The Moorings Care Limited

The Moorings Retirement Home

Inspection report

Egypt Hill
Cowes
Isle of Wight
PO31 8BP

Tel: 01983297129

Date of inspection visit:
15 November 2018
16 November 2018

Date of publication:
09 January 2019

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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The Moorings Retirement Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This inspection took place on 15 and 16 November 2018 and was unannounced.

The home is registered to accommodate up to 39 people, including people living with dementia care needs. There were 38 people living at the home when we visited. The home is a large building, based on multiple levels. There is a range of communal areas where people can spend their time and all bedrooms had en-suite bathrooms.

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

Although people told us they felt safe at The Moorings, we found not all staff were clear about the correct action to take in the event of a fire. Most other risks to people were managed effectively. The risks associated with some blood thinning medicines had not been assessed but this was addressed during the inspection.

There were clear recruitment procedures in place to help ensure only suitable staff were employed; however, these were not always followed.

Staff acted in people's best interests, but did not fully follow legislation designed to protect people's rights. Some staff did not demonstrate an understanding of related legislation designed to protect people's freedom.

Staff were suitably trained and said they felt supported in their work. However, there was not a process in place to demonstrate that new staff had the necessary practical skills before they were permitted to support people on their own. Records of one-to-one meetings between managers and staff were not adequate to show staff had been offered appropriate support and personal development.

Although new quality assurance procedures had recently been put in place, these had not identified the concerns we found during the inspection. Therefore, the procedures had not been fully effective.

Staff felt motivated and were engaged in the running of the service; however, records of staff meetings did not demonstrate how issues raised by staff were progressed or resolved.

There were enough staff deployed to meet people's needs. Staff knew how to protect people from the risk of abuse.

All areas of the home were clean and there were procedures were in place to protect people from the risk of infection.

People's nutrition and hydration needs were met and people were satisfied with the quality of the meals.

Staff monitored people's health and supported them to access healthcare services when needed. They also made appropriate use of technology to support people.

People consistently told us they were treated in a kind and compassionate way and we observed positive interactions between staff and people. Staff respected people's privacy and protected their dignity.

Staff encouraged people to be as independent as possible and involved them in discussions about their care.

Staff knew people well and took a person-centred approach to the delivery of care and support. They responded promptly when people's needs changed and were committed to supporting people at the end of their lives to have a comfortable, dignified and pain-free death.

People had access to a range of activities based on their individual interests and used creative approaches to engage people.

There was a complaints procedure in place and people told us they felt able to raise concerns. There was an open and transparent culture where visitors were welcomed. Positive links had been developed which benefited people.

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.

Not all staff knew the correct action to take in the event of a fire. The risks associated with blood thinning medicines had not always been assessed. However, this was addressed during the inspection and other aspects of medicines management were safe.

Appropriate recruitment procedures were in place, but these were not always followed to ensure staff were suitable for their role.

There were enough staff to meet people's needs. Appropriate procedures were in place to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff acted in people's best interests, but did not always record the views of relevant people when making decisions. Staff did not understand legislation designed to safeguard people who were subject to restrictions of their freedom.

Staff were suitably trained and supported in their work. However, assessments of the practical skills of new staff were not recorded before they were permitted to support people on their own. One to one meetings with staff were not completed effectively to ensure any development needs were identified and followed up.

People's nutrition and hydration needs were met and people were satisfied with the quality of their meals.

Staff supported people to access healthcare services and made appropriate use of technology to support people.

Adaptations had been made to the home to help make it supportive of the people who lived there.

Is the service caring?

Good

The service was caring.

People were treated in a kind, considerate and compassionate way by staff.

Staff knew people well and used this knowledge to initiate conversations and interact positively with people.

Staff respected people's privacy and encouraged people to be as independent as possible.

Staff involved people and their families, where appropriate, in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Staff demonstrated an extensive knowledge of people's needs. They met people's needs in a personalised way.

Care plans were developed in conjunction with the person and relevant family members.

Staff responded promptly when people's needs changed.

Staff supported people at the end of their lives to have a comfortable, dignified and pain-free death.

People were empowered to make as many choices as possible.

People had access to a range of activities suited to their individual interests.

People knew how to raise concerns and there was an appropriate complaints procedure in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance tools used to assess the service had recently been amended and were not fully effective.

There was an open and transparent culture where visitors were welcomed. However, the duty of candour requirements had not been followed fully.

People, family members and healthcare professionals praised

the management. Feedback was used to enhance the service.

There was a clear management structure in place. Staff were happy and motivated. They had developed positive links with the community that benefited people.

The Moorings Retirement Home

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 15 and 16 November 2018 and was unannounced. It was completed by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed all information we had received about the service, including previous inspection reports and notifications. Notifications are information about specific important events the service is legally required to send to us. We also considered information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with five people who used the service and five family members or friends of people who used the service. We spoke with a director of the provider's company, the registered manager, the deputy manager, seven care staff, an activities coordinator, a member of kitchen staff and two housekeepers. We received feedback from three healthcare professionals, a social care professional who had contact with the service and the manager of a pre-school group that had links with the home.

We looked at care plans and associated records for seven people and records relating to the management of the service, including: duty rosters, staff recruitment files, records of compliments and complaints, accident and incident records, maintenance records and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short

Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We last inspected the service in September 2016, when we did not identify any concerns and rated the service good overall.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe at The Moorings and had no concerns. However, we found not all staff were clear about the correct action to take in the event of a fire. The home was a large building, based on multiple levels. Most of the people being accommodated had reduced mobility and were living with dementia, so would need support to be evacuated. Although the fire procedures were prominently displayed throughout the building, staff were not always familiar with them. Some staff did not realise that the procedures varied from day to night; others told us they would immediately evacuate people using an external fire escape. This was contrary to the set procedures and would put people at risk of harm. We discussed our concerns with the registered manager, who assured us they would remind staff of the correct procedures and undertake additional fire drills.

Other environmental risks were managed appropriately. Maintenance staff checked the temperature of water outlets every month, including those in people's rooms. In addition, gas and electrical appliances were checked and serviced regularly.

Individual risks to people were usually managed effectively. All care plans included risk assessments which were relevant to the person and detailed specific actions required to reduce the risk. These included risks relating to falls, nutrition, swallowing and skin integrity. Some people were taking blood thinning medicines that could put them at risk of bleeding if they sustained an injury; a risk assessment had been completed for a person prescribed one type of blood thinning medicine, but not for people prescribed a different type. We raised this with the deputy manager and by the end of the inspection risk assessments had been completed for everyone who was prescribed a blood thinning medicine.

There were clear processes in place to obtain, store, administer, record and dispose of medicines. A family member told us, "[Staff] give [my relative] their medicines and wait to make sure she takes them as she wouldn't remember." Medicines were only administered by staff who had been suitably trained and assessed as competent by one of the managers. Medicine administration records (MARs) confirmed that people had received their medicines as prescribed.

There were clear recruitment procedures in place to help ensure only suitable staff were employed; however, these were not always followed. For example, a full employment history had not been provided for one staff member; this meant the provider was not able to consider whether the applicant's background impacted on their suitability for employment. For another staff member, sufficient references from previous care employers had not been sought. The staff member had worked for three care providers within the previous two years; two care providers had supplied references, but a reference from the third care provider had not been requested. A further staff member had only worked for one care provider previously, yet a reference from that provider had not been requested. The provider was unable to confirm that the staff members conduct had been satisfactory in their previous care roles and had not verified their reasons for leaving. The registered manager told us they would amend their recruitment checklist to help ensure the correct procedures were followed consistently in future.

In all cases, checks with the disclosure and barring service (DBS) had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

There were enough staff deployed to meet people's needs. One person told us, "The Staff have time for me, I am not rushed at all." A family member told us, "There are enough staff most of the time and there's always someone available in the lounge." The registered manager told us staffing levels were based on people's needs, their own observations and feedback from staff. This process had led to an increase in staff in the evenings which staff said had proved beneficial for people.
There were appropriate systems in place to protect people by the prevention and control of infection. A person told us, "This home is kept very clean as is the equipment." A family member said of the home, "It never smells and [my relative's] room is always clean." We saw that all areas of the home were clean. Staff had completed infection control training, had access to personal protective equipment and wore this whenever appropriate. They described how they processed soiled linen, using special bags that could be put straight into the washing machines in the laundry. The laundry room was organised and operated in a way that minimised the risk of cross contamination. The provider had completed an infection control audit and told us there had been no outbreaks of infection in the previous 12 months.

Staff protected people from the risk of abuse and understood their safeguarding responsibilities. They had received training in safeguarding adults and records confirmed they knew how to use the provider's whistle blower policy. A healthcare professional told us, "I've not had any safeguarding concerns [about people living at The Moorings] whatsoever." Staff assured us they would not hesitate to notify managers if they had any concerns and knew how to contact external organisations for support if needed. Staff were aware of people who were prone to behave in a way that put themselves or others at risk of abuse and described the action they took to reduce the risk. For example, a staff member told us, "We are good at defusing situations and intervening [to protect people], like when [a person] went to throw a drink over someone; we intervened and [supported them] to move to another room."

Requires Improvement

Is the service effective?

Our findings

People told us they received effective care from competent staff. A person told us, "The staff are very good here; they are happy, there is a good atmosphere." A family member told us, "I'm more than happy that [my relative] is being looked after well. Staff seem very competent." Another family member praised the care their relative had received after a short stay in hospital. They said, "She's got a lot better, she's eating well and has gained weight." Healthcare professionals echoed these comments, including one who told us, "I like the home. I think it's an effective home."

Staff acted in people's best interests, but did not fully follow the Mental Capacity Act, 2005 (MCA). The 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. Most of the people living at the home lacked capacity to make some or all decisions relating to their care needs. Where this was the case, staff had assessed the person's capacity using an appropriate tool and made best interest decisions on their behalf. Staff consulted with people close to the person and those having power in law to make decisions on their behalf. However, this did not always happen prior to the decision being made. On some occasions, this occurred during a review meeting some weeks later and the views of those consulted were not always recorded. Therefore, the provider could not confirm that they had taken the views of relevant persons into account before making decisions on behalf of people. We raised this with the registered manager who identified this as an area for improvement.

We heard staff seeking verbal consent from people before providing care and staff described how they always acted in the best interests of the people they were supporting. One person told us, "The Staff do seek my consent and I am able to ask for support if I need them." A staff member explained how they followed people's wishes; they said, "[One person] likes baths, but doesn't like having her hair washed. It's her choice, we would never force it."

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. Some DoLS authorisations had been made and others were awaiting assessment by the local authority. Where conditions had been attached to the DoLS authorisation, we found these had been followed. For example, staff had followed a condition to liaise with the family of one person and their GP to explore as aspect of their care. However, we found some staff did not understand DoLS and were not clear about the additional powers the authorisations gave them to ensure people were supported to receive care and support in a safe setting. We discussed this with the registered manager who assured us they would provide extra training to staff.

Clear processes were in place to monitor the expiry dates of the DoLS and to submit renewal applications in good time. However, we identified a DoLS renewal for one person had not been made and the DoLS

authorisation had expired a week previously. We brought this to the attention of the registered manager, who immediately submitted a renewal application.

Staff were suitably trained and supported in their work. New staff completed an effective induction into their role; this included time spent shadowing, (working alongside experienced staff), until they felt confident they could meet people's needs. Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. However, although staff completed a knowledge check on completion of their care certificate, there was not a system in place to record the assessment of their practical skills. We discussed this with the registered manager who undertook to introduce a process to confirm that staff were practically competent before being allowed to support people on their own.

Experienced staff followed a programme to refresh their training regularly. This included the provider's 'mandatory' subjects, such as safeguarding, infection control and food hygiene, as well as subjects relevant to their role, such as end of life care, falls awareness and dementia awareness. Staff were also supported to gain vocational qualifications in health and social care.

Staff followed best practice guidance and demonstrated an understanding of most aspects of their training. For example, they used a recognised tool to assess risks to people's skin integrity; they used moving and handling equipment competently; they communicated with people living with dementia in a supportive way using short sentences and gave people time to respond.

All staff received one-to-one sessions of supervision. These provided an opportunity for one of the managers to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal with one of the management team, to assess their performance. Staff told us the supervision sessions were helpful and spoke positively about the support they received from management on a day to day basis. However, the recording of issues discussed during supervisions was very limited and did not include actions or outcomes from the conversations. For example, a typical example simply said, "[The staff member] is happy in their role, feeling more confidence and has no concerns." The registered manager acknowledged that more information was needed to help ensure staff support and development needs were identified and met effectively. They showed us a new tool to record discussions with staff which they said they would introduce for the next round of supervisions. They said they also had plans to start observing staff practice as part of the supervision process; this would further help managers assess whether additional support was needed.

People's nutrition and hydration needs were met and people were satisfied with the quality of the meals. One person said, "I've no complaints about the food, it's always good here. I find they give me just enough. I wouldn't want any more, I'd feel overwhelmed." Another person said, "The food is good and there is a choice. Drinks are always available, they come around with coffee or tea." A family member told us, "[My relative] has always been a difficult eater, but since she has been here she eats everything and enjoys her food. I have found that drinks are always available here at all times."

Each person had a nutritional plan to identify their dietary needs. Some people needed their meals prepared in a certain way to meet their individual needs and we saw these were provided consistently, including low-sugar options for people living with diabetes. The main meal of the day had been changed to 4:00pm, with a lighter meal offered at midday and snacks made available in the evenings. Staff told us this had been "an overnight success". People had better appetites, enjoyed the meals more and had put on weight. In addition, people who had been receiving nutritional supplements no longer needed them. People confirmed they were happy with the change, including one who told us, "The light lunch works for me; we

eat our main meal later."

We saw photographs were used to help people choose their meals in advance. Plates with rimmed edges and beakers with handles and spouts were used, where required, to support people to eat independently. Staff were attentive to people during meals and monitored the amount people ate and drank using food and fluid charts. When people needed support to eat, this was provided in a dignified way on a one-to-one basis. A family member told us, "The staff always help [my relative] to eat on days when she finds this difficult."

Staff monitored people's health and supported them to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. A healthcare professional told us, "The staff are very on the ball, if anyone is deteriorating, they are proactive in getting them seen quickly." When people were admitted to hospital, staff usually accompanied them and provided written information about the person to the medical team to help ensure the person's needs were understood.

Staff made appropriate use of technology to support people. Staff could view people's care plans on portable, hand-held computers on which they also recorded all the care and support they delivered. This helped ensure people's records were up to date. If planned care was not given, an alert was sent to supervisors so they could follow it up. Special pressure-relieving mattresses had been provided to support people at risk of pressure injuries and a system was in place to help ensure they remained at the right setting. In addition, an electronic call bell system allowed people to call for assistance when needed.

The home had been adapted to support the needs of the people living there. A passenger lift gave access to all floors and most bedrooms had en-suite facilities. There were handrails throughout the communal areas in contrasting colours to make them easy for people to see and use. Most bedroom doors had pictures relevant to the person to make them easier to find and large signs were in place to help people navigate their way around the home. There was level access to the building and to a garden on the ground floor.

Good

Is the service caring?

Our findings

People and their relatives consistently told us they were treated in a kind and compassionate way by staff, who they described as "supportive" and "caring". One person said, "I like it here, everyone is very nice to me." Another person said, "The staff are very caring towards me and others." A family member told us, "[My relative] was reluctant to go in a home but very soon after arriving she was settled in and was very calm." Another family member said, "The Staff are very caring here." A healthcare professional echoed these comments and said, "All carers are very nice and pleasant." The manager of a pre-school group that had links with the home told us, "I couldn't praise the staff there enough. They are so calm and always involve the residents. The atmosphere in there is lovely."

Without exception, all interactions we observed between staff and people were positive, supportive and caring. For example, while supporting people to eat, they engaged with them and gave gentle, encouraging prompts. When using equipment to transfer people between chairs, staff were patient and took time to explain what they were doing and rearranged people's clothing afterwards if it had become creased. When people became upset, staff used touch, appropriately, to comfort them; they bent down to the person's eye level, held their hands and used calm, soothing words. When a person spilt a drink on their trousers, a staff member discreetly took them to their room to change. A staff member told us, "We can always find time to sit with [people] and hold a hand. We are a 24-hour team; everything gets done, but at their pace."

Managers explored people's cultural and diversity needs during pre-admission assessments and in casual conversations as they got to know the person. People's specific needs were recorded in their care plans. This included people's faith needs and whether they preferred male or female staff to support them with personal care. Further information gave staff an insight into the person's interests, background and relationships that were important to them.

Staff had a good understanding of people's histories and gave examples of how they used the information to support people. For example, when a person living with dementia became distressed, a staff member gave them a box of jewellery that they knew they enjoyed. They encouraged the person to interact with it and used it as a prompt for conversation, which distracted them and helped them relax. The family member of another person said of the staff, "They know [my relative] well now and can talk her round when her mood changes. They are very good at that and always patient. Some staff bring in their dogs as they know [my relative] is dog mad." Another staff member told us how they had used their knowledge of a person's family to initiate meaningful conversation with the person during a Remembrance Day service.

Staff treated people with consideration. One person told us, "The staff respect my dignity at all times, they're very thoughtful." Another person said, "The staff do treat me with respect, they call me by my first name." A family member told us, "Everything [staff do] is quite dignified. [Staff] seem to know when [my relative] needs the loo and always close the doors." A healthcare professional said of the staff, "They provide dignity and respect [to people]. They are always cheerful and ready to help and know people really well."

Staff protected people's privacy. When providing personal care, staff described how they closed curtains

and doors and kept the person covered as much as possible. A staff member said, "I get to know people and always explain what I'm doing. With some people, you can have a giggle. I try to empathise with people to make them less embarrassed and am careful with my words so as not to make a big deal about [the support they need]."

Staff encouraged people to be as independent as possible by offering choices and encouraging people to do as much as they could for themselves. A staff member told us, "Some people like doing jobs, like clearing tables and folding napkins. The more we can make them independent by doing those jobs, the better they feel about themselves." Another staff member said, "I always ask 'Is it okay for me to do it, or would you prefer to do it?'." A further staff member described how they encouraged a person to use their walking frame in the mornings, when their mobility was at its best because, "they need to walk to keep their independence". A family member told us they liked the drink making facilities that had recently been installed in one of the lounges for people and visitors to use. They said, "I can have a cup of tea with [my relative] now. She likes to offer it as that's what she used to do [when she was at home], so it's nice that she can still."

People and relatives told us they were involved in discussing and making decisions about the care and support people received. Each person had an allocated key worker to take a particular interest in them and to act as a point of contact for the family. The key workers completed monthly reviews of the person's care plan, in conjunction with them or a family member to help ensure their needs, wishes and preferences were being met. A family member told us, "We know the key worker and they know [my relative] well. They call if there are any problems and we do the care plan reviews with them." Another family member told us, "I have been involved in [my relative's] care plan and the manager keeps me informed of her health and wellbeing."

Good

Is the service responsive?

Our findings

People told us they received personalised care from staff who understood and met their individual needs well. One person told us, "The Staff do know how I like things done." The family member of a person who recently passed away at the home told us, "The Staff were brilliant with [my relative]. She wasn't the easiest to deal with, but they had time for her, she was never rushed." A healthcare professional said of the staff, "They are very person-centred. It's not a case of one size fits all."

Assessments of people's needs were completed before they moved into the home. Care plans were then developed in conjunction with the person and relevant family members where appropriate. The care plans were produced using a computerised template with pre-determined options. This did not always support staff in the delivery of personalised care as the use of free text fields within the template, to capture people's individual wishes and preferences, was limited. The registered manager told us this was because the system was fairly new and they were still learning how to use it to the best effect.

The limited information in people's care plans was mitigated by the fact that staff knew people well and there was a relatively low level of staff turnover. Every staff member we spoke with demonstrated an extensive knowledge of people's needs, backgrounds, likes and dislikes. They knew how each person preferred to receive care and support. They understood the support each person needed with their continence and the level of encouragement they needed to maintain their personal care. They knew which people ate well and which needed encouragement or prompting. They recognised that some people's needs varied considerably from day to day and they could assess and accommodate the level of support needed.

Staff used their knowledge of people to identify and respond promptly to changes in people's needs. A family member said of the staff, "They know if [my relative] starts coughing, they have to get a doctor to her quickly and they do. When they found her heart was racing, they called paramedics straight away; if they hadn't acted as quick as they did it would have been a different outcome."

Staff kept records of the care and support they provided for people and these confirmed that people's needs had been met consistently. For example, they included records of when people had been supported to reposition in bed and records of the fluid input and output of people with catheters, to check they were working properly.

Staff expressed a commitment to supporting people at the end of their lives to have a comfortable, dignified and pain-free death. The family member of a person who had recently passed away at the home told us, "[My relative] needed end of life planning and I was always kept informed of her health and wellbeing up to the end. [Her] dignity was always protected." Most staff were experienced in providing end of life care and had completed training, including at a local hospice. They described how they worked with doctors and community nurses to support people and their families in a compassionate way. However, end of life care plans had not always been developed for people; this posed a risk that things that were important to people, at that stage of their life, might not be known or met. We discussed this with the registered manager,

who told us they had written to the computer software supplier to ask them to develop a suitable template for this. They said they had also started to have conversations with relatives to promote discussion about people's end of life wishes.

People were empowered to make as many of their own decisions and choices as possible. We heard people being offered choice throughout the inspection. People confirmed staff offered them choices and respected their wishes. For example, one person had chosen an individualised menu designed around their likes and dislikes. A staff member told us, "Things are very flexible here, people have more choice, more freedom than [other homes I've worked at]." Another staff member said, "One person [living with dementia] will eat anything, but we still give them the choice."

People had access to a wide range of activities based on their individual interests. These were advertised on a large poster that was accessible to people. These included exercise games, arts and crafts, musical entertainment and sensory relaxation sessions. One person told us, "I like to do knitting and they encourage me with that." A family member said, "[My relative] likes the sensory room that they have on certain days, she enjoys that."

The activities coordinator took a creative approach to organising activities to help ensure they met people's cognitive, social and active needs. They used information about people's life histories and backgrounds to create activities that were relevant to people. They also described how they assessed how each person would respond to each activity and tailored it to suit their skills and abilities, based on "what they can, rather than what they can't do". For example, one person was unable to take part in carpet bowls, but enjoyed the atmosphere of the event, so was given a sensory ball that they could hold and interact with while the game was in progress. Where people did not wish to take part in group activities, staff spent time with them on a one-to-one basis, for example reading to them or reminiscing about their lives. One staff member told us, "We adapt to people's needs every day. For example, yesterday, one resident didn't want to listen to the music, so we sat next door and had a chat over a cup of tea."

There was a complaints procedure in place and people told us they felt able to raise concerns. One person said, "If there was a problem I would talk to the manager. There haven't been any since I moved here." A family member told us, "I've got the [registered] manager's email address and can ring her if I've got any concerns or I could speak to the deputy [manager]." We viewed records of recent complaints. These had been investigated and responded to promptly, in accordance with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

People and their families told us they felt the service was run well. Comments from people included: "The home is very good and well managed, I believe"; "It's very jolly here, there's a good atmosphere. It must be well managed, it runs very smoothly" and "I think the home is well run". Comments from family members included: "Everything seems well organised and it has been pretty consistent. I would definitely recommend it"; "This Home is very well run; the management are very competent and caring" and "The home is very well managed, it's very good indeed". A healthcare professional told us, "I think very highly of the managers. They are very aware of their residents and know their health needs." Another healthcare professional told us, "The [registered] manager is a fantastic leader. Staff are always cheerful and ready to help and they work well as a team."

Although people were happy with the management, we found their quality assurance systems were not always effective. The provider had recently amended the audit tools used to monitor the service, including medicines management, infection control, food safety, health and safety. Some of these had brought about improvement; for example, the medicines audit had identified inconsistencies in the recording of 'as required' medicines and this had been addressed; and reviews by key workers had helped ensure that people's needs were known and met. However, the audits had not identified the concerns found during this inspection. These included a lack of risk assessments for some medicines, inconsistent recruitment procedures, a lack of knowledge by staff about fire safety procedures and DoLS and the absence of a procedure to demonstrate that new staff were practically competent. We discussed this with the registered manager who acknowledged that the new auditing systems needed further time to become fully effective.

The provider conducted questionnaire surveys of people and their relatives and feedback from these was used to improve the service. For example, feedback suggested more side tables would be useful and asked that they were cleaned more often. We saw extra side tables had been put in place and we observed staff cleaning them frequently.

Staff were engaged in the running the service. Records showed staff meetings were held regularly to update staff on any changes and provide an opportunity to make suggestions for improvement. However, apart from a brief agenda, records of matters discussed at the meetings were not kept, so the provider was unable to demonstrate how issues raised by staff were progressed or resolved. We discussed this with the registered manager who undertook to maintain more comprehensive minutes of these meetings in the future.

There was an open and transparent culture where visitors were welcomed. A family member told us, "Staff always make me welcome and I get invited to all the parties." A duty of candour policy was in place; this required staff to act in an open and transparent way when accidents occurred. The registered manager showed us examples of where they had apologised to family members in writing when required; however, the letters sent to family members did not include any information about the circumstances of the incident or any investigation that was planned. We discussed this with the registered manager who refreshed their understanding of the relevant regulation and undertook to ensure this was done in future.

There was a clear management structure in place consisting of the provider's representative, the registered manager, the deputy manager, a head of care, shift leaders and senior carers. Each understood their responsibilities and staff told us they worked well together as a team. This was confirmed by family members, comments from whom included: "The Staff do seem to get on well together here. There is a very happy atmosphere and everyone gets on" and "Staff are generally very good here and get on well and there is a calm atmosphere".

People benefited from staff who were happy in their work, felt appreciated and were motivated. Comments from staff included: "I'm happy and feel valued"; "Things have really improved. [The registered manager] is clearly in control. She is a constant and follows through on any requests we make"; "Management are approachable, they always have time for you; I'd have no qualms going to them with any concerns" and "[The registered manager] is very supportive and encouraging".

The provider told us they expected staff to treat people with dignity and respect and to promote their independence. These values were documented in a staff handbook that was given to each member of staff when they started working at the home. From our observations and discussions with staff, it was clear staff understood and followed this ethos consistently.

Staff had developed positive links with the community that benefited people. One, with a local pre-school group involved young children visiting the home and people being taken to visit the children at their school. The manager of the pre-school group told us the children and people living at The Moorings enjoyed the visits and said, "They bounce off each other. The little ones help the older residents and they look after the little ones. They sit and have snacks together. The residents eat well because they think they're showing the children what to do, it works really well." The registered manager told us, "The whole demeanour of the residents improves and they become more alert." A staff member echoed this and said, "[One person] used to sleep all day and night and we'd never seen them get excited about anything; but when the children came, she joined in the games and engaged with them. It was the most active I have ever seen [the person]. [Another person] was absolutely beside herself when we took her to see their nativity play, she absolutely loved it. [People] seem to get energy from nowhere when they are with children." Two pupils from a senior school had also completed work experience placements at the home and we were told people had enjoyed interacting with them. A further link was with a church choir that visited once a month to sing with people, which we were told they "loved". In addition, the home produced a monthly newsletter for visitors to help keep them involved in the home and informed of changes and events. In addition, the home produced a monthly newsletter for visitors to help keep them involved in the home and informed of changes and events.