Moorland House Limited

Moorland House

Inspection report

20 Barton Court Avenue
Barton-on-Sea
New Milton
Hampshire
BH25 7HF

Tel: 01425614006

Date of inspection visit:
05 December 2016
06 December 2016
12 December 2016

Date of publication:
14 February 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Moorland House offers accommodation for up to 20 people who require personal care, including those who are living with dementia. We carried out an unannounced inspection on 5, 6 and 12 December 2016 and found breaches of legal requirements.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timescale.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

At our previous inspection in October 2015 we identified the provider was not meeting seven regulations. Systems and processes were not established and operated effectively to prevent abuse. Staff failed to recognise restrictive practice and to assess less restrictive options for people's support. Risk assessments were not always completed and regularly reviewed and actions were not taken to mitigate risks. Staff training, and procedures regarding the administration of medicines were inconsistent and did not ensure the proper and safe management of medicines. Staff recruitment procedures were not established and operated effectively to ensure safe recruitment decisions. Consent to care was not always sought In line with current legislation and guidance. Staff were not familiar with and able to apply the principles and codes of conduct associated with the Mental Capacity Act 2005. The provider had not acted at all times in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. People were deprived of their liberty for the purpose of receiving care without lawful authority. Systems in place to assess, monitor and improve the quality and safety of the service were not operated effectively, in particular in regard to people's health and welfare. Records in respect of service users, persons employed and the management of the regulated activity were not accurately maintained.

Following the inspection, the provider sent us an action plan telling us the steps they were taking to make the improvements required. In July 2016 they sent us an updated action plan which informed us they had completed their actions or they were in hand. At this inspection, we found some improvements had been made. For example, staff training, supervision and appraisals had been completed. Staff recruitment procedures had been improved and all appropriate checks had been completed. Some improvements had been made to the safety of the environment.

However, on-going concerns remained in all other areas of the management of the home and in the care of people who lived there.

There was a registered manager in place at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the home. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run.

We found the registered manager did not fully understand their responsibilities in relation to meeting the Health and Social Care Act 2008 regulations. They had failed to notify the commission of events required by law. They had not understood the seriousness of the concerns we highlighted during our inspection.

Systems to monitor and assess the quality and safety within the home were not effective. Audits had not identified short falls in the management of the home and people's care that we identified during our inspection. The provider's action plan had not been adequately monitored for progress and to identify areas that still required improvement.

The registered manager and provider had failed to display their ratings in the home and on the website which we discussed with the registered manager on the second day of inspection. On the third day of inspection we noted the rating was displayed in the lobby but not conspicuously as required by law. The registered manager had not acted sooner on an action from an audit in November 2016 to do this. The website was updated by the provider following the inspection to display the rating as required.

Whilst people and relatives told us they felt the home was safe, we found on-going concerns. Staff had received safeguarding training, demonstrated an understanding of key types of abuse and explained the action they would take if they identified any concerns. However, whilst some incidents had been reported, other incidents, such as verbal abuse and intimidation between people, had not been identified as safeguarding concerns and had not been reported to the local authority safeguarding agency or to the Care Quality Commission as required by law.

Individual and environmental risks relating to people's health and welfare were not always identified and assessed to reduce those risks. This was an on-going concern. Risk assessments were not always in place to provide detailed guidance to staff in how to protect people from harm. Incidents and accidents were not analysed effectively to learn lessons and reduce the likelihood of them happening again.

Systems in place to ensure the storage and administration of medicines, including controlled drugs, were not safe. Medicines records were incomplete and inconsistent. Staff were assessed for competency to administer medicines, however not all staff had received regular training to do so. This was an on-going concern.

Staff did not always follow legislation designed to protect people's rights and ensure decisions were made in their best interests. The registered manager did not fully understand the Mental Capacity Act 2005 and

allowed relatives, who did not have the legal right to do so, to make decisions about their family member's care. This was an on-going concern. Whilst improvements had been made in relation to restraint, the registered manager had not ensured they supported a person to meet the conditions within a Deprivation of Liberty Safeguards authorisation.

There were insufficient staff deployed to meet people's needs at all times. People were left unsupervised for long periods of time in communal areas during the mornings when staff were busy getting other people up. People's emotional and social support needs were not always met as staff did not have time to sit and engage with them until later in the afternoons when other tasks had been completed. Some activities were planned throughout each week, however, it was noted there were no activities planned at weekends when there were less staff and more pressure on their time.

Most people were supported to maintain their health and well-being and had access to healthcare services when they needed them. However, we noted other examples of people not receiving the care they required in a timely way. Staff did not always act in line with the home's 'falls protocol' or take appropriate action to request medical advice for people sustaining a head wound following a fall.

Staff treated people with dignity and respect and ensured their privacy was maintained most of the time. However, we observed some interactions and use of language, which was not meant unkindly, but that did not promote dignity and respect.

Initial assessments were carried out before people moved into Moorland House to ensure their needs could be met. Information was used to develop plans of care for people most of the time. However, this was not always the case and changes to people's care needs were not always reflected accurately in their care plans. People's care records were not always accurate or up to date.

People were supported by staff who had received an induction into the home and appropriate training, professional development, supervision and appraisal to enable them to meet people's individual needs. Staff meetings took place and staff said these were helpful and enabled issues to be discussed. Staff felt supported by the management team and were confident to raise any issues or concerns with them.

People were supported to have enough to eat and drink and that met their specific dietary needs. People received individual physical assistance to eat when required and were provided with specialist equipment to enable them to maintain their independence to eat where possible.

The service was responsive to people's needs and staff listened to what people said. People and, when appropriate, their families or other representatives were involved in decisions about their care planning.

Staff were caring and sensitive when people became anxious or upset, providing re-assurance and appropriate touch. People and families were encouraged to celebrate people's birthdays and received presents from staff.

People were encouraged to provide feedback on the service provided both informally and through satisfaction surveys. Residents meetings enabled people and family members to meet with staff and discuss any issues relating to their care. People and relatives confirmed they knew how to make a complaint and would do so if they had cause to.

Plans were in place to manage emergencies including alternative accommodation should the home need to be evacuated. Equipment, such as hoists, was regularly serviced.

We identified 9 breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the back of the full version of our report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People and their families felt the home was safe. However, the manager and staff had not always identified when people were at risk of abuse or harm and had not always followed safeguarding procedures. Individual risks to people had not always been assessed and action had not been taken to minimise the likelihood of harm.

Medicines were not managed and stored safely and staff could not be assured that people always received their medicines as prescribed. There were not enough staff to meet people's needs at all times.

Recruitment practices ensured that only staff who were suitable to work in social care were employed. The home was clean and tidy.

Is the service effective?

Inadequate

The service was not always effective.

Most people had access to health professionals and other specialists if they needed them. However, referrals for medical advice and treatment were not always made in a timely way.

The registered manager and staff did not always protect people's rights because they did not have sufficient understanding of the MCA 2005, best interest decisions and DoLS.

Some improvements had been made overall to induction and on-going training, supervision and appraisal to enable staff to support people in their role.

People were supported to have enough to eat and drink in a way that met their specific dietary needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always communicate or use language that respected people's dignity and privacy.

Staff understood the importance of respecting people's choices and developed caring and positive relationships with them. They provided gentle reassurance to people when they were confused or anxious.

Staff supported people and their families to express their views and be involved in making decisions about their care and support and promoted people's independence.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Most people had care plans which were personalised and focused on their individual needs, choices and preferences, although some people did not always have relevant care plans specific to their needs. The registered manager involved people and their representatives in planning care.

There were limited opportunities for people to participate in activities for their physical, social and emotional stimulation.

People and families knew how to make a complaint if they wanted to and felt confident any concerns they had would be responded to.

Is the service well-led?

Inadequate

The service was not well-led.

The registered manager did not fully understand their responsibilities in relation to meeting the requirements of the Health and Social Care Act 2008.

The registered manager and provider had failed to effectively identify, assess and monitor the health and safety and quality of care within the home putting people at risk of harm. Action plans were not effectively monitored to identify and reflect areas still requiring improvement. Records were not always accurate, up to date or reflective of people's current needs.

People, their families and staff had opportunities to feedback their views about the home and quality of the service being provided. Staff felt supported in their role.

Moorland House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We also needed to check the provider had the made improvements we told them to make during our inspection in October 2015.

The inspection was unannounced and was carried out on 5, 6 & 12 December 2016 by a lead inspector, accompanied by a second inspector on both the 5 & 6 December.

Before the inspection, we reviewed all the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed information of concern we had received from the local authority safeguarding team.

We spoke with four people living at the service and four relatives. We observed people being cared for and supported at various times in communal areas during our visit to help us understand the experience of people who could not speak with us. We spoke with four members of the care staff, the chef and the registered manager. Following the inspection we also received feedback about the service from two community care professionals.

We looked at a range of documents including five people's care records, six medicine administration records (MARs), and six staff recruitment, supervision and training records. We also looked at other records related to the running of the home, such as complaints, incidents, accidents and monitoring the quality of the service provided.

The home was last inspected in October 2015 where we found seven breaches of regulations.

Inadequate

Is the service safe?

Our findings

People told us they had no concerns and felt safe living at Moorland House. One person told us "I feel safe here. If I call them [with my call bell] they come quickly." Another person commented "I feel safe and well looked after." A relative told us "They do keep an eye on [my family member]." Although people felt safe, we found evidence at this inspection that contradicted their views.

During our previous inspection we had identified a number of concerns in relation to the safety of people living at Moorland House. Whilst there was improvement in the areas of recruitment and restraint at this inspection, we found other serious concerns.

People were not always protected from harm. At our previous inspection we found that risks to people had not always been identified or adequately assessed to enable staff to take appropriate actions to minimise the risks. We found on-going concerns at this inspection. For example, one person had a clear identified risk of choking as they had choked on two separate occasions in April 2016 but when we reviewed their care records, there was no care plan or risk assessment to guide staff in managing this risk. We raised this with the registered manager who later found a care plan in an archived file. However, there was insufficient detail to guide staff in how to monitor the person, prevent them from taking food from other people or provide robust actions to minimise the risks of choking. The person's care had not been managed in line with the home's 'Choking prevention policy.'

Staff had not always followed their falls protocol, assessed the risk of injury and sought appropriate medical advice following falls. On the third day of inspection we noted one person had cuts to their forehead and a large bruise under their right eye. The registered manager told us they had fallen out of bed onto their alarm mat the night before. They told us they had not requested medical advice. This is contrary to the actions required for a head wound stated in the protocol. When asked, the registered manager told us staff had found the person during a routine check. We asked if the alarm mat was working, and they stated it was. However, this had not alerted staff to the person falling out of bed. Another person had been having increased falls. On one occasion they had fallen and records stated they had sustained a bleeding head wound and lump to the right side of their head. Records showed that staff had not sought medical advice for the head wound and this was confirmed by the registered manager.

Between 27 May 2016 and 6 August 2016, three people left the home unnoticed on three occasions. They were found in the street by neighbours and on one occasion by a member of staff who was driving along the road on their way home. The police were called on two of these occasions to return the people home. Risk assessments for the three people had not been reviewed following these incidents and no other action was recorded.

Incidents which affected people's health or wellbeing were not adequately investigated to identify the causes, learn the lessons and reduce the likelihood of them happening again. Risk assessments were not always reviewed following incidents to ensure up to date guidance was provided for staff.

The failure to assess risk and do all that is reasonably practicable to mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continuing breach.

Safeguarding procedures were inadequate and did not fully protect people from harm. At our previous inspection we found that incidents of abuse and improper treatment had not always been identified or reported. We found on-going concerns at this inspection. Staff had received training in safeguarding adults and had an understanding of the key areas of abuse and their responsibilities for reporting any concerns. We noted that some incidents within the home had been reported as required. However, the registered manager and staff had not always recognised abuse or other safeguarding concerns, as described above, which had therefore gone unreported to the local authority safeguarding team and to the CQC as required by law.

One person had behaviour that could be challenging to other people. Staff confirmed the person could be aggressive and could upset others but had not identified this as a safeguarding issue. We reviewed the person's care records and found there was no risk assessment or care plan in place to guide staff in managing the person's behaviour. We observed the person behaving aggressively towards another person, calling them names, threatening them with their walking stick and making verbal threats to 'hit' them and 'get' them. The registered manager witnessed this person being verbally abusive during the same incident and asked them not to talk to the other person 'Like that.' They took no further action. They had not recognised that this constituted abuse. We reviewed their safeguarding policy file which included the Hampshire County Council's 'Levels of response and seriousness guide to safeguarding adults.' This clearly identified verbal threats and intimidation as low level abuse with guidance about the required action to be taken. We spoke with the registered manager about this incident who acknowledged they had not managed the incident in line with agreed multi agency policy and procedures.

People had not always been properly assessed for safe moving and positioning. We observed one person, of small frame, being hoisted in the lounge from an armchair to a wheelchair by two care staff. We noted the sling was a large toileting sling and when raised, the person looked as though they might slip through the bottom of the sling. We asked the registered manager to check the sling belonged to the person who had used it. They confirmed it did and commented "[The person] has lost a lot of weight over the past few months. It does need re-assessing." They also told us they had requested new slings from the provider "Months ago" but these had not been forthcoming. Following the inspection the provider told us the person had gradually been putting on weight since April 2016. They did not agree with the registered manager that they had therefore lost a lot of weight recently. They confirmed that slings were ordered when a need was identified and the person had now been re-assessed for a new sling.

Following the inspection, we spoke with the local authority safeguarding team about these and other incidents we had identified at our inspection. They confirmed they had not been made aware of these by the registered manager or staff. Following this discussion, CQC made seven safeguarding referrals to the safeguarding team as part of our duty to keep people safe from harm.

Failure to recognise and protect people from abuse and improper treatment was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continuing breach.

At our previous inspection, we found that systems for the storage, administration and management of medicines were not safe. We found on-going concerns at this inspection. Whilst staff competencies had been checked in January 2016, no staff had received refresher training within the past year. Three staff had not received training since October 2013 and one staff member who had received a competency assessment

had not had any training, according to the training records shown to us. On the first morning of the inspection we found the medicines trolley in the dining room, unattended, with the key in the lock. There were several people sitting in the dining room, but no staff were present. We spoke with two members of staff who both explained they were not responsible for the key being left in the cabinet, but made no attempt to remove the key when we showed it to them. After further discussion with the second staff member about the risks to people accessing medicines, they removed the key.

Room and fridge temperatures had not been taken regularly to ensure that medicines were stored in line with the manufacturer's guidance. For example, records showed temperatures had only been recorded on nine days within the month of November 2016. There were no records for the first five days in December. The registered manager confirmed temperatures should be taken every day. The provider could not therefore ensure medicines remained safe to be given or would remain effective.

Controlled drugs (CDs) were not safely managed. CDs are drugs classified under the Misuse of Drugs Act 1971 and have specific requirements in relation to storage, administration and recording. The CD register was not completed consistently and drugs received had not always been appropriately recorded. We found discrepancies in the reconciliation of CDs in the register compared to stock held. Changes had been made to records without an appropriate audit trail. A medicines audit had been completed on 11 December 2016, which showed there were no issues with medicines. This had not identified any concerns, such as those we had found.

Medicine administration records (MARs) were in place for each person who received medicines. However, we noted there were several gaps in the recording of people's medicines. The provider could not therefore ensure people had always received their medicines as prescribed. We also noted a number of handwritten changes to instructions on people's MARs. These had not been dated, signed or counter signed and there was no explanation of why these changes had been made or on whose authority, which would be expected in line with national good practice guidelines.

Failure to manage people's medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continuing breach.

People were not supported by sufficient staff to meet their needs. There were three care staff on each morning and afternoon shift. Staff said this was not always enough staff on duty to meet people's care needs. One member of staff told us people's needs had increased and there was "Hardly time to chat to them." A relative told us they thought the service had sometimes been "Struggling with staff ratios." They said "They only need one resident to be demanding more attention." This was confirmed by our observations throughout the inspection. We observed each morning that care staff were not present in the communal areas as they were busy getting people up. During these times, we intervened and called on staff to help people. For example, when they were at risk of slipping from their chair or needing the toilet. We noted staffing had been discussed during 'resident's meetings' and more recently at a staff meeting in September 2016 where it was stated "At times during the day there is no member of staff on the floor, there should be one carer at all times and carers should takes jobs in turn so that there is always one carer visible/available." This had not been implemented consistently. We observed that staff did have more time to sit and spend with people in the afternoons and engaged with people positively.

Night staff comprised one waking night and one sleep in member of staff. However, staff told us the sleep in staff had to be woken during the night to assist with repositioning. The registered manager told us they had reviewed the staffing and identified a need to increase the night staffing and day staffing levels, but had not yet spoken with the provider about this. They told us this would enable them to have more time to manage

the home, rather than working alongside staff providing care.

The provider had a system in place to assess the suitability and character of staff before they commenced employment. This had improved since our previous inspection. Staff files had been updated and contained all of the information required. Each applicant had submitted an application form with a full employment history and a health declaration to confirm they were fit for work. All applicants attended an interview and references were obtained from previous employers to confirm they were of good character. Applicants were required to undergo a Disclosure and Barring Service (DBS) check before confirmed in post. DBS checks enable employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with adults who may be at risk.

There were appropriate plans in place in case of an emergency or other event that required immediate action. For example, if there was a loss of electricity or a fire. Personal evacuation plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. It was noted some people required vertical evacuation using an 'Albac mat.' We spoke with two staff about training in the use of the mat. One said they had received training, the other said they had not which may have compromised the efficiency of an evacuation. The emergency plan contained useful phone numbers of utilities, accessible transport and contingency plans for alternative accommodation in the event the home had to be evacuated.

Equipment within the home, such as hoists and fire extinguishers were regularly serviced. The home environment was clean and we observed that staff were aware of infection control procedures. Protective clothing was available and in use by staff. Training records showed that staff had completed training in infection prevention and control in 2016.

Inadequate

Is the service effective?

Our findings

People told us they had access to health care support when they needed it to help keep them well. One person said "When I'm in a low mood they [Community mental health nurse] have come to see me." A relative told us the staff "Seem competent" and confirmed their family member had received a visit from the doctor when they were unwell. People confirmed staff asked them for their consent before providing any care or before entering their rooms.

Although people said staff asked them for consent they had not always protected people's rights. Consent to care was not always sought in line with the Mental Capacity Act (MCA) 2005. At our previous inspection we identified that the registered manager and staff did not understand the principles of the MCA 2005 and Deprivation of Liberty Safeguards (DoLS). We found on-going concerns at this inspection. Whilst most staff had received recent training in the MCA 2005 and DoLS, they showed varying degrees of understanding in relation to people they were supporting. The registered manager continued to demonstrate an inadequate understanding of The MCA 2005 which provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. When there was a risk people lacked mental capacity to make decisions about their care, mental capacity assessments had been completed for day to day living, but they had not been completed for other more significant decisions, such as the provision of alarm mats in people's bedrooms.

Where relatives had stated they had lasting power of attorney (LPA), the registered manager had not requested evidence of this to ensure they had the relevant legal authority to make decisions on behalf of their family member.

Failure to act at all times in accordance with the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continuing breach.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The registered manager understood some of their responsibilities and had submitted DoLS applications to the local authority for authorisation where required. However, they had not followed specific conditions applied to one person's DoLS authorisation to ensure they received the least restrictive practice. The registered manager had failed to meet the conditions of the DoLS.

Failure to act in accordance with the Deprivation of Liberty Safeguards Code of Practice was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is a continuing breach.

The provider had taken steps to improve the management of restraint in the home. At our previous

inspection, we observed one person was restrained in their wheelchair by a lap belt for long periods of time. Staff had not looked at other least restrictive practices to keep the person safe and had not sought the appropriate authorisation. At this inspection, we saw the person walked around freely. Staff confirmed that the person sometimes still wore their lap belt to secure them safely in their wheelchair at mealtimes. This had been agreed by care professionals involved although it was not now a regular event.

At our previous inspection, we identified that most staff had not received adequate training, supervision or appraisal to support them in their roles. At this inspection, we found overall improvements had been made. For example, most staff had received training in fire safety, moving and positioning and emergency first aid. All care staff assisted with meals and were observed in the kitchen making drinks and snacks, although we noted most staff had not completed food hygiene training. This had been classified as 'developmental' by the provider and only four care staff had completed this. The provider had not ensured that all staff involved with the handling of people's food had the appropriate training to do so. Statt told us they had opportunities for further development. One member of staff told us they had completed a level 2 diploma in health and social care and were currently completing level 3. They described how this had helped them to better understand and work with people living with dementia.

New staff completed an induction that included working alongside experienced staff. The provider had introduced the national Care Certificate which sets out common induction standards for health and social care staff, which new staff had completed. A recently recruited member of staff told us their induction was thorough and the managers and staff team were supportive. They said they had initially found personal care difficult. They said "I found it quite hard to take it all in. I spoke with [the registered manager] who said 'please give it a try'. I was buddied with [other staff] who encouraged me to be more hands on."

Staff told us they received regular supervision meetings and an annual appraisal which provided them with opportunities to discuss their work performance, concerns and any training with their line manager. We saw records of meetings which confirmed this.

People had access to health care when they needed it most of the time. Records showed that staff contacted health professionals such as GPs or dieticians when people lost weight or had become unwell. People had access to a range of preventative health care services including chiropody and opticians.

We observed staff patiently assisting people to the dining room to eat and offering a choice of where they wanted to sit. The dining area was clean and well-presented. Staff were observant and gave verbal prompts and encouragement to people to ensure they ate as much of their meal as they wanted. For example, one member of staff moved between tables asking people if they wanted help to cut up their food, or assisting them to put food on their fork or spoon to prompt them to start eating. People were provided with the appropriate equipment, such as adapted cutlery and plate guards to enable them to eat as independently as possible. Two people required full assistance to eat and each had an allocated member of staff to help them. They ate at their own pace and were not rushed.

People said they had enough to eat and drink and the food was good. Comments included "I can choose what I have to eat. I can have snacks or drinks at any time I want" and "They know my [food] likes and dislikes." People made mixed comments about the food but most people enjoyed their meals. Staff offered alternative choices when people said they didn't want a particular meal. People were also given a choice of drinks to have with their meals, such as squash or water.

People's support plans included nutritional assessments and details of their dietary requirements and support needs. The chef was knowledgeable about people's dietary requirements such as soft or diabetic

diets. The chef told us how they met these needs by ensuring appropriate ingredients were ordered, such as sweeteners to replace sugar in cakes and puddings. They told us communication between care and kitchen staff was good and they were informed of any changes affecting a person's diet, appetite or weight. They were clearly passionate about cooking and providing home cooked food for the people at Moorland House.

Requires Improvement

Is the service caring?

Our findings

People told us they were happy with the care they received. People's comments included; "They [staff] are so kind, we couldn't wish for kinder staff" and "I'm very happy here. They [staff] look after me really well" and "The staff are lovely." Relatives told us people were treated with respect and comments included "The staff are all very nice. My [relative] is happy" and "All the staff are very caring" and "They're very good with [my relative]."

Although we heard people and relatives were happy with the way staff treated people, we observed some interactions which demonstrated they were not always treated with dignity and respect. Whilst these interactions were not meant unkindly, they did demonstrate that staff did not always think about how the language they used could be derogatory. For example, we heard staff referring to people who required full assistance to eat as 'feeds' and the staff who supported them as 'feeders.' We heard other people who lived in the home also used this language when referring to others. This identified people by labelling them according to their support needs and was not respectful or dignified.

During mealtimes, the member of staff who moved between tables, prompting and encouraging people to eat did not sit with them at their level at the table. This led to them standing over, or to the side of people while they helped them with their food. This was not dignified for the people receiving the support, although the staff member spoke kindly and enthusiastically while they did so. We discussed the above issues with the registered manager who said they would address it with staff.

Staff did not always maintain people's privacy and confidentiality. We observed on a number of occasions that staff did not always maintain discretion when they were discussing people. For example, on one occasion we intervened to find staff when a person was asking to use the toilet. We mentioned this to a member of staff in a low voice for privacy. The member of staff immediately called out in a loud voice to another member of staff for assistance "[The person] wants to go to the toilet." This did not protect the person's right to dignity and privacy.

At other times, staff treated people with dignity and respect. We observed they knocked on doors before entering people's rooms and asked for permission before providing any care or support. People received personal care in the privacy of their bedrooms.

We noted that staff were kind, caring and friendly in their approaches to people's care. There was a good rapport between staff and the people they supported with lots of smiles and banter. A member of staff told us "I love them all to bits. You do get attached to them."

Staff encouraged people to celebrate their birthdays. We observed one person received a birthday present from staff, which they unwrapped and seemed delighted with. People and staff joined together and sang happy birthday to them.

Staff were compassionate and used gentle, appropriate touch to help reassure people if they become upset

or anxious. For example, one person was wandering along the downstairs corridor looking confused. A staff member asked them softly if they were okay and suggested getting a cup of tea. They put their arm around their shoulder and gently led them to a chair and settled them before going to make the tea.

We observed staff supporting people in the communal areas of the home and noted they had a good knowledge of the people they supported and encouraged people to maintain their independence as much as possible. A staff member told us "Sometimes they just need a little prompting and praise. Sometimes they need more help than at other times." Staff supported people and relatives to express their views and be involved in making decisions about their care and support.

Staff facilitated relationships between people using the service, their families and staff and people were supported to keep in contact with friends and families. Visitors were welcome at any time although they were encouraged to avoid mealtimes and this was confirmed by relatives we spoke to. However, we saw records that showed relatives were also able to stay and eat with their family members if they wished.

Requires Improvement

Is the service responsive?

Our findings

People were satisfied with the care they received overall. One person told us "They [staff] do talk to me and ask me what I like and don't like." Relative's comments were positive including "[My family member] is fiercely independent. She doesn't ask for help but gets attention when she needs it" and another relative said "They're brilliant. They try to keep me informed." They said they had not been involved in any reviews but didn't think that had been necessary.

Pre-admission assessments were completed with people, their families and healthcare professionals which helped ensure that their individual care needs and preferences could be met. Following the initial assessment, personalised care plans were developed which provided guidance to staff about how each person would like to receive their care and support. This included their skin integrity, mobility, personal care and any aids they used to help with, for example, their mobility sight and hearing. Whilst staff had a good knowledge of the people they supported, we noted that people did not always have care plans in place to guide staff in how to support them with specific needs, such as behaviour. Most care plans were reviewed monthly, although we found a number of inconsistencies and conflicting information in some people's care plans. We have explained more about this in the well led section of the report.

People's social and emotional needs were not always met. Some people commented that there wasn't much to do. One person told us "There's not a lot. They do have entertainers sometimes but it costs money. They have to pay for them. We keep ourselves busy." Another person told us "I like to go to church when I can get there. [The registered manager] knows I'd like to go." They said they would like to light a candle for their family but couldn't get there. However, they also told us they liked to knit and showed us a scarf they were knitting for a homeless person. We observed another person who enjoyed running around the garden to keep active and were encouraged by staff to do this.

The home had an activities programme displayed in the hallway which detailed activities during the weekday afternoons. These included a pianist, singing and motivation (exercise). We observed on one afternoon that an entertainer visited, as planned, and played an organ and sang songs which some people attended, seemed to enjoy and sang along to. A member of staff told us such entertainment was rare and "Care staff don't have time" to interact with people for social or recreational purposes. Following the inspection the provider told us "Our activities coordinator left at the end of October and we are currently recruiting a replacement. There were 11 planned events for December involving external visiting entertainers and activities providers, and there had been 14 in October and 11 in November, so it cannot be said that such events were 'rare'. These externally-provided activities are in addition to the activities provided by the staff within the home."

We observed there was little stimulation for people in the mornings. Each morning of the inspection, we observed most people sitting in the lounge in their chairs asleep or looking silently around the room. One person spent much of their mornings in the dining room with their head resting on the dining table. We observed staff chatting more with people in the afternoons when they had more time to spend with them and engage in conversation. However, there were no planned entertainment activities at weekends when

staffing levels were lower than on weekdays. This meant less opportunity for staff to spend time with people as there were less staff and they had more work to do. The registered manager explained they were looking in to recruiting volunteers to assist with activities and to spend time chatting with people but this had not yet been implemented.

People told us they felt able to raise any concerns or complaints with care staff or the registered manager but had not had cause to do so. The complaint records showed that one formal complaint had been received in April 2013. However, there was an entry in a person's communication record about concerns raised by relatives in March 2016. Although this was not recorded in the complaint log, there was a record of on-going communication during the period of the concern, although no outcome was recorded. We spoke to the registered manager who explained what the outcome had been and that the relative was satisfied. We later spoke with the relative who confirmed they were happy with the way their concerns had been dealt with.

Inadequate

Is the service well-led?

Our findings

People and relatives told us the registered manager was well known to them and was visible within the home. One person told us about a time they were unwell and said "[The registered manager] helped me a lot." A relative commented "I think it's one of the best" and another told us family members visited often and they "were very pleased with what they saw."

People were asked for their views about the care and support they received. Satisfaction surveys had taken place and the results of these were discussed with people and families during 'resident's meetings'. People had commented the standard of food and choices was very good and residents rooms and areas overall were very well rated for their cleanliness. When concerns were raised, such as problems with laundry, these were listened to and action taken to try to address them. Feedback was recorded from a local GP who said "In view of the challenges that some of the poorly residents present, they seem to do a good job."

Although people told us they were satisfied with the service, we found a number of concerns.

The registered manager did not fully understand their responsibilities in relation to managing a regulated activity. They had failed to identify and inform the commission of events required by law, such as safeguarding concerns.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The registered manager and provider had failed to display the rating from their previous inspection as required by law. This was also an action from an external audit carried out on 10 November 2016, however, on 6 December 2016, the registered manager asked us if they had to display it. We confirmed they did. This was seen to be displayed on the third day of our inspection on 12 December. However, we noted it was not displayed conspicuously, as required by regulation 20A of the Health and Social Care Act 2008. We had also noted the ratings were not displayed on the provider's website. We spoke with the registered manager about this who told us they would speak to the provider, as they dealt with the website. We noted on 3 January 2017 that this had still not been done and wrote directly to the provider. They confirmed this was completed on 9 January 2017 and when we checked we saw this had been done.

The registered manager had not effectively monitored the culture within the home and did not always lead by example. They had not identified certain incidents of verbal abuse and intimidation within the home as safeguarding concerns and consequently, staff had not questioned some behaviour which constituted abuse and safeguarding. They had also not identified specific language used by staff which could be derogatory to people they supported. We observed a notice in the downstairs bathroom which stated "Please do NOT leave any toiletries in the bathroom. Doing so can result in an inspection failure. Thank you." The registered manager confirmed they had put it up and said they were trying to stop staff leaving things in the bathroom. However, this was not an appropriate message for staff as it detracted from the risk of cross contamination and ingestion of harmful products by people.

At our previous inspection, although staff had a good knowledge of people's support needs, we noted that a number of people's care records were not accurate, up to date and did not always reflect their current needs. At this inspection we found on-going concerns. For example, one person had recently started to receive all of their care in bed due to their deteriorating health. Their care plan for personal care was dated 28 December 2013 and had been reviewed. However, there was no mention that they now received personal care in bed.

The person also had a falls care plan dated 18 November 2013. This had identified the person was mobile and didn't use any aids to help them walk. This had not been reviewed since 23 October 2014. It referred staff to the mobility care plan. This was dated 28 December 2013. It also stated the person walked independently with no aids. It did not reflect the person's current loss of mobility. On 3 November 2015 the person had moved to a different room. Care plans written after this date reflected the correct room number. However, several existing care plans including their falls risk, mobility and personal care plans had not been updated to reflect this change.

Another person had a falls and mobility care plan dated January 2016 stated the person 'only walks a few steps.' A care plan review on 15 August 2016 stated the person 'is now immobile and no longer weight bears.' In October 2016 a review recorded the person 'will weight bear for short periods of time.' There was no information to explain the change in their mobility which was confusing. The registered manager confirmed the person had fluctuating mobility but this was not recorded in their care plan.

We found a number of similar examples and spoke with the registered manager about the way care plans and reviews were recorded and conflicting information in care plans and within the review information. They agreed this was confusing and that the care plans were not up to date. They said they normally re-wrote the care plans each January, however, several of the care plans we saw were dated 2013 and had not been re-written annually as described by the registered manager.

Failure to maintain accurate, up to date, complete and contemporaneous records was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This was an on-going breach from our previous inspection.

Systems to identify, monitor and assess risks within the home were not effective. At our previous inspection we identified some concerns with the safety of the environment. We noted some steps had been taken to make improvements at this inspection. For example handrails had been fixed to corridor walls and window restrictors were now in place. This was confirmed by one person who showed us their bedroom window and said "I used to be able to open my window wider but they were worried about people falling out." However, we identified on-going and additional concerns. For example, water temperatures were not always taken before people had a bath or shower to reduce the risks of scalding. This had been identified at our previous inspection and although a recording system had been implemented, it was not consistently applied.

The registered manager showed us a maintenance book in which staff recorded faults or defects for the attention of maintenance staff. However, there was no system in place to routinely assess the environment for hazards. For example, the boiler in the downstairs toilet was not adequately screened off and hot pipes and metal work were accessible to people. Combustible materials, such as bedding, duvets and pillows were stored on an open trolley in an upstairs corridor creating a fire hazard on a fire exit route. Two radiator covers were not fixed to the walls and could have caused a person injury. We showed these to the registered manager who was unaware of these issues and had not identified them as hazards.

Failure to assess, monitor and mitigate the risks relating to the to the health, safety and welfare of people

and others was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This was a continuing breach.

Systems to assess, monitor and improve the quality of the service were ineffective. The provider had supplied us with an updated action plan in July 2016, which showed that most of the actions from the previous inspection were completed or were in hand. At this inspection we found that many of the actions stated as completed were still of concern. For example, the action plan stated "all potential safeguarding issues are referred to the local safeguarding authority; All incidents are now fully recorded in the resident's care notes together with the action taken; The temperature of baths is now routinely taken before a resident is immersed; [Medicines] staff will check the previous rounds records to ensure there are no gaps [on MARs]." We did not find this to be the case. Safeguarding concerns had not always been identified or reported. Care plan audits and medication audits and incidents and accidents audits had not identified there were still on-going issues, as we found during our inspection. Incidents and accidents and near misses were not routinely or robustly investigated and learnt from to reduce the likelihood of them happening again.

The provider told us they had employed an external consultant to carry out checks on the service and support the registered manager with improving the quality of the service. The consultant had visited after the last inspection and helped develop the action plan. The provider told us they felt confident they "Were getting there. Nothing's perfect." The consultant's most recent visit had been on 10 November 2016. They stated in their report "The action plan submitted to the CQC has been fully completed." We found this was not the case. Whilst some recommendations had been made by the consultant, the registered manager had not yet implemented all of these effectively or at all. The provider also told us they visited the home two or three times each week "To keep an eye on things." However, they had not identified that the registered manager was failing to meet the requirements of the regulations.

Failure to effectively assess and monitor progress against action plans to improve the quality and safety of services was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014. This was a continuing breach.

Staff told us they felt well supported to carry out their roles. One staff member said they felt able to discuss any concerns with colleagues and managers and they were confident issues would be dealt with appropriately. They felt they could admit to any mistakes and said the registered manager and provider were both approachable and friendly. Staff were involved in the running of the home. Staff meetings had taken place in April and September 2016. Minutes of a meeting held in September 2016 showed they had discussed a number of issues including laundry, general care of residents, cross infection and medications. It was clear that issues were discussed and actions agreed, but these were not always put into practice.

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 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to submit notifications of events to the Commission when required.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to always act in accordance with the Mental Capacity Act 2005.

The enforcement action we took:

We served a warning notice on the registered provider and registered manager and told them to take action to meet the requirements of the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to do all that is reasonable practicable to identify, assess and mitigate risks to people's health and safety. The provider had failed to ensure the safe and proper management of medicines.

The enforcement action we took:

We served a warning notice on the registered provider and registered manager and told them to take action to meet the requirements of the regulation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to always protect people from abuse and improper treatment. The provider had failed to always act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

The enforcement action we took:

We served a warning notice on the registered provider and registered manager and told them to take action to meet the requirements of the regulation.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to assess and monitor the quality and safety of the service, and risks to people's health and safety were not effective. Records relating to the care and treatment of people were not always accurate, up to date or fit for purpose.

The enforcement action we took:

We served a warning notice on the registered provider and registered manager and told them to take action to meet the requirements of the regulation.