Akari Care Limited

Moorfield House

Inspection report

6 Kenton Road
Gosforth
Newcastle upon Tyne
Tyne and Wear
NE3 4NB

Tel: 01912135757

Date of inspection visit:
11 January 2017
12 January 2017

Date of publication:
06 April 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 11 & 12 January 2017 and was unannounced. This means the provider did not know we were coming. We last inspected this service on the 25 and 26 November 2015. At that inspection we found the service was not meeting one of the regulations that were in force at that time. We found that the service had not ensured that staff had been given the on-going training they needed to keep their knowledge up to date.

On this inspection we saw progress and plans to address staff training needs. However four further breaches of legal requirements were found.

Moorfield House is a care home which provides nursing and residential care for up to 35 people. Care is primarily provided for older people, including people who live with dementia. There were 23 people living in the home at the time of this inspection. The top floor was currently not being used.

The service had 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us contradictory things about the service. Everyone we spoke with said that the staff were kind and caring. However, while some people were happy with the care given, others were not. People told us that at times there were not enough staff available to answer their call bell and provide support when they needed it. Care and support was mainly based around completing tasks and did not always take account of people's differing needs, and there was little time for one to one time with people.

We also received mixed views from relatives about the care. Some said they were satisfied with the care while others said they had concerns about their relatives not getting care in a timely manner.

We recommended that the service undertake a full review of the dependency levels of people to check how many staff are needed to effectively meet people's needs, and adjust staffing levels accordingly. With consideration given to the roles of staff to determine whether staff were being effectively deployed and managed to best effect.

The training given to staff had improved. The registered manager had reviewed the provision of staff training and begun to address the deficits identified at the previous inspection. We still found a need for this training to be more co-ordinated rather than a blanket provision for the whole staff team.

All staff had been scheduled to receive an annual appraisal during 2017. However we found the frequency and quality of the supervision and appraisals that staff received was poor and did not address practice and staff development issues.

People told us they felt safe. Staff were aware of the different types of abuse people might experience and of their responsibility for recognising and reporting signs of abuse.

We recommended that the provider reassess how staff could access information on safeguarding policies and procedures and how safeguarding could become embedded into the operating systems to have a higher profile in the home.

Possible risks to the health and safety of people using the service were not always assessed and therefore appropriate actions were not always taken to minimise risks. This was in regard to hazards in the home, such as infection control measures, and when managing risks to people falling and behaviours that may challenge the service.

People were supported to meet their health needs and access a range of healthcare services. They were assisted to take their medicines safely by staff who had been appropriately trained. Nutritional needs were monitored and specialist advice was sought when necessary. People were offered a varied diet with choices of meals and, where needed, were assisted with eating and drinking. We received positive feedback about the quality of the meals.

People told us that their family could visit whenever they liked and were made to feel welcome. People spoke highly of the newly appointed activity coordinator and the range of in-house activities that had taken place recently. However people's ability to go out was limited to staff availability and to having a relative able to take them out.

The majority of care plans were reviewed and updated on a regular basis to reflect changes in people's needs. We found some were not always updated with the latest advice following a healthcare review.

People told us they were consulted about and involved in their care planning although we found this was not always clearly documented. Many of the care plans lacked detail about people's personal backgrounds, hobbies and interests.

People's capacity to make decisions and gaining their consent to care and treatment was not always formally documented.

We recommended that the service looked for good practice methodology in this area so that people's capacity, ability to give consent and support needs in this area are assessed and recorded more thoroughly.

Some people were not aware of how to make a formal complaint and felt that when they raised issues informally these were not taken up by the management of the home.

We recommended that the service ensured that the complaints procedure is made readily available and is in accessible formats for people to use.

The provider had a range of systems in place for monitoring and reviewing the service, however we found these were not fully effective. Record keeping was not always up to date or accurate around areas such as daily notes, care planning, risk assessments, complaints and on the actions taken to ensure the effective running of the service.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to supporting staff; person centred care; safe care and treatment and governance. You can see what action we

told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

At times staff were not effectively deployed to provide support to people with their personal care in a timely manner.

Risks were not always assessed and appropriate measures to keep people safe from harm had not always been taken.

Staff were recruited appropriately and relevant checks on their background were carried out to ensure suitable staff were employed to work with vulnerable people.

People were assisted to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Training opportunities for staff had improved but there were was a lack of a coordinated approach to identify and prioritise those staff who needed it the most. Supervisions and appraisal offered were infrequent and of a poor quality.

Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However, people's capacity and consent to care and treatment was not always recorded in enough detail.

People received the support they needed to eat their meals and have a healthy diet appropriate to their needs.

Is the service caring?

Good

The service was caring.

Staff supported people with their personal care needs in a sensitive and dignified way.

The privacy and dignity of people who used this service were promoted and protected. Staff were familiar with the needs of the people they supported.

People's personal choices and preferences about the support they would like at the end of their life were clearly documented.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's life stories, hobbies and interests were not always recorded and care plans did not identify how these needs would be met.

Activities and entertainments were taking place and more were being planned and developed. The support provided to allow people to engage in the local community was limited.

There was a system in place for receiving, handling and responding to concerns and complaints. However a number of people living in the home and their relatives were not aware of how to make a formal complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

At the time of this inspection there was a registered manager in post. The provider had set up a new senior management team and structure for the organisation that included more rigorous checks on the quality of the service provided.

Audit systems were being used to aid service improvement; however they had failed to identify the issues and concerns we found during our inspection.

While we saw some good practice and care this was not consistently applied across the home.

The registered provider has a duty to notify the Care Quality Commission of certain incidents and this had not always been done.

Moorfield House

Detailed findings

Background to this inspection

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

This inspection took place on 11 & 12 January 2017 and was unannounced. This inspection was undertaken by an adult social care inspector, a specialist advisor in dementia care and an expert by experience working on behalf of CQC. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection we reviewed the information we held about the service. We contacted the local authority, social workers and healthcare professionals who came into contact with the home to get their views.

During the inspection we checked the building and talked with eleven people who lived in the home and eight visitors. We also spoke with staff including the registered manager, regional manager, two nurses, one senior carer, five care workers and three members of ancillary staff. We reviewed a sample of six people's care records, nine staff personnel files and other records relating to the management of the service. We also undertook general observations in communal areas and during mealtimes.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe and protected from harm in the home. Some people had complex needs that meant we were not able to gather their views. Those people that we were able to speak to told us they felt safe and secure at the service and informed us of what made them feel safe. One person told us "I do feel safe in here yes, because I can call someone from my room if I need help or anything like that." Another person told us "I feel very safe and secure here because there are always people around".

One person told us "I get my medication at set times and the girls know what they are doing." Another person advised "I usually get my medication at the same time each day. Sometimes it varies; it just depends when they come around." People told us that staff availability could vary especially at weekends. One person said, "Sometimes, the staff take a little while to get me but they are very busy all the time and I know they do their best."

Visitors and relatives told us that they felt it was very safe at the service for their family members. One relative told us "I feel it is totally safe for my family member yes, it's a secure place with a code and a sign in book, it is always closely monitored you know." Another relative told us "It is great that my family member is safe here and that they actually feel safe in themselves is great piece of mind for me and the rest of the family to be honest". Another relative told us "This is a very safe place for my family member as there are people around if they need any help and the staff are great."

We looked at how the service managed the prevention and control of infections. We saw that during personal care tasks staff were using appropriate disposable aprons and gloves. There was no lingering malodour in the home. The majority of staff reported having had training in infection control and in the safe handling of food but not all staff were up to date. The home had an outbreak of influenza A and a number of people had been in hospital with the virus. However the measures to reduce the spread of the outbreak were not obvious in the home. There were no posters to alert visitors so they could take extra precautions. There were no additional sanitizers around the home. We also noted that there were no hand wash instruction posters in staff toilets and public toilets. There were other areas that demonstrated a lack of understanding or attention to reducing the spread of infection, for example the light pull cords in toilets were made of cord and were dirty and bins for disposing of paper towels were of the hand lift style. A number of pedal bins had the pedal mechanism broken. We also saw that staff uniforms were not clean. These all posed an infection control and cross contamination risk.

We spoke to the registered manager about the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance. This is the national guidance for infection control that nursing homes must by law adhere to. However the registered manager was not aware of this document. One of the requirements of the Code is to nominate an infection control lead for the home so that they could have oversight and ensure that all the required measures were in place. On the inspection the operations manager for Akari said this would be put in place and training would be provided to whoever was nominated as the lead. She arranged for the pedal bins to be replaced the same day.

We found that the registered provider had not protected people against the risk of infections. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a business continuity and emergency contingency management plan which covered the actions to be taken in order to continue the service in the event of an emergency. These set out the roles and responsibilities of individual staff members in responding to an emergency and the resources that would be required. Plans were in place to respond to emergencies such as fire, evacuation of the building and the failure of essential services. Each person using the service had an emergency evacuation plan, a copy of which was kept in the service's emergency bag located near the front entrance. However we noted that the senior carer responsible as a Fire Warden for the home had not had up to date training for the role. We also found from records and from speaking with staff that the home was overdue a fire evacuation practice.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting and water temperature and quality were undertaken. The service also had contracts in place for the routine maintenance and servicing of equipment. However, we noted potentially hazardous heaters along the main corridors with exposed sharp edges that had potential to cause serious harm to people. The provider took immediate action to address this.

We found that the registered provider had not protected people as they had not done all that was reasonably practical to mitigate risk. This was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the registered manager that staffing levels were based on dependency and were calculated on a monthly basis. In the care records we reviewed we saw evidence people's dependency was reviewed and updated on a monthly basis. This information was then used to determine appropriate staffing levels for the following month. The registered manager told us staffing levels were also reviewed following new admissions to the home and that there was also the flexibility to review and amend staffing levels in response to changes in people's needs.

People, relatives and staff we spoke with felt there was generally sufficient staff to meet people's needs. During our visit we observed there were enough staff on duty to safely meet people's needs. We saw people with mobility difficulties were assisted safely and staff suitably assisted people who might be at risk when they were eating and drinking. We did see that at busy times some people had to wait to be taken to the toilet and some people said they had to wait after calling for help either by shouting or with their buzzer. We also saw occasions when the lounge was left unattended, when we had been told this should always staffed.

We recommend that the management team undertake a full review of the dependency levels of people to check how many staff are needed to safely meet people's needs, and adjust staffing levels accordingly. The registered manager told us that they would also consider the roles of staff and whether they were being effectively deployed and managed to best effect.

When we reviewed people's care records we found as part of initial assessment potential areas of risk were identified. In the majority of the records we reviewed we found where a risk factor was identified a specific plan had been put in place to support the person. We noted from the sample of care records we looked at that risk assessments had been completed, including falls risk assessments and bed rail assessments. Accidents and incidents had been recorded and where people had fallen frequently we saw that they had been referred to the falls clinic to help establish the cause and what could be done to minimise future risks.

However, the level of information and detail recorded within risk assessments varied and not all information

was transferred into the care plan. We found the moving and handling care plans for people using the service were quite limited in informing staff of how to safely move people. These did not provide specific guidance to staff about the techniques and equipment required to safely assist people, for example one person was recorded as requiring a hoist but in another plan it was stated that they could weight bear and did not require a hoist. Another had recently been to an NHS Falls Clinic due to increased falls in the home but the risk assessment had not been updated with the most recent advice. There was no information on the size of the sling to be used. The care plan did not include details of the equipment or techniques to be used by staff when assisting this person to transfer to their wheelchair from their bed or vice versa.

Records for two people identified that they could, at times, present with behaviours that could place them or others at risk of harm. Risk assessments were not in place on how to safely manage behaviours that may have challenged the service. We found there were some instructions documented in a care plan but these were very brief and did not set out in a planned way of how to go about diffusing and de-escalating these behaviours and what to do if this did not work. Where people had prescribed medicine to assist them when they became agitated there was no plan to inform staff of when and how this should be used.

We highlighted these issues to the registered manager who confirmed these care plans would be reviewed and updated following the inspection and training arranged for the senior. We were also told by the operations manager that a new care planning system was being introduced that would link each risk assessment with a very specific care plan to instruct staff on how to keep people safe and meet their needs.

We looked at how the home protected people from harm and potential abuse. The provider had a safeguarding policy and procedure in place that was accessed on the home's computer. However, when we checked the policies and procedure the home was using these were out of date and were from a previous provider of the home. There was also a lack of information around the home about reporting abuse such as posters in the staff room, or details in the home's brochure. The local authority guidance held in the home was out of date being from 2009. This meant that staff and people living in the home did not have up to date information such as telephone numbers to report any allegations of abuse.

Nearly all staff had been provided with updated training with regards to safeguarding adults. Training was provided to staff on the different types of abuse and the signs and symptoms people being abused may display. When we spoke with staff, they confirmed that they had undertaken this type of training recently. Staff we spoke with were aware of their responsibilities for reporting any concerns or suspicions of abuse. When we checked staff supervision and team meeting records we found no reference to safeguarding practice issues to ensure that individual staff understood their roles.

The provider had a whistleblowing policy and procedure in place but staff we spoke with were not sure how to access this policy. Staff said they had limited access to the computer where all the provider's policies were held. There was no information about whistleblowing displayed in the home and both the safeguarding and whistle blowing polices were not individualised to the home and local area. The provider took action on the day of the inspection to ensure staff were given copies of the whistle blowing policy.

We recommend that the provider reassesses how staff can access information, how safeguarding can become embedded into the operating systems and have a higher profile in the home.

We reviewed the staff files for five staff members who had been recruited by the service in the last two years, and those of four staff who had been working in the home for several years. We found potential staff members were asked to complete an application form which covered areas such as their previous experience and qualifications, a full employment history and details of two referees. Appropriate checks

were undertaken with the Disclosure and Barring Service (DBS) to establish whether staff members had a criminal record. Two references had been sought in the majority of the files we reviewed; however, in two of these files we found only one reference had been received. We highlighted this to the registered manager who said they would look into this to ensure a second reference was sought.

We looked at the management of medicines. We were informed the service had recently adopted a new, electronic medicines system. We observed the use of this system during a medicine round completed by one of the nurses. The nurse used a hand held device to open up medicine administration records (MAR) for each person they administered medicine to. These records included a picture of the person to help ensure medicine was given to the correct person. Medicine due to be administered was highlighted on the hand held device. The nurse scanned the medicine, administered it and then recorded the administration on the device. Errors or alerts were automatically identified. During the medicines round we observed the nurse followed good hand hygiene practice. We also observed the nurse asking people for their consent prior to administering their medication. We did note however that the nurse was frequently interrupted by other staff, for example to answer a query from a GP on the telephone.

We recommended that the provider looks at ways to ensure that staff are not interrupted when administering medicines; with consideration given to this when the provider assesses staffing levels and the most effective ways to deploy staff.

The service had a medicine policy and procedure in place which had been updated to reflect the introduction of the new electronic system. This policy and procedure stated staff members who administered medicine should have their competency checked on a yearly basis. Records we reviewed confirmed this had been done and there were no highlighted areas of concern. We found the temperature of the treatment room and fridges were regularly monitored and recorded and records indicated these were within safe ranges.

We found deficits in individual risk assessments, environment risk assessments and in infection control measures.

Requires Improvement

Is the service effective?

Our findings

People told us they felt they received an effective service from staff who knew what they were doing. People made many positive comments about the support they received from the staff in the home. One person told us "If I need anything I only have to ask and they always know what I need or how I like things." People also told us the GP visited the home and that if they needed to see a GP this would be arranged for them by staff. One person said, "Staff are good at telling if I'm off colour and will suggest I see the GP."

Relatives and visitors had positive comments about the care and support provided. They spoke highly of the staff who assisted their family member. One relative told us "The staff are excellent here". We received one complaint that we handed to the regional manager to deal with on the day of our inspection.

We asked people what they thought about the food provided in the home. One person commented, "Very good, I like it. Another said, "We get lots to eat and drink. The staff bring me a jug of juice in my room as well through the day." Another person advised, "The food is good here, no question about that. I have gained weight as well since coming in here so they must be doing something right."

The provider's policy for supporting staff included a commitment to providing four supervisions and an annual appraisal each year. Staff records we reviewed did not contain this number of supervision sessions and many staff reported not having had supervision for some time. We saw one staff record showed the last supervision in February 2016 and another in March 2016. When we looked at the content of those supervisions that had taken place they were sparse and did not address practice and staff development issues.

We were told that nurses had delegated some tasks to care staff such as changing catheter bags, Percutaneous Endoscopic Gastrostomy (PEG) food bags and carrying out observations, such as blood pressure and taking pulses. The care staff we spoke with said that the nurse had shown them how to do it. However there had been no recording of this training given and there were no competency checks being carried out to ensure these delegated tasks were being carried out safely. We discussed this with the registered manager and operations manager who said they would carry out competency checks with staff carry out these duties as soon as a matter of priority.

We found that many staff were also well overdue an annual appraisal. The frequency and quality of the supervision and appraisals that staff received was poor and did not address support, training needs or staff development issues. We saw in one staff members notes that they had dyslexia and in another that staff had reported to the manager about the manner of another staff member. There was no mention of either of these development needs in these staff supervisions.

Although the registered manager had an annual appraisal planner with dates scheduled for the completion of the remaining annual appraisals she acknowledged some of these staff members had not received an appraisal in over a year. We found staff had not been given the necessary support, in terms of annual appraisals and supervisions to perform their roles.

We found this to be a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014 as we found staff did not receive appropriate supervision and appraisal to support them to carry out their roles effectively.

At the last inspection the home was found to not be training staff to the required levels and was in breach of the regulation regarding this. On this inspection we reviewed the staff training matrix, looked at individual training records and spoke with staff and found overall compliance had improved. At our last inspection overall compliance with training was at 59% of the core training needs identified by the provider, and 43% of the service specific training. At this inspection training was up to 82% for core subjects and 60% for service specific training.

We discussed staff training with the registered manager and she showed us the training plan for the year. She had allocated two days per month for training days and had arranged a 12 month plan that would ensure all staff were fully up to date by the end of this period. This confirmed staff were due to undertake training in the following areas; safeguarding, mental capacity, infection control, food safety and allergy, basic life support, moving and positioning, dementia awareness and challenging behaviour. However, when we examined individual staff training records we found that some staff had taken repeat courses whilst records showed other staff had not received some updated training. For example one staff member had been on the use of bed rails training three times in a year but had not completed any infection control training for two years. We also saw from training records and from speaking to the senior staff member for moving and handling training for staff that their own training was not up to date.

We discussed this with the registered manager who told us deficiencies in the training programme had already been identified as an area for improvement. The registered manager informed us action had been taken to arrange appropriate courses throughout the rest of the year. Following the inspection the registered manager sent us details of the training courses scheduled to take place over the following three months. This confirmed that staff would be prioritised according to their training needs. We also found that the registered manager and the administration assistant were not familiar with using the computerised Akari training planner and systems. The regional operations manager informed us that they would both receive support and training on the use of these and that this would help to monitor and prioritise future training across the whole staff team.

New staff received an induction before starting work with people. As part of this induction, staff were provided with the opportunity to get to know people using the service, familiarise themselves with policies and procedures and shadow experienced members of staff. Prior to being allowed to provide care to people unsupervised, staff also had to successfully complete moving and handling training. One new staff member told us, "The whole staff team have been great, I can ask them anything and they have been really supportive."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person

of their liberty were being met.

We reviewed the records the service kept of DoLS applications. We found these were being made to the relevant local authority where deemed appropriate. We saw evidence these were monitored and action taken to update these on an annual basis as required. Appropriate plans of care were in place to ensure that people's care and support needs were met in the least restrictive way. We saw recordings of use of bed rails and the appropriate best interest meetings that had been held.

Staff we spoke with were aware of the need to gain people's consent prior to providing care or treatment. Staff told us they would explain what they were going to do before providing care or treatment to a person and that they would respect their wishes if they declined care or treatment. We saw evidence of staff seeking permission from people prior to providing them with care during the inspection.

However, we found that the recording of people's capacity was either inconsistent or it was not mentioned within the care plans. Where it was recorded this was very brief and there was no separate care plan to show how a person should be supported to make decisions by way of additional communication support. This made it difficult to tell what level of capacity people had and the support they needed to make both day to day and more complex decisions. We did see statements in people's care plans such as "Family deal with finances." However, we could not find any evidence of whether people had a Last Power of Attorney or LPA (LPA is a legal tool that allows the person or the courts to appoint someone to make certain decisions on a person's behalf) and if so, whether this applied to welfare and treatment or finances or both. We also saw in care plans that family had signed on people's behalf but the home was not sure if they had the legal right to do so.

We recommended that the service looks for good practice methodology in this area so that people's capacity, ability to give consent and support needs in this area are assessed and recorded more thoroughly. To include any help people may need to communicate wishes and with reference to LPA and any other legal status for each person, such as a Mental Health Act section if required.

There were systems in place to ensure people identified as being at risk of poor nutrition were supported to maintain their nutritional needs. We identified areas of good practice in monitoring people's nutrition and hydration. For example, staff assessed people's risks of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietician when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely. For example where people had difficulty in swallowing, staff followed the health professional's advice to provide food that had been pureed. We observed that people were provided with food that was suitable for their medical needs, for example soft foods or pureed meals. We saw that the meals that had been pureed were set out in separate portions to keep the tastes distinctive and to the original colour. This was recognised good practice.

We saw staff support people who needed assistance with their meals in a caring manner whilst maintaining dignity, respect, and their independence. People we spoke with told us they were happy with the food they received. People's care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies and preferences. When the MUST indicated a person was at risk of weight loss then people were put onto more rigorous monitoring, such as fluid and food balance charts and were weighed more frequently. The registered manager monitored weight loss and gain on a monthly basis for the whole home and took appropriate action when a person continued to lose weight. This information was also shared with the cook to make them aware of people's changing dietary needs.

People had access to their GP on a weekly basis. Staff were prompt at calling the GP for acute health problems when needed. One person's relative said, "They get the doctor out quickly if [name] is not very well; they're working with the doctor at the moment to monitor [name's] medication". We saw evidence that people had regular support from a range of healthcare professionals such as psychiatric services, diabetic nurse and podiatrist. We spoke to a visiting health care professional who said, "The home engages well with families and knows the residents well. They follow my advice and are good at making referrals for support. People I visit are always clean and look well cared for."

Good

Is the service caring?

Our findings

People spoke highly of the caring nature of the staff who supported them. Comments included; "The staff are absolutely great here. They really do treat you with respect and dignity and you can also have a really good laugh as well." Another person told us "The staff are nice here yes, no complaints there. I find them courteous, respectful and polite and kind." "The laundry service is fantastic-great turnover. So, efficient always comes back even if I have not put labels in them. They take great care you know."

A visitor told us "The staff are brilliant here you cannot fault them they are always great with everyone here." Another relative told us, "We chose this home because we wanted something really local where we could visit every day and what we've found it's been like an extension of our home. We are like one big family." Another visitor told us, "My family member has been living here for two years and cannot do anything at all for herself, the staff have to do everything. They spend a lot of time with her and they talk to her as a person even though she can't respond, it warms my heart. They really are exceptional."

We observed staff interactions with people and saw these were positive and caring. Staff were polite, friendly, patient and caring in their approach to people and their relatives. Relationships between staff and people in the home were clearly based on mutual respect and affection. Staff and people appeared at ease in each other's company and smiled and chatted freely. One relative when describing how caring staff were said, "The activities organiser had printed pictures of the people at their events and put them on a notice board area which is a nice touch for family to see. Also, she recently used the funds to make a calendar of the photos she had taken for each person to give to their family member for Christmas which is lovely." We were told that staff frequently did fundraising to give people in the home parties and a summer trip out.

People's dignity was maintained by the actions of staff. We saw staff knock on people's doors and wait for a response. People were seen to be comfortable in staff presence and were often seen smiling at them. We saw people's dignity was maintained by providing discreet coverings for their clothes at lunchtime and tables pleasantly set with good quality tablecloths and flowers. People looked well cared for and well-groomed, wearing clothes of their own taste and preferences.

Staff we spoke with were knowledgeable about the people they supported and were able to tell us information about their likes and dislikes. People's preferred name and details of their next of kin and relevant healthcare professionals were also captured. In addition to this, specific preferences in areas such as people's night time routine and meal times were also detailed. People we spoke with felt the staff knew them quite well.

People who were being looked after in bed or in their own rooms were not ignored by staff and we observed that all of them had their buzzers to hand so they could call staff when they wanted them. We observed staff keeping an eye on people who stayed in their own rooms. Staff went in to chat, offer help and food and drinks. Personal care needs were managed behind closed doors and people needing help were asked and supported with their needs discreetly and with dignity.

We observed routines in the home were flexible and people and their relatives told us they were able to make everyday choices such as when to get up and go to bed. We were told by several people that they could go to bed when they wanted. Some people told us they like to go to bed early, others that they like to go around 10pm. One other person told us "I love to read a lot so I usually go to bed around 11.pm. The staff are absolutely fine with this."

A guide to the service was provided to people that informed them about what they could expect from living at the home. A range of information was also displayed for people and their relatives to refer to. This included details of social activities, dates of the next resident and relatives meetings and copies of the latest survey results.

People and their relatives all told us they were consulted about their care and treatment and staff we spoke with confirmed this. We also saw evidence of the use of advocacy services in one of the care records we reviewed.

On the day of our inspection visit there was no one at the home receiving end of life care. We spoke with staff about how people were supported at the end of their life and we looked at a sample of care records that included care plans specifically documenting people's preferences when they came to the end of the life. We saw that one person had decided that they did not wish to be resuscitated in the event of a cardiac arrest. Their records clearly documented that they had been involved in the decision making process, together with their GP and a close relative. Their preferences had been clearly recorded.

Requires Improvement

Is the service responsive?

Our findings

We asked people about how responsive and flexible the home was to either their changing needs or to concerns or complaints. People felt they were well cared for on the whole and many said that things to do in the home had improved recently as the home had employed a new activity co-coordinator. People spoke highly of the newly appointed activity coordinator and the range of in-house activities that had taken place recently.

However a number of people said they would like more activities in the home. One person also told us "I would really like to do more activities as I do get a little bored in here to be honest. I know there isn't really the funding. I just find it's hard to mix sometimes when people around are always sleeping. I need a bit more stimulation". Another person told us "I would love to have more quizzes. I really need something to stimulate my brain as all these activities are catered for those who have dementia and it just doesn't work. The quizzes rarely go ahead." One person told us, "I would like to go out a bit more, for day trips, shopping trip, or even just to chat with different people."

Relatives told us that entertainments and activities in the home had increased recently. One relative told us, "The activity organiser is great, the best we have had so far she tries to encourage people to maintain people's hobbies to provide social inclusion and enjoyment. It would be nice if we had more singers in. We had a Doris Day tribute and an Elvis one in recently and it was marvellous." We saw there was a list of activities listed on the notice board on each floor including hoopla, indoor skittles, bowling, deck quoits. The weekly schedule included Armchair Exercise, and hand massages for those who could not join in or communicate as well as baking cakes, coffee, and chat.

However, there was little in the way for people to engage in themselves. For example, there were no visible jigsaws, card games or dominoes left out in the lounge areas. We also found that there was a lack of equipment or an adapted environment for people living with dementia, such as clear door signage and sensory equipment. We did not see that people's life history had been used to develop things like scrapbooks, picture books or flash cards to help stimulate and engage people.

The home had recently employed an activity coordinator who had already increased the activities in the home. We saw people being engaged in activities in groups and individually. We checked the activity programme for the home and this was now much more varied than it had been. We looked at the individual daily records for people and we could see that many more activities had been recorded over the last few months. The activity co-coordinator told us, "I'm getting to know people and what they would like. I'm also going on-line to look at activities to suit people with dementia." However people's ability to engage in the local community was limited and people had to rely on relatives to take them out. This meant that some people were at risk of being socially isolated and lacked stimulation.

We spoke to six relatives who were visiting. The comments were very complimentary and they told us there was no restriction on visiting times. We asked family members if they were kept informed about their relative's care. They told us, "The staff are good about letting us know if there is anything wrong or there are

changes." And another said, "Staff ring me if there is anything wrong, straight away, we are very happy with the care."

We observed that staff treated people in a way that was person-centred. People's routines were flexible and we saw people making choices to have a lie-in or to eat their meals where they chose. We also saw that staff made an effort to ensure that people were dressed in a way of their choosing and this reflected their individual taste. We found that bedrooms also reflected people's own taste and their lives before they came to the home.

We found that assessments were not in enough detail and were not updated when a person's need changed. The paperwork staff were using was inconsistent and the recording of risk and details that staff should follow to deliver people's care was located in different places in a person's file. This had led to staff not knowing all the care and social needs of each person. For example, one person's moving and handling care plan and assessment did not match. One record stated the use of a hoist and in other records the use of a stand aid was advised. Where hoists were used the details of how to use this safely with a person lacked detail of the equipment to be used and how this should be done in a way that causes the least distress to the person.

We read care files and we saw some variations in the quality of these. We saw some good nursing plans for people with health problems. However as with the assessments, not all of the care plans were detailed or up to date. There were a number of examples, for example one plan for a person with diabetes had gaps in the guidance. Another plan on reducing the risk of pressure areas needed to be updated. Some of the dementia care plans needed more details about how to support people who were reluctant to receive care or became distressed due to disorientation. These plans did not flow to give staff a step by step guide of what to do next if a person carried on being agitated.

The majority of the care plans did not set out people's backgrounds, personal histories, hobbies and interests. In discussion with staff they told us they had worked there for a number of years and knew a lot about the people who lived in the service. This relied on staff remembering information and verbally passing it on to other staff rather than making sure all staff were aware of the same information about people. This meant that it was difficult to offer activities and interests that were person centred. This is particularly important when supporting people who live with dementia where it is crucial to know people's backgrounds so that they can be engaged with in a manner that is meaningful to them.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Person centred care.

The provider had a system in place for receiving, handling and responding to concerns and complaints. This procedure outlined what a person should expect if they made a complaint, with guidelines as to how long it should take the service to respond to and resolve a complaint. However, this was held on the home's computer and not readily available to people. Information about the complaints procedure in the home by way of posters and leaflets was limited. We discussed this with the home's operations manager who redesigned the information on the computer and made it bespoke to the home and printed this off to give to people.

The majority of people we spoke with said they were very pleased with the home and the care given to their relative. However a number of people living in the home and relatives were not aware of how to make a formal complaint. One relative, while being generally happy with the care, had an on-going concern that they felt they had not been listened to. We raised this with the operations manager who then spent time

addressing their concerns.

We recommend that the provider ensures that the complaints procedure is made readily available and is in accessible formats for people to use.

Requires Improvement

Is the service well-led?

Our findings

The home had a registered manager who had become registered as manager for Moorfield House in June 2016. They were fully aware of their registration requirements and had ensured that the Care Quality Commission (CQC) was notified of any events which affected the service.

Part of a registered managers or registered providers responsibility under their registration with the Care Quality Commission is to have regard to the regulated activities they provide. One of these relates to the registered managers/registered provider's responsibility to notify us of certain events or information. We checked our records before the inspection and saw that accidents and incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant we were able to see if appropriate action had been taken by management to ensure people were kept safe. However, during the inspection we also found that during 2016 the registered provider and manager had failed to notify us about serious falls that resulted in people either requiring hospital treatment or medical treatment. The CQC require this information, so that where needed, we can take follow-up action. The registered manager was however reporting these into the providers reporting systems so that accidents could be monitored. We have since received notification about people having falls in the home that resulted in hospital treatment.

Overall we gained positive views about people's experience of the quality of the service they received. People were positive about being involved in choice of meals and the design of menus and being asked more about activities. With other areas we could see that people's choices and preferences around their life style and care choices had not been gathered either at all or in enough detail, and where they had, these had not always been implemented. This meant that people did not have a full say or voice in the running of the service.

A number of relatives we spoke with reported that they felt the service was well-led and managed. However, there were several that did not feel this way. One relative advised "I am happy with the staff here they are great but I do not find the management approachable." Another relative told us "If I ever needed to speak to the management here I would but I find that they don't really listen."

When we checked the accuracy of records in the home we found these were not always well maintained. We saw that the home held daily records in each person's bedroom and these were used by care staff to record their care interactions with people. For example, recording daily amounts of fluids and food and how often a person had been helped to reposition. When we checked these we found they were not always completed or did not contain the same information as the care plans.

Accidents and incidents were recorded and had been regularly monitored by the home's registered manager to ensure any trends were identified, monitored, investigated and results were evaluated. In addition, any safeguarding concerns were recorded and checked for trends.

While the home was audited on a quarterly basis by a member of the provider's governance team and visited monthly by the regional manager we found these checks were not ensuring that people received safe

and effective care. We saw in more detail how the registered manager used the monthly weight audit and falls audit to check that people were receiving the right support from healthcare professionals. However as previously noted, care plans were not always updated accordingly.

Checks were made on the buildings physical environment including safety checks of floors and surfaces, areas requiring decorating, stairways, lighting, ventilation and windows. These identified where improvements were needed and the information was then fed into a service improvement plan. Records were in place to show the action taken to address improvements identified and timescales. Additional audits, checklists and reports had been undertaken for kitchen cleaning, all areas of the home cleaned by domestic staff and food served.

However these audits had failed to identify the issues and concerns we found during our inspection. While we saw some good practice and care, this was not consistently applied across the home. It was of particular concern that these systems had failed to identify that care records lacked any detail on people's histories or life stories. This is crucial to supporting people with dementia.

We also found that both the registered manager and the home's administration officer were not familiar with the providers systems and operational mechanisms. For example in how to use the training matrix and that the registered manager was not aware that the home had a dedicated leisure/activities budget. The home did not have copies of legal guidance and good practice guidance to refer to. For example the Infection Code of Practice and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014- Guidance for providers on meeting the regulations. Other important documents were out of date, such as the local authority safeguarding policy and the providers, Akari policies and procedures and had not been kept up to date and put into place. The regional manager explained how they were working with the home's registered manager to draw up an action plan of the planned changes and how many of the shortfalls we found on inspection would be addressed by the new systems going forward.

This was a breach of Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had set up a new senior management for the organisation that was to include more rigorous checks and additional support to registered managers.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not protected people against the risk of receiving care or treatment that was unsafe or inappropriate by means of thorough care plans based on people's assessed needs. We found that the registered provider had not made suitable arrangements to ensure that people's psychological, emotional, social, cultural and spiritual were met by the home. People were not provided with appropriate opportunities or meaningful activities based on person-centred care that met their needs and reflects their personal preferences. Regulation 9(3)(a)-(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not protected people as they had not fully assessed and done all that was reasonably practical to mitigate risk. Regulation 12(2)(a &b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA RA Regulations 2014 Good governance Systems or processes had not been established

Treatment of disease, disorder or injury	to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activity.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The service had not ensured that staff had received appropriate support, training, personal development and appraisal as is necessary to enable them to carry out the duties they were employed to perform. Regulation18(2)(a)