Care Quality Commission

Moat House Care Home Limited

Moat House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of the service on 13 January 2016.

Moat House provides care for 101 older people. At the time of our inspection 94 people were using the service. Accommodation is on three floors, all accessible by stairs and a lift. People's rooms have an en-suite and are spacious. Facilities include a cinema, a working `pub', a shop, a café and an enclosed landscaped sensory garden.

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

People were protected from abuse. Staff understood their responsibilities to identify and report any signs of abuse using the provider's safeguarding procedures. People were protected from avoidable harm through risk assessments. These included information for staff about how to support people safely and without undue restrictions.

Staffing deployment was based on needs of people using the service. If people's needs increased, additional staff were deployed. The provider's recruitment procedures ensured as far as possible that only people suited to work at Moat House were employed.

The provider's arrangements for the storage of medicines were safe. Only staff who successfully completed training in management of medicines supported people with their medicines.

People using the service were supported by staff with the right skills and knowledge. Staff were supported through effective training and supervision. Staff understood and practised their responsibilities under the Mental Capacity Act 2005. They sought people's consent before they provided care and support. No person had restrictions on their liberty unless it had been authorised under the Deprivation of Liberty Safeguards.

People were supported with their nutritional needs. They had a choice of nutritious food and were protected from the risks of malnutrition and dehydration. People were supported to access health services when they needed. The service arranged for health professionals to visit the service to attend to people's health needs.

Staff developed caring relationships with people using the service. They were able to do this because they understood people's needs and their life stories. Staff were attentive to people's needs and supported them to be comfortable.

People using the service and their relatives had opportunities to be involved in decisions about their care and support. They had access to information about the service and their individual care plans.

Staff treated people with dignity and respect. People were able to spend their time the way they wanted and their choices were respected. People were able to spend private time alone or with relatives in their rooms.

Before people came to live at Moat House they had a pre-admission assessment of their needs. After six weeks, a more comprehensive care plan was developed. We identified a single instance of a pre-admission assessment not being thorough and a family not being kept informed about an aspect of the person's care. This was the subject of a complaint made by the family which was under investigation at the time of our inspection.

People using the service and their relatives had access to a complaints procedure and other means of providing feedback about the service. Complaints were investigated and responded to, but not all written responses advised people where they could take their compliant if they were not satisfied with the response, although the complaints procedure did include that information. The provider told us that in future they would add that information to complaint response letters.

The service had a registered manager. They were supported by an operations director, a management team at the service to deliver a service in line with the provider's statement of purpose. All understood the CQC registration requirements.

The provider's quality assurance procedures kept up to date with changes in legislation and were used to monitor and assess the service's compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Those procedures were used to drive improvement at the service.

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 safe. Staff understood and practiced their responsibilities to protect people from abuse and avoidable harm without restricting people's freedom. The provider's recruitment procedures were robust and staff were suitably deployed. Arrangements for the management of medicines were safe.	**Good**
Is the service effective? The service was effective. People were supported by staff with the right knowledge and skills. Staff were supported through effective training and supervision. People were supported with their nutritional and health needs.	**Good**
Is the service caring? The service was caring. Staff developed caring relationships with the people they supported. People using the service or their relatives were involved in decisions about their care and support. People's privacy and dignity were respected.	**Good**
Is the service responsive? The service was not consistently responsive. People received care and support that was centred on their needs, though a person's pre-admission assessment had not been thorough.	**Requires Improvement**

People were supported to participate in meaningful activities.

People's feedback, including concerns and suggestions, were acted upon though a family of a person using the service had complained that was not the case. Complaints response letters did not inform people where they could refer a complaint to if they were dissatisfied with the response. .

Is the service well-led?

Good

The service was well led.

The provider promoted an open culture where people, relatives and staff were encouraged to raise concerns and make suggestions.

Management and staff shared the provider's aims and objectives.

The service operated effective procedures for monitoring and assessing the quality of the service.

Care Quality Commission

Moat House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 13 January 2016 and was unannounced.

The inspection team consisted of two inspectors 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. Our expert-by-experience had expertise in caring for older people.

Before our inspection we reviewed information we had about the service. This included notifications we had received from the provider about notifiable incidents that had taken place at Moat House. We also reviewed information we had received from relatives of a person who used the service in the form of a complaint about the service. We used that information to help plan our inspection though our regulatory powers did not include investigating complaints.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what it does well and improvements they plan to make.

We spoke with 13 of the 94 people using the service on the day of our inspection, one of their relatives and six relatives of people we did not speak with. We looked at seven people's care plans and associated records. We observed how staff interacted with and supported people using the service. We spoke with the operations director, registered manager, compliance manager and five care workers. We also spoke with a health professional who was visiting the service.

We looked at records about the training and support staff received; and looked at two staff recruitment files to see how the provider recruited people to work at Moat House. We looked at records of staff meetings, `residents' meetings and a summary of the most recent satisfaction survey carried out by the provider. We

looked at records associated with the provider's procedures for monitoring and assessing the quality of the service and the management of complaints.

Good

Is the service safe?

Our findings

When we spoke with people they gave us a variety of reasons for feeling safe. These included that they felt safe when staff provided care and support. A person told us, "I feel safe when staff support me with my personal care." People also told us they felt safe at night time. One told us, "I feel safe at night because staff are on duty." Another person told us, "The night staff check on you during the night to make sure you are okay."

The provider had policies and procedures for protecting people from abuse. Staff we spoke with were familiar with those procedures and knew how to identify and report any signs that a person was either at risk or had experienced abuse. They described how they looked for changes in people's mood, sleeping and eating patterns and appearance as possible indicators of abuse. They knew how to report abuse and told us they were confident that any safeguarding concerns they raised would be taken seriously. A care worker told us, "I'm 100% confident I'd be taken seriously." Training records we looked at showed that staff had attended training about safeguarding vulnerable people. Visitors we spoke with had no concerns about their relative's safety. One told us, "My [person using service] has been here for five years. I've had no cause for concern."

People's care plans included assessments of risks associated with their care routines. These risk assessments included information about how to support people safely to minimise the risk of harm or injury. People told us they felt safe when staff used equipment during personal care routines. A person told us, "I am hoisted into the bath. I feel very safe when they do this." Where people were at risk of falls in their rooms fall mats with sensors were supplied to alert staff if a person had fallen. A person told us, "There is a mat next to my bed for if I fall out of bed in the night, that makes me feel safe." The steps taken to keep people safe did not restrict their independence to do as much as they could themselves. For example, for some people care staff were present whilst people carried out their own personal routines. For other people staff were on hand to assist if necessary. A person told us, "They don't let you get into or out of the bath without them being there for your safety.

The provider had procedures for the internal reporting and investigation of accidents and injuries occurring at Moat House. Since our last inspection in July 2014, six people suffered injuries from falls or suspected falls. Each of those incidents were reported by staff and steps were taken to reduce the risk of further falls or associated injuries. For example, a person had been referred to an NHS Falls Clinic and people were supplied with falls mats in their rooms to protect them from injury. People's risk assessments were reviewed and amended to include information about changes in how people were supported to reduce risk of similar accidents happening again.

Another factor contributing to people's safety was that the premises were well maintained. They were protected from risks of harm from accidents because the provider had effective maintenance procedures. For example, water temperatures were regularly checked to prevent a risk of people scalding themselves when washing. The home had annual checks to ensure it was free from legionella in the water supply. The home was tidy and free of clutter which meant people were protected from the risk of trips and falls. People

using the service had individual fire evacuation plans. We looked at a `maintenance log book' in which staff recorded things that required repair or replacement. We saw that prompt action was taken to fix things. For example, after damage to a falls mat was reported on 5 January 2016, it was replaced the following day.

The provider had robust arrangements for recruiting new staff. People applying to work at Moat House had to provide evidence of their suitability in their application forms and also provide relevant documents if they were selected for interview. Successful applicants did not start working with people using the service until all the required pre-employment checks were carried out. These included Disclosure and Barring Service (DBS) checks. These checks help to keep those people who are known to pose a risk to people using CQC registered services out of the workforce. The provider required potential recruits to provide two suitable references. New staff worked a probationary period during which their conduct and performance was monitored. People using the service could be confident that the provider sought to ensure as far as possible that only people suited to work at Moat House were employed.

Staffing levels were decided by the registered manager. They based their decisions on the needs of people using the service. If people's level of dependency increased, extra staff were deployed. People we spoke with didn't say anything to suggest they felt not enough staff were on duty. People's comments about staffing were positive. It was one of the reasons people gave for feeling safe at Moat House. A person told us, "They [staff] answer my call bell quickly when I use it." Others told us that staff took time to have conversations with them. Relatives we spoke with raised no concerns about staffing. Care workers we spoke with told us they felt enough staff were on duty. When we looked at staffing rotas and information about staff training, we saw that enough suitably skilled and experienced staff were deployed. Staff absences were usually covered by other staff or, less frequently, agency care workers who had worked at Moat House before. Our observations on the day of our inspection were that people's needs were attended to promptly because enough staff were deployed.

The service's arrangements for the management of people's medicines were safe. Only staff trained in medicines management supported people with their medicines. We observed a `medications round'. We saw that the medications administrator checked they were giving people the right medicines. They explained to people what their medicines were for. People told us they received their medicines when they expected. A person told us, "They give me my medication regularly and never miss one. They make sure you take them." Other people told us they had their medicines at the right times and that the medicines administrator always told them what the medicines were for.

Medicines administration records (MARS) were used to record whether people had taken their medicines. If a person refused to take their medicines a record of refusal was made and the reasons for circumstances for refusal were recorded. This meant that staff supporting people with their medicines and the registered manager could identify risks associated with people not taking their medicines and seek advice from a pharmacist of the prescribing doctor. However, we noted an occasion when a person's refusal to take medicines had not been recorded in line with the provider's procedures.

Arrangements for the storage of medicines were safe. This included storing medicines securely and at the right temperature. Arrangements for disposal of medicines that were no longer required were effective. An audit of medicines management at Moat House was carried out by the pharmacist who supplied medicines in November 2015. They were satisfied with the arrangements the service had in place.

Good

Is the service effective?

Our findings

People we spoke with told us they thought staff had the right skills and knowledge to meet their needs. A person told us, "I am happy here because the staff know what they are doing." A relative told us, "The standard of care is very high." Comments from other relatives included, "The carers are very good" and "The staff do an excellent job."

Providers are required by regulation to induct, support and train their staff appropriately. In our guidance for providers we expect them to demonstrate that staff have, or are working towards, the skills set out in the Care Certificate, as the benchmark for staff induction. The Care Certificate was introduced in April 2015. It covers 15 standards of care. The provider enrolled eleven new staff to the Care Certificate and at the time of our inspection eight had successfully completed the course work. New staff had a 12 week induction period during which they were supported by an experienced care worker. Staff we spoke with told us they felt that the training they received equipped them to carry out their roles and refreshed and updated their skills and knowledge. A care worker told us, "I had a good induction and training at Moat House which has helped me provide good care to people." Another told us, "The training has helped me to do my job. I've learned so many things."

A training manager reviewed the effectiveness of the training to monitor how well staff put their training into practice. They also monitored the delivery of a staff training plan. At the time of our inspection the delivery of training was on-track with the plan. This meant that staff had received relevant training to help them carry out their roles.

Staff were supported through regular, usually monthly, supervision meetings with their line-manager. A care worker told us, "I've had monthly supervision meetings. I'm reminded about my training." Another told us, "We have regular supervision meetings. I feel listened to." Staff were supported to study for qualifications in health and social care. Over a third of the staff had achieved diplomas in health and social care and others were studying for a diploma.

When we spoke with care workers about people's care plans they showed a good understanding of the content of the plans. They understood what people's needs were. Staff shared knowledge about people that used the service at `handover' meetings that took place when there was a change of shift. This meant that staff starting a shift were updated about people's latest needs.

We saw and heard staff demonstrate effective communication with people who displayed behaviour that challenged others. Staff spoke discretely with people and supported them to engage in activity that reduced or removed their anxiety. This showed that staff put their training about supporting people who sometimes displayed behaviour that challenged into practice.

People using the service could be confident that they were supported by staff with the necessary skills and knowledge.

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

The registered manager understood their responsibilities under the MCA. They followed the DoLS procedures when necessary. Staff we spoke with showed awareness for the MCA and understood they could provide a person with care and support only if the person gave consent. A person using the service told us, "The staff always ask if it is okay before doing anything." A care worker we spoke with told us, "I ask for a person's consent before I provide personal care. I take my time and give them time to respond, whether it's by word or facial expression." We saw care workers requesting people's consent; and when they did they did so with clarity and patience.

Care plans we looked at included assessments of people's mental capacity to make decisions. Where they lacked capacity to make certain decisions, for example if they did not understand why medicines were essential for their well-being, decisions were made in their best interests. The decisions were recorded in people's care plans together with information about how people should be supported. For example, we saw care plans with `best interests' decisions about how to support people by giving them their medicines in their food or drinks.

Under the MCA, a person is presumed to have mental capacity unless there is evidence to the contrary. People's care plans included a section called `cognition'. This was reviewed monthly by the registered manager or a senior care worker to assess whether presumptions of capacity to make decisions about care and support could continue. Where there was evidence that called into question a presumption of capacity, a mental capacity assessment was carried out. We found that the service was acting in accordance with the requirements of the MCA.

People using the service spoke in complimentary terms about the meals they had at Moat House. Comments included, "The food is very good, well balanced and filling", "The food is generally good there are always choices" and "If you don't like the food they prepare, they would make you something else."

At the time of our inspection none of the people using the service had complex or special nutritional needs that required monitoring. However, the provider had procedures in place for assessing, monitoring and managing people's nutritional needs if the need arose.

People had a choice of nutritious meals that were prepared by a cook. People with dietary requirements or preferences were able to have meals of their choice. The cook and kitchen staff had information about people's dietary preferences which ensured that people had meals they liked. People could have their meals in their rooms or in communal dining areas. Relatives were able to join their family members for meals. When we observed a lunch-time meal in a dining area we saw that people were supported to have an enjoyable and sociable experience.

A person using the service told us, "We are offered tea and cold drinks during the day." We saw that to be the case throughout the day of our inspection. Staff provided people with drinks and snacks of their choice throughout the day.

People were supported with their health needs. Care workers we spoke with told us how they identified changes in people's health. They looked for signs that people were unwell, for example changes in mood, behaviour, sleeping and eating patterns. Any concerns were acted upon by calls to health professionals to visit. A person told us, "The doctor comes to see me, [to treat a condition], and nurses come and change the dressing often." Another person told us, "A doctor, dentist, optician and chiropodist are available to the residents." We saw a thank you card from relatives with the comment `I thought the staff were brilliant looking after [person] when they were ill.'

People were supported to access to health services such as dentists, opticians and chiropodists. People using the service were registered either with a GP of their choice or a local GP practice.

Before our inspection the provider carried out a survey of health professionals who visited the service. Three respondents made comments that the staff at Moat House were very knowledgeable about the health needs of people using the service.

People could be confident that their nutritional and health needs would be met by staff who understood their needs.

Good

Is the service caring?

Our findings

People we spoke with told us they felt staff were caring. A person told us, "The staff look after me wonderfully; they are very good at looking after me." Another person told us, "The staff are kind, caring and respectful." We saw feedback that relatives had left on comments cards. One comment, dated 4 January 2016, said `As a family we were touched by the acts of kindness' from staff. We saw 27 compliments that had been made about the service since our last inspection, all of which praised staff for being kind and compassionate.

People talked to us about why they felt they mattered to the service. People told us that staff supported them with decisions about what to wear. A person told us, "I choose with the carers what I will be wearing for the day." They told us they liked their bedrooms and the fact that they could have their rooms furnished to their taste. As we walked around Moat House we saw that people's rooms were personalised. No two rooms we saw looked the same. A relative of a person who used the service told us it mattered to the person that their room was to their taste.

Staff we spoke with told us about how they developed caring relationships with people using the service. They used the information in people's care plans to get to know them, this included information about what was important to them, their likes and dislikes. A care worker told us, "We talk to people about their lives and the jobs they had." Staff increased their knowledge about people by talking with them. People using the service told us that staff took time to talk with them. Relatives told us that too. A relative told us, "The staff are always friendly. They always have time to discuss things." Another relative told us, "The carers are very good. They get on very well with [person using the service] and from what we see other residents." We saw and heard staff engaging in conversations with people and being attentive to their needs. Staff asked people if they were comfortable and helped people to adjust their posture. When staff supported people they explained to people how they would assist them and continued to talk to people and offer encouragement and reassurance whilst they supported them. A person using the service told us, "The staff know what my needs are. When I am in pain they know; I am offered pain killers." What people told us and what we saw and heard showed that staff put into practice what was expected of them.

People using the service were given a `service user guide' or had access to one. The guide explained, in generic terms, how their needs would be assessed and included information about the service and its facilities. At the time of our inspection the registered manager was managing a project to replace paper care plans with electronic versions. People had access to their care plans. A person told us, "The care plan is online for me to read at my leisure."

People who were able to be involved in decisions about their care and support were involved. A person told us, "I was involved in drawing up my care plan and I understand what is in it." Another person told us their family was more involved. A relative told us, "I've been involved. I'm kept very well informed of things about [person using the service] and I've been asked for my opinion." A relative of another person told us, "I am involved. I feel a part of it [care planning and delivery]."

Staff working at Moat House had received training about caring for people with dignity and respect. How they put their training into practice was monitored by the training manager and through observations by the registered manager, deputy manager and senior care workers. Dignity in care was promoted through policies and procedures and at staff meetings.

We saw staff treating people with dignity and respect. For example, a care worker discretely adjusted a person's clothing to protect their modesty after the person changed their posture whilst seated. Staff referred to people by their preferred names. We saw care workers ensuring that people were comfortable and they responded promptly when people required support.

People were able to have private time to themselves either in `quiet' areas at Moat House or in their rooms. Some people told us they liked to stay in their rooms because that was what they preferred to do. People's rooms were spacious and personalised and places they could invite their relatives to. Relatives were able to visit without undue restrictions. A person using the service told us, "Visitors can come at any time." We saw relatives visiting throughout the day of our inspection. Entries in the visitor's book showed that relatives visited from early morning to late evening. A health professional visiting the service told us that whenever they visited Moat House they were able to provide care in the privacy of a person's room. They added that they always saw staff treat people using the service with dignity and respect.

People using the service and their relatives could be confident that they supported by staff who understood how to treat people with kindness, dignity and respect. A reason for that was that a relative of the provider used the service which demonstrated they felt the service was caring.

Requires Improvement

Is the service responsive?

Our findings

People using the service contributed to the assessments of their needs before they began to use the service. This was called a `pre-admission assessment' that formed the persons care plan for the first six weeks of their stay which was referred to as a `trial period'. After that period a more comprehensive care plan was developed involving the persons if they were able to be involved or their relatives.

All of the care plans that we looked at apart from one contained detailed pre-admission assessments. However, we found that one had incomplete documentation and two contradictory entries about how a person cooperated with staff. There was a difference of opinion between the family and the provider about what had been agreed during the pre-admission assessment. The complaint was responded to through the provider's complaints procedure. Shortly after our inspection the relative referred their complaint to the Local Government Ombudsman, the body responsible for investigation complaints about care homes. We also found that relatives had not been informed when a person using the service had refused their medicines.

Other care plans we looked at were personalised and included information about what was important to people, things they liked or were interested in and how they wanted to be supported. People using the service told us that staff responded to their requests promptly, that they could have a supported shower or bath when they wanted. We saw that care workers put their knowledge of people's care requirements into practice when they supported people. For example, care workers ensured that people were provided with the precise types of pressure cushions and other personal care items they required. When we looked at people's daily care records we found that these provided assurance that people were supported in line with their plans. For example, where people required regular observations or support with changing their posture, we saw from records that these took place. A relative of a person using the service told us, "The care is very good. The staff are kind and attentive." Care workers we spoke with, including agency care workers, were knowledgeable about the contents of people's care plans. A health professional who visited the service told us, "I can see that the people I visit receive good care."

People were supported to follow their interests and hobbies. A relative told us, "Even though [person using the service] is unable to participate in activities, the carers know what they like. They get involved in activities such as singing or music events." We saw from records of residents meetings that people talked about activities they enjoyed. These included crosswords, quizzes, bingo, making bird feeders and growing tomatoes in the garden. We saw a person being shown how to knit and others reading newspapers and magazines.

A relative told us that their parent had once been reluctant to mix with other people but since being at Moat House they "participate in music activities and mix with other people which they enjoy." People using the service were supported to use a computer with a social media facility to contact relatives. Other facilities at Moat House included a working `pub', a cinema, a café, and a 1960s style kitchen where people could socialise. Over 20 people belonged to a knitting club at Moat House. We saw lots of photographic evidence that people used those facilities which all contributed to them avoiding social isolation.

The service had an active programme of activities that included visits by professional entertainers. People with religious needs were supported to practise those because the service organised visits from representatives of different churches. Some activities involved a local school and others celebrated occasions such as Burn's Night and saints days. Information about activities was available in people's rooms and in communal areas and on notice boards.

When we spoke with the activities coordinator they told us about how they had taken note of research about activities for people with dementia. We saw that people with dementia were supported with `reminiscence' activities and sensory and tactile objects to provide comfort. People had access to a sensory garden. These kinds of facilities were recognised as beneficial by research about dementia care.

People's care plans were reviewed monthly. People and relatives who wanted to be involved in those reviews were involved. Relatives we spoke with told us they were involved in reviews of care plans. One told us," I am involved in mums' care plan, and have recently been involved in the review." Another said, "I've always had the information and clarity about [person's] care."

People were able to raise concerns. A person who had made a complaint told us, "I was very satisfied about the way my complaint was dealt with." Two people's relatives told us that the manager had acted immediately on concerns and suggestions they had made. We saw a notice board where people using the service and relatives were able to pin `have your say' notes with suggestions or observations they had about the service.

Information about the complaints procedure was available in `service user's guides' and clearly visible on a notice board in the reception area at Moat House. When the provider carried out a survey of people using the service 15 people reported that they didn't know about the complaints procedure. The provider immediately informed people about the procedure. The operations director told us they were looking into an `easy to read' design of the complaints procedure to make it more easily understood.

Since our last inspection the service had received 13 complaints. One was still under investigation. Others were managed in line with the provider's complaints procedure which was that complaints were investigated and actions were taken to make improvements to the service if necessary. Investigations included interviewing staff and, if necessary, meeting with the complainants before making a written response. We noted that whilst the complaints procedure referred to informing people where they could take their complaint to if they were not satisfied with the response, the final response letters did not. The operations director told us that complaint response letters would in future include that information.

Good

Is the service well-led?

Our findings

People using the service, their relatives or representatives had opportunities to be involved in developing the service. They had those opportunities at reviews of care plans, residents meetings, through the provider's comments and suggestions procedures. A person using the service told us about residents meetings. They said, "We have resident's meetings once per month." Relatives we spoke with also knew about the meetings but did not always attend. A relative told us, "There are relative's meetings but unfortunately I have not attended any, however you are asked your opinion." Relatives told us that they were able to speak with the registered manager, deputy manager and staff if they wanted to make suggestions or provide feedback. A relative told us, "The managers and staff are very accessible."

Residents meetings took place every three to six months. The most recent meeting took place on 3 December 2015 when 17 people using the service or their representatives attended. We saw from the records of that and previous meetings that people made suggestions that were acted upon. For example, after people asked if they could have colouring books they had heard about and new cutlery, both were ordered. A person using the service told us, "There is always improvement if you ask for something."

People using the service and relatives also had opportunities to provide feedback and ideas through an annual survey. A person told us, "I remember filling out questionnaires." The survey included questions covering a broad range of people's experience of the service; for example whether they were happy with their rooms, the facilities and quality of care. People's responses were positive. People responses identified a need to remind people about the complaints procedure and this was acted upon.

Staff had opportunities to be involved in developing the service. Those opportunities formally occurred during one-to-one supervision meetings they had with their line manager and staff meetings. Staff told us they could make suggestions at any time.

The management and staff shared a clear vision about what it wanted to achieve for people using the service. This was set out in its service user guide and statement of purpose which was available for people using the service and relatives to read. A family had made a complaint which included their belief that the service had not lived up to its standards, but other people we spoke with expressed only satisfaction with the service.

The provider promoted an open and transparent culture at Moat House. This was promoted at staff meetings. Minutes of a meeting that were distributed to staff contained the statement `We aren't here to hide anything; we need to be open and honest. We are all human, none of us is perfect.' The provider had whistle-blowing procedures which staff could use to report concerns without fear of repercussions.

Part of the provider's quality assurance procedures were regular observations by the quality and compliance manager that staff were practising dignity and respect when they supported people. These checks were used to keep under review whether staff were supporting people in line with the provider's statement of purpose and aims and objectives.

The management structure at Moat House was such that senior managers were visible and available to people using the service, relatives and staff. Relatives commented on that to us. One told us, "One of the positives here is that we have access to the manager or deputy and we can raise any issue and it will be dealt with."

All the staff we spoke with expressed that they were well supported through supervision and training and that they felt motivated. Comments from staff included, "Moat House is a really good place to work", "It's the best place I've ever worked", and "It's an excellent company to work for." Over one third of the staff had achieved diplomas in Health and Social Care.

The service had a registered manager who was aware of their responsibilities under CQC registration requirements. They were supported by an area manager who regularly visited the service. The registered manager reported to the area manager about the quality of the service. The area manager attended meetings with the owner and provider to discuss Moat House and other care homes they were responsible for. The owner was present at Moat House during our inspection. When we spoke with them it was evident they had knowledge of a complaint that was being investigated. This showed that the provider took an active interest in the service.

The provider's procedures for monitoring and assessing the quality of the service were effective. The procedures assessed compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a `quality and compliance' manager who carried out a series of audits and checks and who reported their findings to the registered manger and operations director. The area manager carried out their own checks to verify the reports they received.

The quality assurance procedures were used to identify what the service did well and what could be improved. For example, feedback from people about the clothes laundry resulted in a review and improvements of that aspect of the service.

People using the service could be confident that their and their relative's views mattered to the provider.