

Moorland House Limited

Moorland House

Inspection report

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Date of inspection visit:
16 November 2022
17 November 2022

Date of publication:
13 January 2023

Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Inadequate ●

Is the service effective?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Moorland House is a residential care home providing personal care to up to a maximum of 23 people. The home does not provide nursing care. At the time of our inspection there were 15 people using the service, some of whom were living with dementia. The accommodation at Moorland House is arranged over 2 floors accessed by a passenger lift and by stairs. There is a communal lounge 2 dining areas and a secure garden area.

People's experience of using this service and what we found

Risk to people had not always been assessed and risk management plans were not always in place to guide staff. Improvements were needed to ensure the safe and proper use of medicines, and infection control risks were not consistently being managed safely. Staff recruitment processes did not promote safety. Observations indicated that were sufficient numbers of staff deployed, but we were not assured that staff were always suitably knowledgeable and skilled. Improvements were needed to ensure that robust investigations consistently took place to establish the reason for incidents and accidents so that learning might be shared.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. However, improvements were needed to ensure that the Mental Capacity Act 2005 was fully understood and implemented in line with legal frameworks. Care plans lacked completeness or contained conflicting information.

Improvements were needed to ensure that each person was provided with the support they needed with their dietary needs. Completion rates for developmental or specialist training which was designed around the needs of people using the service was poor and we were concerned about the competence of some staff, their ability to apply their training in practice or to effectively communicate with people. The provider, who had taken on ownership of the service in July 2022, had an extensive plan in place to undertake improvements to the environment. People felt that staff supported them to stay as well as possible and there was evidence that staff worked with a range of community healthcare professionals.

Governance arrangements were not effective at identifying all of the areas where the safety and quality of the service was compromised. Feedback described cultural issues amongst some of the staff team which had detracted from the ability of the new leadership team to manage the service effectively and drive improvements as quickly as they would have liked. The provider is taking action to put in place additional support, a new manager has been appointed and an external consultant hired. People spoke positively about the new provider and of their commitment to listen to their feedback and use this to improve the service.

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 20 November 2018).

Why we inspected

This inspection was prompted by a review of the information we held about this service.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from good to requires improvement with breaches based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well-led key question sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement

We have identified breaches in relation to safe care and treatment, governance, recruitment, safeguarding people from abuse and the need for consent.

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

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor 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 safe.

Details are in our safe findings below.

Inadequate ●

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 always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Moorland House

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

The inspection was undertaken by 1 inspector 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.

Service and service type

Moorland House 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. Moorland House is a care home without 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, however, they had resigned from their post. This was due to take effect from the 20 November 2022. The registered manager had not, however, been in the service since February 2022. Since that time the home had been managed by the deputy manager.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

We used information gathered as part of a monitoring activity that took place on 10 August 2022 to help plan the inspection and inform our judgements.

We received feedback from 2 health and social care professionals.

We used all this information to plan our inspection.

During the inspection

We spoke with 8 people living in the home and 3 relatives. We also spoke with the deputy manager, 6 care staff and a member of the housekeeping team as well as the operations manager and nominated individual.

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- People did not always receive the support they needed to remain safe; risk management plans did not always provide staff with sufficient information about how they were to mitigate the risks to people's health and wellbeing.
- One person's moving and handling requirements were complex, but there was no care plan or risk assessment in place to guide staff.
- Another person could at times experience seizures, they had no seizure care plan. The provider had recently arranged for staff to have training on caring for people with epilepsy but there was no individualised plan in place for the person. Staff gave us conflicting information on how they would respond were the person to experience a seizure.
- Another person's care plan and risk assessments were not reflective of their current needs. For example, it did not record their correct dietary needs or reflect the level of support they needed with their mobility. Their falls risk assessment had not been updated following recent falls. This person had been assessed by a healthcare professional as requiring a modified diet due to swallowing risks. The professional's report stated that the person should be supervised whilst eating due to these risks. We observed the person eating their lunch but there were no staff present. We brought this to the attention of the deputy manager. On the second day of our inspection, we reviewed this person's meal. The meal was meant to be a level 4 smooth puree. We found that it had lumps in it. We brought this to the attention of the management team who addressed this.
- There was inconsistent use of the systems in place to record and monitor safety related events. Post falls checks were not consistently taking place to ensure that people were not deteriorating.
- We visited 2 people in their rooms. Due to identified risks of falling, they had been provided with alarm mats which were used to alert staff that they were mobilising. In both cases, the alarm mat had been pushed under the bed and would not have activated if the person were to mobilise.
- We observed 1 person had some difficulty using the stairs. We reported this to the deputy manager but found that there had been no assessment of the person's competence to use the stairs safely.
- Another person we visited had been provided with a drink in a lidded beaker. They had been left lying flat. They complained to us that they were not able to tilt the beaker sufficiently to drink from it. We were also concerned that drinking whilst lying flat could increase the risk of choking. We stayed whilst the person rang for further assistance. The carer that attended did then reposition the bed safely for drinking.
- Some environmental risks were not adequately managed. A fire door which should have been kept shut was found to be propped open.
- The providers legionella risk assessment recommended a range of ongoing checks to manage risks associated with the hot and cold water systems. These were not in place. There had been some recent water

analysis which did not find legionella.

There was an inconsistent approach to managing risks to people's health and wellbeing. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People told us they felt safe at the service. One person said, "Yes I feel safe, I have my buzzer... They look after me pretty good" and another said, "Yes I do feel safe living here... the staff here are good, and I find them caring".

Using medicines safely

- Improvements were needed to ensure the safe and proper use of medicines.
- We reviewed the medicines administration records (MARs) for October and November 2022 and found 8 occasions where staff had not signed the MAR or recorded a non-administration code. Staff undertaking the next medicines round had not reported this to enable action to be taken to understand the circumstances of why the gap was present. This is important as it may be necessary to seek a review by the GP.
- MARs indicated that multiple medicines were out of stock for periods of between 2 weeks to 1 month. The deputy manager told us that in some of these cases, following discussion with the GP, these medicines had been stopped but the MAR had not been updated. However, there was a lack of evidence of these instructions from the prescriber.
- We found regular medicines were being administered as if they were a PRN, or 'as and when' medicines and PRN medicines were in some circumstances being given regularly for extended periods of time without this being escalated to the prescriber for review.
- No record had been made on the MAR as to why PRN was given or whether it had been effective. This helps staff monitor any themes or trends that might need escalation to the prescriber.
- Two tablets were found in a plastic bag in the medicines trolley. The deputy manager was able to identify one of these, but not the other. It was not clear what medicine it was, nor which person it had been prescribed for, or why it had not been administered. There was no information in the medicine's disposal book.
- There were opened eye drops in the fridge. The box said they should be discarded 28 days after being opened, but no date of opening had been recorded.

Whilst there was no evidence that people had been harmed, medicines were not consistently being managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed medicines being administered in a person centred manner.
- People were happy with the support they received with their medicines. One person said, "I am happy with them dealing with my medication, I was talked through all the medication when I first came here, I don't know all of what I take now off by heart, but I trust them".

Preventing and controlling infection

- We identified a number of concerns regarding infection control.
- On a number of occasions, we saw staff not wearing their mask properly. One staff member's mask was ill fitting.
- We twice saw staff walking around the home in aprons and gloves that they had been wearing whilst providing personal care to people in their rooms. These should be removed as soon as possible and discarded safely.

- We saw a clinical bin used for discarding personal protective equipment was overflowing with used aprons.
- Visitors were not being encouraged to wear masks. We saw 2 visitors walking through the communal areas of the home following their visit to their family member. They were not wearing masks.
- The deputy manager told us that visitors were asked some screening questions to ensure that they did not have any symptoms of transmissible viruses or infections. However, neither of the visitors we spoke with said this was happening in practice.
- Cleaning schedules were in place and it was evident that the housekeeping team worked hard. There were, however, gaps in the daily cleaning schedules and some areas of the home were in need of a deep clean. Some equipment also needed cleaning including people's wheelchairs.
- Records relating to the cleanliness of the kitchen and the safety of food also contained some gaps.

Whilst there was no evidence that people had been harmed, infection control risks were not consistently being managed safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was responding effectively to risks and signs of infection.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

- Visiting could take place flexibly and booking was no longer required. Visits took place in private in people's room.
- Feedback about the visiting arrangements was positive with all relatives saying they felt welcome at the service. One relative said, "It's nice being able to pop in rather than having to make an appointment". People felt that staff supported them to stay as well as possible.

Staffing and recruitment

- Improvements were needed to ensure that staff recruitment processes promoted safety.
- We reviewed 4 staff files. None of these contained any information about the staff member's employment history, any interview notes or fully completed application forms. There were no employment references. Without this information, it is not possible to determine whether the prospective staff member had previously worked in health and social care. Where this is the case, it is a requirement that the provider seek satisfactory evidence of the staff members conduct when they were in this role.
- The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions by carrying out checks on whether staff have any criminal convictions that might make them unsuitable to work in a setting such as a care home. They also offer a check of the 'barred list'. This is a check as to whether the person had been 'barred' from working in a care setting due to concerns about their past behaviours. In 3 of the 4 DBS checks viewed, there had been no check of the barred list.

Recruitment procedures were not established and operated effectively. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Other checks were in place including right to work checks and health declarations.
- During the inspection, our observations indicated that, overall, there were suitable number of staff on duty

to meet people's needs. The longer standing staff knew people well and were kind and unhurried when meeting people's needs.

- We did not observe that people had to wait unduly for assistance and staff were mostly deployed to ensure that communal areas were supervised. We did note 1 occasion where this was not the case and we have spoken about this above.
- Rotas were in place, but there was a lack of clarity around how these were planned to meet the numbers of people receiving a service.
- Whilst we were told that gaps in the rotas were filled with agency staff, however, the provider was unable to provide evidence of which agency workers had worked which shift. This is important to ensure that the provider has oversight of the numbers, skill mix, competence and experience of the team providing people's care.
- Overall staff felt that the staffing levels were suitable, but all of the longer term staff we spoke with raised concerns with us about the communication skills of some of their newer colleagues and felt this impacted on some staff being able to respond to people's needs. We have spoken more about this in the 'effective' section of this report.
- Overall, people were satisfied with the staffing levels. One person said, "Carer numbers are about right, I don't have any complaints about that" and another said, "I have my bell, I use when I have to, I know someone will come". One person expressed their discomfort at only having male staff on duty at night. Rotas showed that this had been the case for last 3 weeks prior to the inspection. The provider told us they were taking action to address this with immediate effect.

Systems and processes to safeguard people from the risk of abuse

- During the inspection we became aware of 2 concerns of a safeguarding nature. Internal investigations had or were taking place to ensure that people were protected from abuse, but neither incident had been escalated to the local authority so they could have oversight of the investigation to ensure that all relevant actions had been taken to address immediate risks and to ensure people's safety.
- Despite recent training, some of the newer staff were not able to demonstrate an acceptable knowledge of safeguarding practices.

Learning lessons when things go wrong

- Staff understood their responsibility to report safety related incidents and there was evidence these had been reviewed by the deputy manager.
- There was some evidence that post falls huddles had, in the past, been used to review the circumstances of falls and help plan further preventative strategies. This approach had not been used in respect of the falls in September or October 2022.
- Our discussions with the deputy manager provided assurances that remedial actions had been taken following falls. For example, seeking advice from relevant healthcare professionals and informing family members.
- We were less assured that robust investigations consistently took place to establish the reason for the incident, or to ensure that learning might be shared. For example, we saw that in 1 recent incident, a person had fallen in their room. They were not in reach of their call bell and so had had to shout for help until someone heard them. The incident review of this, had not considered whether there was any additional equipment that might improve the person's safety moving forward. The person concerned told us, "Since my fall, the buzzer does come out further but I still can't always reach it".
- In response to a number of incidents, we found that general terms such as 'continue to monitor' were used. It was not clear to us what this meant in practice and how this would improve outcomes and safety for people.
- A new monthly, more probing, analysis of all incidents and accidents had recently been introduced so that

any themes and trends might be identified.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- It was not always evident that staff had completed a full assessment of people's needs either before admission or shortly after. One person who had been at the service for a week did not have any care plans or risk assessments in place.
- In other examples viewed, care plans lacked completeness or contained conflicting information, whilst others were more reflective of people's needs.
- There was some evidence of care plans containing personalised information and an assessment of the person's communication needs, but this was not consistent.

Care plans lacked completeness or contained conflicting information. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Daily records indicated that people were not being supported to clean their teeth or dentures. We observed that some people had a build-up of food and plaque on their teeth.
- The provider told that there were plans in place to introduce an electronic care planning system early in 2023. This would result in all care plans being reviewed, updated and made more personalised.

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, 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.

- Improvements were needed to ensure that the MCA was fully understood and implemented in line with

legal frameworks.

- A number of people using the service lived with advanced dementia, but there was no evidence that people's capacity to consent to the care and support being provided had been assessed, or for example, before a DoLS application had been submitted.
- It was not evident that consent had always been obtained in line with legal frameworks. That is, we saw evidence that consent forms had been signed by a third party who did not have the legal authority to do this. Where the person lacked capacity to sign the consent form, there was no mental capacity assessment or best interests' consultation in place to inform care planning.

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

- A DoLS application had been submitted for most of the people living in the home. There was a tracking system in place to monitor the dates DoLS had been authorised or needed to be reapplied for.

Staff support: induction, training, skills and experience

- We were concerned that the service had not completed sufficient checks to ensure that new staff understood and were able to apply their training in practice.
- We observed that 1 new staff member was not able to effectively communicate with a person when supporting them with a transfer. The staff member was also not working in sync with the second carer and this led the transfer being chaotic. We were concerned that had meant the interaction was not a positive or safe experience for the person.
- We saw some interactions where it was clear that the person was experiencing difficulty in understanding staff due to the care workers command of English.
- We spoke with staff about their understanding of how to respond to safeguarding incidents or other safety related events such as choking. Despite having completed relevant induction training, we were unable to understand the response of 2 staff due to their limited command of the English language.
- Staff raised concerns with us about the communication skills of some of their colleagues and the potential impact this could have on people's safety if they were not able, for example, to follow instructions. One staff member said, "We have got more staff, but the wrong staff, I can't understand the new ones, they don't understand me, communication is key. It's an accident waiting to happen. The residents are talking about it, I've never felt so on edge, I'm worried".
- We observed 1 such interaction. A person was trying to request that staff bring her a cup of tea in the correct type of cup for their needs. Both staff failed to fully understand what the person wanted / needed and as a result, the person's need was not met.
- Most staff were up to date with the training that the provider deemed to be mandatory. This was training in safeguarding, emergency first aid, infection control and moving and handling.
- The provider also offered staff developmental or specialist training which was designed around the needs of people using the service. This included topics such as falls prevention, diabetes, end of life care, food hygiene and dementia awareness. No staff had completed any of this training. A healthcare professional also identified some concerns about the training saying, "The staff are very caring, but I am not convinced the level of training has been appropriate, improvements have been observed since the business was sold".

This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We discussed these concerns with the provider. They have made arrangements to allocate staff to different roles whilst they receive further training and support with their English language skills.

- Staff received and induction and a programme of supervision was in place.

Supporting people to eat and drink enough to maintain a balanced diet

- We saw some positive interactions where staff were supportive when encouraging people to eat and drink, however we also noted some concerns.
- Some people were left to eat independently with little interaction from staff who were standing back observing but not offering people assistance. This resulted in 1 person being left to eat in an undignified manner until another staff member noticed this and intervened.
- We observed 1 person telling their carer that they were feeling rushed when being supported with their lunch. The care worker acknowledged this and said they would slow down. The care worker did slow down, but then began to speed up once again. The person responded by saying that they would try and feed themselves, telling us, "It is being shoved into my mouth". The lady did then try to feed herself but due to her sensory needs, the food was falling off their plate. We checked this person's weight records and saw that they were losing weight.
- Food and fluids charts were maintained for each person. The chart was not easy to extrapolate information from and there was no evidence that these were being reviewed to provide assurances about food and fluid intake.
- We noted that the chart did not provide assurance that drinks were offered / taken outside of mealtimes or the mid-morning / mid-afternoon drinks rounds. This would be in keeping with our observations during the inspection. There was a section on the chart for recording 'late drinks' at 7pm. There was only 2 entries for this drinks round over the 10 day period that we viewed the food and fluids charts for.
- We visited 4 people who chose to spend their time in their rooms. Three of these did not have fluids in their room.
- At the mid-morning drinks round, we heard staff offering people a choice of a tea or orange juice. People were also asked if they wanted a biscuit. We observed that where a biscuit was chosen, 1 biscuit was placed on the table beside the person. No plate was offered.
- A more effective system was needed to share information with the chef about people's dietary needs. They had not known for example, that 1 person was dairy intolerant. We saw this person being offered a jacket potato with cheese on, which they had to refuse.
- The mealtime service did seem to be a positive experience for most people and the food being served looked and smelled appetising.
- Overall, the feedback about the food was that it was satisfactory. People spoke positively about the salads that were available and the scrambled eggs they could have at breakfast.
- However, we noted that there were no condiments on the table at lunch. We heard 1 person handing over their plate saying the meal had been nice but had not had any salt on it. Another person was supported to eat their meal in the lounge but at the same time, the housekeeper was hoovering the area.
- A new chef had very recently been appointed and they had plans to review the menu with people using the service and include more choices, more vegetarian options and develop the range of snacks available.

Adapting service, design, decoration to meet people's needs

- The décor in some parts of the home looked tired and worn with some areas needing repair or updating. For example, carpets were worn and rippled creating a potential trip hazard. Paintwork was damaged and worn throughout.
- A number of people's rooms lacked any sense of personalisation. Curtains looked crumpled and some furniture was worn or chipped which did not look pleasing, but also presented an infection control risk.
- One person told us their bed was uncomfortable to sleep on. To address this, their family member had bought a mattress topper. Another person's relative told us, "The rooms are tired and could be a lot nicer".
- Another person had been admitted to the home for respite a week prior to our inspection. The person

received bed based care, but they did not have a radio or television in their room for stimulation or entertainment. Later when we spoke with this person again, they told us that they had preferred being in hospital, we asked why, they said, "There were more people to talk to".

- The bath had not been in use for over a year as the bath lift was unsafe and needed to be replaced. This meant people could only have showers.
- There was some accessible signage to support people to recognise where the toilets or communal rooms were, but in general, whilst comfortable and homely, the environment was not fully adapted to meet the needs of those living with memory loss or dementia or other sensory deficits, and did not enable them to meaningfully interact with the environment in which they lived.
- The provider, who had taken ownership of the service in July 2022, had an extensive plan in place to undertake improvements to the environment. They had already started repairs to the roof and a repainting programme. Ten new profiling beds had, for example, been delivered to replace the older divan beds that were being used. Plans were also in place to enhance the outdoor spaces and make these more accessible to people.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- People felt that staff supported them to stay as well as possible and there was evidence that staff worked with a range of community healthcare professionals. We were able to see examples where people had been referred to external services for further assessment and treatment. A healthcare professional told us, "Over the past year that we have been completing weekly ward rounds the escalation of issues has improved with more issues escalated to us as they arrive. The ward round list is usually quite detailed with questions raised, they are good at following medical advice".
- Where people needed support to travel and attend healthcare appointments, this was provided through extra staff being rostered which was positive.
- Staff had made links with a healthcare professional who had provided training and support with the implementation of Restore 2. This is an escalation tool that includes the use of physical observations to assess whether a person's health is deteriorating and in doing so supports the decision making of healthcare professionals.

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 good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Whilst there were a number of audits and checks undertaken by the deputy manager, these were not effective at identifying all the areas where safety or quality were compromised.
- The inspection identified concerns regarding how risks to people were mitigated, the safe management of medicines, infection control practices and the safety of recruitment checks. We also found that legal frameworks regarding consent were not being effectively implemented and that governance needed to be more robust.

The provider had not ensured that there were effective systems in place to assess, monitor and improve the service. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager had been absent from the service since February 2022 and had now resigned from their post as of November 2022. This meant the deputy manager had been managing the service. The deputy manager told us they had found this period a challenging time. They described a poor culture amongst some of the staff team which had detracted from their ability to manage the service effectively. They had also often been called upon to cover care shifts due to staffing challenges which had limited the time available to them to embed changes and drive improvements.
- The deputy manager had not had any formal supervision for over a year and they openly acknowledged that there were areas where they needed to further develop their skills and knowledge. This included areas such as managing and investigating safeguarding concerns and implementing the Mental Capacity Act 2005.
- The current provider had taken ownership of the service at the end of July 2022. They had already started to implement a programme of improvements and had a plan in place to further develop the service and the environment.
- They had made arrangements for their operations manager to spend 2 days a week at Moorland House supporting the deputy manager. The provider was also spending a significant amount of time each week at the service.
- A new manager had already been appointed and was due to start in January 2023. A local healthcare professional commented on the improvements that had been made since the change of ownership saying, "I am very pleased that Moorland has a new owner who has been very engaged in understanding the problems and wants to improve the service, [Deputy manager] has been working very

hard to improve standards, but Moorland requires a new registered manager to help embed new changes".

- In response to our inspection findings, the provider has submitted an action plan providing assurances about the immediate actions they were taking to address our concerns. They have also appointed an external consultant to provide support and quality assurance checks to ensure that people were receiving good quality care and support.

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

- The deputy manager was aware of their responsibility to act in an open and transparent way when things went wrong, and we saw examples where relatives had been notified of safety related events that had occurred.
- The deputy manager had not, however, embedded a process of following this with a fuller summary of the outcome of investigations, including an apology. This is an area for improvement.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- We saw that the longer term and established staff knew people well, promoted their independence and took a genuine interest in providing support in way that would enhance the person's day. For example, we saw that 1 person was becoming a little distressed. Staff recognised this and encouraged the person to come and sit beside another person. The staff member facilitated a discussion between the 2 people around a shared interest which had a positive outcome for both people.
- Rather than use wheelchairs to support people to move between areas of the home, staff were using a more time consuming but individualised approach to support a person to walk and maintain their mobility.
- Staff spoke tenderly about the people they cared for and told us about the loss they felt when people died. For example, 1 staff member told us, "It's hard when they die, me and [staff member] are the ones that get them dressed, it's an honour to do it, we choose an outfit, you still speak to them the same way as if they were alive to give them respect".

The care nature of staff was commented on by a healthcare professional who told us, "The care and love the carers show to the residents is wonderful".

- We did see a number of neutral interactions, where newer staff lacked enthusiasm for the tasks they were completing or were disengaged from the support they were providing to people.
- The provider spoke of there being some challenges in terms of staff embracing change since they took ownership of the service and there had been a large turnover of staff.
- Current staff also spoke of concerns regarding the recent culture within the service and of there not always being a shared commitment from all of the staff team to make the service the best it could be. It was clear from our discussions that some staff still did not feel comfortable being fully open about some of their concerns.
- Most staff though felt that the culture within the service was improving. Staff told us, that they now had a better understanding of why changes were needed within the service and that they felt the deputy manager had been doing a good job in difficult circumstances. For example, 1 staff member said, "Before, if there was an issue with the residents, we passed it on, but nothing happened, we have more trust it is acted on now" and another said, "[Deputy manager] needs a pat on the back, she has improved things, she takes all the flak from everyone, here to 9/10 o'clock at night sometimes, she is very approachable".
- The service employed staff to focus on the provision of activities, but all staff took a role in this. An activities timetable was shared with us which included activities such as arts and crafts, quizzes and games. During the inspection, we saw staff briefly playing ball games with people and leading gentle exercise sessions. People appeared to be enjoying these.
- On both days an external entertainer also visited for singing and music sessions which again people were

engaging with.

- A number of people told us that the activities could be further improved to ensure that these were more in keeping with their interests and prevented isolation. One person who chose to spend time in their room, did express some loneliness and told us that whilst staff had tried, at times, to provide some one to one time, this had not been focussed around their interests. She told us, "I don't want to hear them read children's book. They added, I'm not putting them down, they are good really and do try". Another person told us, "They play games here sometimes, but I can't be up for their silly games...all it is, is a ball being patted forwards and backwards". A third person said, "There is not a lot of stimulation here for me... I would like someone with the same interests as me, but sadly that is not forthcoming".

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People spoke positively about the new provider and of their commitment to listen to their feedback and use this to improve the service. One person told us, "[Provider] is nice and chatty, I think he listens and takes it all in and has people come along here to suss things out...he really does listen".
- A relative told us, "At every point they [New provider] are making changes, they have decorated the room, they have changed the washing machines, they have gone above and beyond".
- Whilst relatives generally said that they felt staff kept them informed about their family members wellbeing and updated them about incidents such as falls, there was a lack of evidence of people, and those important to them, taking part in care planning and reviews and this was an area where improvements were needed.
- There was some evidence that the provider had recently invited people, their relatives and staff to give feedback about the service via questionnaires. These were yet to be collated and analysed and used to plan and implement further improvements to the service.

Working in partnership with others

- The leadership team and staff worked with a range of health and social care professionals to meet people's needs.
- The provider responded in an open and transparent way to requests for information to support this inspection.

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	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>Consent had not always been obtained in line with legal frameworks. This was a breach of regulation 11 (1) (3) (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>Risks to people had not been adequately assessed or planned for. Medicines and infection practices were not being consistently safe.</p> <p>This was a breach of regulation 12 (1)(2)(a)(b)(g)(h) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured that there were effective systems in place to assess, monitor and improve the service. Care plans lacked completeness or contained conflicting information. This was a breach of regulation 17 (1)(2) (a) (b) (c) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed</p> <p>Recruitment procedures were not established and operated effectively. This was a breach of regulation 19 (3) (a) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 18 HSCA RA Regulations 2014 Staffing</p> <p>The provider had not ensured that staff had the competence, skills and experience to care for people effectively. This was a breach of regulation 18 (1) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>