home that provides care to older people, people living with dementia, people with physical disabilities and complex medical needs. The home is registered to provide support to up to 38 people in one adapted building. There were 36 people living at the service at the time of our inspection.

People's experience of using this service and what we found
Despite some positive experiences for people living at the Moorhouse, risks to people's safety and well-being were not always managed well. Lessons were not learned when things went wrong, and there was a lack of confidence in the internal management and clinical oversight of the service.

Staff were not deployed or led appropriately which meant people did not receive the care they needed in a timely way and the service was not cleaned to a satisfactory standard. Safe infection control processes were not consistently followed because no one had taken responsibility in this area.

Whilst registered nurses ensured most people received their medicines as prescribed, the systems in place to support and audit safe medicine management did not reflect best practice. Care records were also not always completed accurately which heightened concerns given the high use of agency staff who were less familiar with people needs.

There was a disconnect between staff and managers which impacted on both the quality and safety of people's support. A negative culture across staff and management teams had developed with a focus on blame rather than reflective practice and teamwork. The provider acknowledged the impact of this and shared the additional support they were putting in place to manage this.

Since our last inspection, Moorhouse had extended its range of support to include care for people living with dementia. Neither the environment nor training of staff had been sufficiently adapted to deliver this support well. A lack of understanding of the principles of the Mental Capacity Act 2005 (MCA) had meant that people were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests.

People were largely positive about the staff that supported them and said that care staff treated them with kindness and respect. Kitchen staff had a good knowledge of people's dietary needs and preferences which enabled people's nutritional and hydration needs to be met.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

Rating at last inspection
The last rating for this service was good (published 18 June 2021)

At our last inspection we recommended that the provider seek advice and guidance in developing their strategic monitoring of the service. At this inspection we found that whilst significant actions had been taken to strengthen the provider's oversight of the service, issues within the internal management of the service had meant that people's experience of care had not improved.

Why we inspected
We received concerns in relation to the management, staffing and safety of the service. As a result, we undertook a focused inspection to review the key questions of Safe, Effective and Well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from Good to Requires Improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements in each of the areas we inspected. You can see what action we have asked the provider to take at the end of this full report.

The provider has engaged fully with us both during and following this inspection. They have already sent us a detailed action plan of the improvements they have made and intend to make. Through feedback from our partner agencies who have continued to visit the service, it has been possible to evidence that the additional support going in to Moorhouse has enabled immediate improvements in respect of the most serious concerns we identified.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Moorhouse Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to the quality and safety of the care people receive, deployment of suitable and sufficient staff, cleanliness & suitability of the premises, obtaining valid consent and effective leadership and management of the service.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an updated action plan from the provider to understand what they will do to further improve the standards of quality and safety. We will work alongside the provider and local authority to monitor their progress. We will continue to review the information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Moorhouse Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Moorhouse Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Moorhouse Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 7 March 2023 and ended on 16 March 2023. We visited the location's service on 7 & 8 March 2023.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
During the course of our inspection activity, we spoke with 10 people and received feedback from 21 relatives about their experiences of using the service. We interviewed 8 members of staff and spent time with the registered manager and nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. Feedback was also received from 4 visiting professionals.

We looked at a range of documentation relating to people's care and the management of the service. These included the medicine records for 16 people and support plans for 7 people. We also reviewed the recruitment information of 5 members of staff and documents relating to the training and supervision of 8 staff. A variety of records relating to the management of the service, including incidents and accidents and audits were also viewed.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse

- Whilst people told us that they generally felt safe living at Moorhouse, many relatives identified concerns that their loved ones were at risk of not always receiving the right support. One family member told us, "I do worry about [Person's name] choking. Staff frequently place food down on a tray in front of [them] whilst [they] are in bed without bothering to ensure [they] are properly sat up." Likewise, another relative said, "I just don't have the assurance that nursing staff are on it in terms of risk and governance. I guess I just don't feel confident in their nursing practices."
- During the inspection an incident was identified that is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information indicated potential concerns about the management of risk in respect of falls. This inspection examined those risks, and we asked the provider to take some immediate action to ensure all staff understood people's individual risks and knew when to seek immediate medical advice following an accident.
- Risks were not always appropriately understood and managed to ensure people were consistently kept safe and free from neglect. For example, delays in people receiving personal care placed them at a higher risk of developing pressure wounds. One relative told us that during a recent lunchtime visit their loved one was lying in bed "Soaking wet and in discomfort." Staff told us that they frequently didn't get enough time to provide personal care until late morning or early afternoon. Two staff commented, "People get pressure sores because they are sat for too long in wet pads."
- Whilst it was not possible to evidence that those people who had pressure wounds at the time of the inspection were not receiving appropriate treatment, it was found to be a theme amongst relative complaints. In addition, an external professional shared that a relative had recently complained to them about the service saying, "Poor care…. Being left in bed and has a pressure sore."
- During our first inspection visit the environment posed risks to people's safety. Cleaning equipment and trolleys were repeatedly left unattended blocking corridors and wires trailed across the floor posed a trip hazard for people walking around. Whilst some of the obstacles could be attributed to the disruption caused by new carpets being fitted, there was no leadership to mitigate these heightened risks and staff moved themselves around the risks rather than mitigating them for others.
- A health and safety inspection organised by the provider was also taking place at the time of our first inspection visit. This also highlighted a number of risks in respect of the environment of the home. In particular the stair gates that had been fitted on each floor were identified to pose an unacceptable risk both in terms of falls and hindering the safe evacuation in the event of an emergency.

The failure to ensure risks to people's safety and well-being were effectively assessed and acted upon was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● In light of the specific concerns raised we shared our information with the safeguarding team at the local authority and sought immediate assurances from the provider. The provider confirmed that they had also recently identified some of the issues and were implementing a series of actions including the appointment of an interim clinical lead to review each person's needs and securing external contractors to address the urgent health and safety risks in respect of the environment.
● Prior to the conclusion of our inspection activity, a number of immediate steps had been taken by the provider to mitigate the immediate risks.
● In addition to the concerns above, we also received positive feedback about the support some people had received which had improved their personal safety. For example, one relative told us, "I am very happy to say that [Person's name] and myself feel she is safe in their charge. Moorhouse have gone out of their way to source the right equipment to enable staff to conduct transfers safely." Similarly, another relative commented, "Definitely, she is safe. She has settled down quite nicely and she's improved since being here."
● At the time of our inspection one person had a pressure wound which was being managed well. Records provided a clear audit trail of the treatment provided by the nursing staff and photos which evidenced the progress of healing the wound.
● Despite previous safeguarding concerns about the management of a person's diabetes we found that staff were managing the risk associated with this aspect of people's care well. One person spoke highly of the support and choice they received in respect of their diabetes care. We also observed staff ensuring people with diabetes received their meals in a timely way.
● Staff understood their roles and responsibilities in respect of safeguarding people from abuse and managers had made appropriate referrals where necessary.

Preventing and controlling infection
● People raised concerns about the standards of cleanliness within the home. One person told us, "Today is first day in 2 weeks that bedroom has been hoovered. All housekeeping do usually is empty bin and clean the toilet."
● Relatives repeatedly told us they were unhappy with the levels of hygiene. One family member told us, "The standard of cleaning has been an issue for a while." Similarly, another regular visitor said, "The level of housekeeping has not been as good as we feel it should be. We often find mess on the floor and on the table from meals not cleaned up, and stocks of toilet paper and other items are not always replenished."
● The standard of cleanliness during our unannounced inspection visit was poor. We found communal bathrooms to be cluttered with dirty commodes and faecal matter on the floor. Carpets were heavily stained and required significant hoovering. Domestic staff on duty were not focusing on the priority areas and there was a lack of oversight and appropriate delegation.
● Staff told us there were regularly not enough housekeeping staff to keep the home clean. One staff member said, "Some days we have no cleaners at all, other days like today we only have the housekeepers for a few hours in the morning – it's not enough and the home is unclean and residents and relatives complaining." Another staff member informed us, "A resident was sick downstairs, and you could still smell the vomit for days. We tell them [managers] but nothing gets done."
● The storage of Personal Protective Equipment (PPE) was chaotic. In the first-floor bathroom, clean PPE was stored above the toilet and a used commode. In the top floor bathroom, easy access stocks had not been kept topped up. One staff member said, "There's just no system for making sure PPE is always readily available. Sometimes we run out of gloves because managers wait for the free supplies to arrive." Whilst we

did observe there to be adequate stocks of PPE across the service, the allocation to different floors was not being managed to ensure gloves and aprons were always easily accessible when staff needed them quickly. Similarly, the soap and paper towel dispensers in the first-floor bathroom were empty and no one knew whose responsibility it was to re-stock.

The failure to adequately maintain clean and hygienic premises and equipment and ensure measures for controlling the spread of infections were appropriately implemented was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We signposted the provider to resources to develop their approach and immediate action was taken to remedy the most serious concerns we raised. Our second visit to the service found that immediate infection control issues had been resolved.
● The care homes approach for visitors was in line with current government guidance. Relatives were seen freely visiting during both inspection days and relatives consistently told us there were no restrictions on their visits.

Staffing and recruitment
● People told us there were not enough staff available to meet their needs. One person said, "I get very lonely; I wake up early but have to wait for a long time until the day staff have time to assist me to get dressed and go downstairs. The waiting really gets me down." Likewise, another person commented, "We have a few more care staff now, but most of the nurses are agency staff who don't know the home. The other day I had to wait until 11:15pm to get my painkillers which I like to have around 9:30pm. It's not the nurses' fault, they come in and have to learn a new system and new people. Nursing staff apologise and say it's just too much work for one nurse."
● Relatives echoed people's concerns about staffing levels and provided examples of how their loved ones did not receive the right care as a result. One family member told us, "He only gets one shower a week and that's only if I insist that goes in the diary at least the day before." Another relative said, "For the past few months I've been concerned that mum is still in bed when I visit. She also goes to bed at 7pm and I think 10am is just too long to be in bed waiting for personal care."
● People and relatives repeatedly expressed frustration at the length of time they had to wait for their calls for help to be answered. One family member told us, "I pressed the bell, and it took just over 20 minutes for someone to respond, and that's with me there." Another reflected, "I do worry what would happen if there was an unexpected event because even I can't find someone to speak to."
● During our unannounced inspection visit, we found that the running of the home was chaotic and at 11am people were still waiting to receive their first personal care support of the day. In addition to the lack of care support, the home was unclean and breakfast trays were still sitting on tables in front of people at 11am.
● Staff spoken with confirmed that our finds were reflective of a typical day. One staff member told us, "When the day staff come on shift at 8am, there are usually 30 residents still in bed – some people want to get up early but have to wait. Until December, the top floor was left without support until 2pm in the afternoon because there were not enough care staff to help them." Another staff member added, "No personal care until 2pm – that's why there were pressure sores, because people were sat for too long in wet pads."
●We noticed that no one was supported to have a bath or a shower during our visit. We asked staff if people had been offered this opportunity. Two staff confirmed, "People are not getting showers – because not enough staff to support them in the morning. Staff don't get time to offer people showers until later in the day, by which point they are dressed and don't want them – so they just go without."

The failure to ensure suitable and sufficient staff were deployed was a breach of Regulation 18 (Staffing) of

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were recruited safely, and appropriate Disclosure and Barring Service (DBS) checks and other relevant recruitment checks were completed. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● The registered manager was able to provide evidence that nursing staff held an up-to-date registration with the Nursing and Midwifery Council.

Using medicines safely
● With the exception of one person who said their evening medicines were sometimes a bit later than they would like, people and their relatives' felt medicines were managed safely.
● An electronic medication system which flagged which medicines were due when, in conjunction with the nursing handover sheet, ensured nursing staff knew which medicines needed to be administered and when. The agency staff on duty was observed giving people their medicines in the way they had been prescribed.
● Whilst the daily management of medicines was found to be safe, there was a lack of clinical oversight and monitoring, and the systems were not in line with best practice. We noticed that one medicine had not been stored in line with the pharmacy guidelines and staff had not consistently recorded when medicines with a short shelf life after opening such as eye drops had been first used.
● Whilst nursing staff demonstrated appropriate practice in respect of the safe management of topical medicines, transdermal patches, and the administration of as required (PRN) medicines – the systems in place did not support this. For example, PRN protocols were not readily available and there were no recording charts to evidence site rotation or application of medicines to the skin.

The failure to ensure the proper and safe management of medicines is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● The factions within the management team and negative culture amongst staff as acknowledged in the provider's action plan meant that when things went wrong the focus was on blame rather than reflection. Concerns identified during the inspection reflected similar themes to those identified during a recent safeguarding investigation which indicated lessons had not been learned.
● Repeated themes of concern were raised by people and relatives. One family member told us, "It feels like you constantly have to have the same conversation about the same problems and yet nothing changes."
● Provider audits highlighted the same shortfalls shared by staff and yet no remedial action had been taken to address the issues that had been consistently identified.

The failure to establish systems and processes that appropriately assessed, monitored, and improved the quality and safety of people's care was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question Good. At this inspection the rating has changed to Requires Improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills, and experience

- Staff did not consistently have the training, experience, and support to deliver their roles effectively. Staff told us that the online training they had accessed in respect of specialist skills such as supporting people living with dementia and positive behaviour support had not been adequate for them to confidently support people accommodated.
- Since our last inspection, the service had altered its statement of purpose to include accommodation and support for people living with dementia. People and relatives told us that staff did not always have the skills to provide such care appropriately. One family member said, "Staff just don't seem to understand how to manage [their] cognitive difficulties and the manager just says she'll be keeping a record of the behaviour. They advertise themselves as a dementia service but even some of the nurses don't know how to speak to people with dementia."
- Staff had not received appropriate training in moving and handling. Despite 12 people requiring physical assistance through the aid of a hoist, staff had only completed online training. The registered manager said that staff competencies had been observed, but staff spoken with said they were not aware they had been assessed. There were no records available to show what checks had been carried out to ensure staff were supporting people safely and in line with best practice.
- Staff told us that they did not feel supported by the management team. Staff said they had repeatedly raised concerns about not having the skills or time to meet the needs of people being admitted to the home. Staff supervision records were not reflective of the challenges staff told us they faced and had reported to their line manager.
- Agency staff did not receive an appropriate induction when arriving at the service. The agency nurse on duty during inspection was leading the shift but told us they had not received any introduction to the home. The registered manager confirmed there was no system or checklist to evidence what induction should have taken place.

The failure to ensure staff received appropriate, support training and professional development, supervision and appraisal to enable them to carry on their duties was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Following the inspection, the provider wrote to us to confirm that a planned specialist dementia training course had now taken place which was attended by 15 staff. In addition, face to face training in other areas including moving and handling and fire safety had also been booked for the near future.
- A new interim clinical lead had been appointed to review the clinical support and supervision of nursing

staff, including the induction of new and agency nurses.

Adapting service, design, decoration to meet people's needs
● People told us that they were not able to access all areas of the home either due to issues with the lift repeatedly breaking down or because there was insufficient space in communal areas. One relative told us, "The lift has been 'out of order' on several occasions. This is not satisfactory as it isolates every resident above the ground floor to their own room 24 hours a day." The registered manager informed us that equipment had been purchased to enable people to access the ground floor during the month of November 2022 when a new part for the lift was being sourced. Staff and relatives however expressed that people were not supported downstairs for social interaction during the periods the lift was not working.
● The design and layout of the environment was not wholly suitable for the needs of people living with dementia or reduced mobility. One relative told us, "The layout of the home just doesn't work. The dining room does not have enough tables and chairs, which means [Person] can't even eat with other people sometimes and the chairs and tables are so close together that people struggle to navigate their way through. The activities room is hardly ever used."
● At lunchtime we observed that there was insufficient space for people to eat together in the dining room and as such some people were being supported to eat in the lounge without a table in front of them. The activities room was largely used as an informal staff area at the time of our visit.
● Bathroom facilities provided the equipment to support assisted bathing, but two bathrooms were observed being used for the storage of wheelchairs and commodes which prevented ready access.
● Signage & decoration around the home did not facilitate easy navigation for people living with cognitive or visual impairments.

The failure to ensure premises and equipment are suitable for the stated purpose was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

● Whilst applications for people who were deprived of their liberty had been made, there was limited evidence in respect of how other best interests' decisions had been reached. As such restrictions were in place, and it was not possible to evidence that other less restrictive options had been explored. For example, we identified two occasions where nursing staff had implemented the use of bed rails without any recorded assessment or best interest discussion.
● Where people lacked capacity to make certain decisions for themselves, the management team had not

always taken steps to engage with other relevant persons. For example, one relative expressed disappointment about not being consulted when their loved one had been moved to a different room. The registered manager was reminded that whilst a person's representative can only make a decision on behalf a person where they hold the relevant Lasting Power of Attorney, this should not exclude them from a best interests' discussion if it is appropriate to do so.
● There was no system in place to ensure the conditions attached to people's DOLS authorisations were monitored and complied with and staff spoken with were not aware of the conditions in place.

The failure to provide support in line with principles of the Mental Capacity Act 2005 was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Whilst there was evidence that people's needs had been assessed prior to admission, there was a lack of collaboration within the management team regarding how people would be effectively supported. As such, nursing placements had been offered without the input or assessment of a registered nurse. This was against the provider's own admission policy and had created a situation where staff had differing views about how people's needs could be met within the service.
● People had experienced delays in receiving appropriate healthcare and support, because communication across the service and the handover of information was not always effective. We observed incorrect information being given to a medical professional during our visit and a relative told us of another occasion where staff had forgotten to add their family member to the weekly GP list which resulted in a delay in them getting assessed.
● Relatives repeatedly told us that items such as dentures, glasses and hearing aids were frequently lost or broken. One relative said, "We've had two sets of broken dentures within 2 months and never happened before." Likewise, another family member said, "We've lost glasses, hearing aids and false teeth in the last month, which will now need to be replaced."

● In addition to the concerns identified, some people and relatives expressed satisfaction about the support people had received on admission to Moorhouse. For example, one family member told us, "They've been assessing her with the GP, and they've got the medicines right in the short time she's been here."
● Another relative praised the way manager and staff had supported their relative to get properly assessed for equipment which had been life-changing for them. They said, "Moorhouse have gone out of their way to ensure [Person's name] health and well-being by sourcing the equipment which enables them to move from bed to chair."

Supporting people to eat and drink enough to maintain a balanced diet
● People were mostly positive about the food they received. One person told us, "The food is very nice. I don't eat fish and they know that." Likewise, a relative said, "I cannot speak highly enough of the chef." □
● People were supported to maintain adequate levels of nutrition and hydration. Observation of the lunchtime meal showed there was choice, good portion size and modified textures were nicely presented. Where people required their drinks to be thickened, this was done in accordance with their prescription.
● Staff, in particular kitchen staff, had a good knowledge of people's dietary needs and preferences and ensured these were respected. For example, one staff member told us, "We provide a balanced diet of protein, vegetables, and carbohydrates. Our diabetic residents have higher ratios of vegetables and protein and less carbohydrates. We also make a diabetic trifle separately with diabetic custard and diabetic jelly.

Therefore, people with diabetes can still have what other residents are having."

● Care records included the use of food and fluid monitoring tools where nursing staff had identified concerns about what they were eating and drinking.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question Requires Improvement. At this inspection the rating for this key question was Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- There was a negative culture across the service which focused on blame rather than improvement. One person told us, "There's just no happiness at the home now. There has been a mass exodus of staff because of the way things are managed and no one is happy."
- Our first inspection day found the service in chaos, with people, relatives and staff seeking us out to share their concerns. We observed both a lack of management and clinical oversight and an absence of teamwork across the service. Morale across the service was low.
- Many relatives told us they felt frustrated that when they raised concerns, nothing changed. One relative said, "We get no communication from the manager and just feel like he's in an institution. I try to offer solutions and ideas, but they never get actioned."
- The repeated loss of people's personal aids such as dentures, glasses or hearing aids highlighted a lack of personalised support and a failure to improve when things went wrong.
- Divisions between the different teams within the service prevented progress being made. Staff provided numerous examples of when they had been shouted out and insulted. One staff member told us, "I'm not supported, but degraded." Likewise, another member of staff reflected, "We are not valued, but we are threatened."
- There was a lack of accountability for mistakes that had been made. As concerns were identified throughout the inspection, staff and management sought to quickly blame others without reflecting on their own roles and responsibilities. The registered manager expressed concern about staff they manage, and yet had taken no action themselves to oversee or mitigate the risks they told us they had identified.
- There were systems in place to notify people and their representatives when things went wrong, but there was no assurance that lessons had been learned. The issues identified in this report reflect similar themes and failings to those highlighted in previous safeguarding investigation reports.

The failure to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Engaging and involving people using the service, the public and staff, fully

considering their equality characteristics; Continuous learning and improving care;

● People told us that the registered manager was not a visible leader within the service. One person said, "She joined in July, but didn't introduce herself until the end of August." Likewise, another person commented, "I honestly don't think I'd recognise the manager, the staff come in and out of my room, but she never has."
● Feedback from relatives about their experience of the registered manager was starkly varied. Whilst some families expressed they had confidence in the management of the home, many others shared examples of where things had gone wrong. One relative told us, "She is a not competent leader and doesn't listen." Likewise, another family member reflected, "We had meetings with the manager and her deputy, but they always just shut you down."
● Whilst there were resident and relative meetings for people to share their ideas and experiences, we received considerable feedback that these forums were not effective in listening to experiences and improving care. One relative reflected, "We had a relatives' meeting in October, and it all sounded positive, but then afterwards felt like it was just for show." Similarly, another family member said, "We've raised all these issues at relatives' meetings; but don't see improvements afterwards. The communication needs to be better."
● Staff did not always feel listened to, valued, or supported. Prior to the inspection we had been contacted by a number of whistle-blowers who shared their concerns about the running of the home. During our visit, staff repeated these concerns. One staff member told us, "The management are just not listening. Like staffing, they are doing the ratios but they're not listening to the fact that residents are not getting the care."
● Records were disorganised and difficult to access. During our inspection we asked for a range of documents relating to people's care. Neither staff members nor the management team were able to access information requested easily. This was especially concerning given the high use of agency staff who were less familiar with people needs and who relied upon accurate and complete care plans to safely support people.
● The internal audits used by the management team had not been effective in identifying the concerns highlighted throughout this inspection or where the provider's policies were not being followed.

The failure to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● At our last inspection we recommended that the provider seek advice and guidance in developing their strategic monitoring of the service. Since that time there have been considerable changes at a senior management level within the provider team and the understanding and engagement from the provider team both internally and externally has been very much improved.
● During the inspection representatives of the provider, including the nominated individual attended the service. The nominated individual was open and transparent about the issues that they too had recently discovered were happening within the home. They shared copies of their own reports which identified many of the failings highlighted within this report and explained the actions they had already begun taking.
● Since the inspection, the provider has sent us a detailed action plan of the improvements they intend to make. Through feedback from our partner agencies who have continued to visit the service, it has been possible to evidence that the additional support going in to Moorhouse has enabled immediate improvements in respect of the most serious concerns to be made.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	The provider had failed to ensure that care and treatment was provided in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to ensure that the systems were in place to ensure that medicines and risks were managed in a consistently safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment
Treatment of disease, disorder or injury	The provider had failed to ensure that the premises and equipment were clean, suitable and properly maintained

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to establish systems and processes that appropriately assessed, monitored and improved the quality and safety of people's care in accordance with regulations and best practice.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had failed to ensure there were sufficient numbers of staff deployed to meet people's needs and maintain the safe running of the service.