Moorhaven Care Home Ltd

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Inspection report

Moorhaven Nursing Home
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25 May 2017

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected Moorhaven Care Home on 23 and 25 May 2017. The inspection was unannounced. The service was last inspected in September 2016, when we found five regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to consent; safe care and treatment; staffing; recruitment and training, and good governance. Following the inspection the provider sent us an action plan which stated the breaches would be addressed. This inspection was to check improvements had been made and to review the ratings.

Moorhaven Care Home is a large property which consists of a Victorian main building with modern extensions. The service provides care and support for up to 33 older people and is accommodation for people who require personal care and nursing. At the time of our inspection there were 24 people living at Moorhaven.

The home had a registered manager in place. 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.

During this inspection, we found improvements had been made and there were no breaches.

The home had recently been redecorated and people told us that they liked the new décor. However, we saw that the outside of the building required some attention as we found rotting timber fasciae and broken guttering.

People who lived at Moorhaven told us they felt safe. Recruitment processes ensured only suitable staff were employed and staff had a good understanding of safeguarding procedures. Training records showed that staff were trained to the level required for them to carry out their work, and additional training was available to enhance the skills and knowledge of the staff. All staff received regular supervision and a yearly appraisal of their work.

There were systems in place to ensure that people received their medicines safely and in a timely way, and care records showed that risks to people's health had been identified and were managed in a way that did not restrict independence. People had good access to healthcare and staff monitored their physical and mental health needs.

We saw that arrangements were in place to assess whether people were able to consent to care and treatment, and staff spoken with understood the need to obtain verbal consent from people using the service before a task or care was undertaken. Where people were unable to consent to their care and treatment the appropriate authorisation to provide support had been sought.

People told us that they liked the food at Moorhaven. We saw that kitchen staff had a good understanding of people's dietary requirements and people were supported to eat and drink in a way that met their nutritional and hydration needs.

There was a friendly and open atmosphere. The people who lived at Moorhaven were treated with respect by staff who recognised their differences and met their needs in a person centred way. Staff showed a good understanding of how people liked their care to be delivered. This was reflected in care plans, which were subject to regular review, and we saw staff were vigilant and recognised changes in need. Issues of concern, such as diet, weight and skin integrity were closely monitored.

There was a variety of activities and social stimulation available and people told us there was enough for them to do. Visitors and people who lived at Moorhaven told us that they had no complaints, and when we checked we saw that no complaints about the service had been made since before our last inspection.

Staff told us that they felt well directed and supported by the registered manager and providers, who monitored the quality of the service by carrying out checks on records, medicines and the environment, and systems were in place for people to provide feedback to improve the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Safe.

There were sufficient staff on duty, safe recruitment processes were followed and staff understood how to keep people safe from harm.

There were effective systems in place to manage and administer medicines.

Where risk was identified appropriate care plans were in place to minimise the risk.

Is the service effective?

Good

The service was Effective.

Staff were well trained and people who used the service told us that they were competent and knew how to meet their needs.

People consented to the care and treatment they received.

Attention was paid to diet and nutrition and people enjoyed the food at Moorhaven

Is the service caring?

Good

The service was Caring.

The atmosphere at the home was calm, friendly and relaxed.

Staff were able to describe the likes and dislikes of people who lived at Moorhaven, and treated people with respect.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was Responsive.

People were involved in the development of their care plans, and documents reflected their needs and wishes.

There was a variety of activities and interaction to ensure people were stimulated.

Is the service well-led?

Good

The service was Well Led.

The registered manager carried out checks to ensure that the service operated effectively.

People who lived at Moorhaven, their relatives and staff told us that the manager was supportive and provided opportunities to seek their views on the quality of the service.

The manager was supported by the service provider.

Moorhaven Care Home Ltd

Detailed findings

Background to this inspection

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

We inspected the service on 23 and 25 May 2017. This was an unannounced inspection. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all of the information we held about the service. This included information we received from safeguarding and statutory notifications since the last inspection. We also sought feedback from the commissioners of the service and Healthwatch prior to our visit. Healthwatch is an independent consumer champion which gathers and represents the views of the public about health and social care services in England. We used their feedback to plan the inspection.

The registered provider completed a provider information return (PIR). This is a form which asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

At the time of our inspection visit there were 24 people living in Moorhaven. During this inspection, we spoke with four people who used the service, and relatives of another three people. We had general conversations with other people who used the service. We spoke with the service assistant director, the registered manager, area manager, four care staff and a nurse.

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

We looked around all areas of the home, looked at how staff cared for and supported people, and looked at food provision.

We looked at the care records for four people, four medicine administration records, and other documents

related to the management of the home, including care planning documentation and medication records. We also looked at six staff files, including staff recruitment and training records, records relating to the management of the home and a variety of policies and procedures developed and implemented by the registered provider.

Good

Is the service safe?

Our findings

At our previous inspection in September 2015, we found a breach of the Health and Social Care Act 2008 (regulated activities) Regulations (2014) in relation to the employment of staff. This was because application forms did not account for gaps in service history or include a section to allow candidates to give information about previous experience. At this inspection we saw that this issue had been addressed. We looked at six staff files and saw that these had been reviewed to include information about previous experience and qualifications, explanations for any gap in employment and an up to date photograph of the person. All the files we looked at had a certificate from the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. These checks help the registered manager to make informed decisions about a person's suitability to be employed in any role working with vulnerable people. Whilst it is a requirement to request a DBS check only at the start of employment, we saw that some of the people who worked at Moorhaven had been employed for more than ten or fifteen years. As an added safety check the registered manager informed us that she had asked longer serving staff to renew their DBS certificates. Application forms, interview records, and references were stored and staff files for nursing staff included their personal identification number to show they were registered with the Nursing and Midwifery Council. Files for new employees contained interview notes, including details on previous work experience and reasons for gaps in employment. Checks had been made to ensure that the staff were eligible to work in the United Kingdom.

The service used a dependency tool to determine how many staff would be required to meet the needs of the people who lived at Moorhaven. The assistant director told us that this was reviewed on a monthly basis. On both days of the inspection we saw that there were sufficient numbers of staff working at the home. In addition to the registered manager and a nurse at each shift there were two senior care workers and four care workers on duty. We looked at staffing rotas for the previous two months and these reflected the number of staff we saw. Rotas were clear and legible showing little sign of amendments and a low level of staff absence. Where care staff were unable to complete their rostered shift, for example, through sickness, gaps were covered by regular staff who were familiar with the service. The service used agency staff if necessary to cover for any nurses who were unable to work their regular shift, if the regular nursing staff were unable to cover the shift.

There were three separate lounges where people could spend time during the day. Whilst this allowed people greater choice and variety in where they would like to sit, it meant that they could be left unattended for long periods. One person, sitting in a lounge with six or seven other people told us, "Staff periodically come and check on us but it can be a long time between checks. A lot of the people who use this room are immobile and can't reach the buzzer, so we might be waiting a long time before someone comes along to help us with our personal needs." Although none of the people in the lounge showed any signs of distress whilst we were talking to this person, we raised the issue with the registered manager, who agreed to consider a more structured use of staff time to allow for regular oversight of communal lounges.

We spoke with some of the people who lived at Moorhaven and they all told us that they felt it was a safe

environment. One person told us, "I came down for a visit and fell in love with the place. I have a really nice room. It is friendly, staff are good. They really put your needs first; I have no worries at all. It's great." Visiting relatives agreed. One told us, "We constantly worried about [our relative] before, but now we know she's safe. It's secure and staff look out for her. I don't worry anymore."

We saw that the home was secure. The entrance was kept locked, with access via a secure key code; this ensured that unauthorised people would have difficulty entering the home, and that staff were aware of who was in the building at any time. There was also a safety unlocking system in place which helped prevent people who were considered as being at risk if they went out alone, from leaving the premises. People had access to a small courtyard to the rear of the building through a rear door which was also a means of exit in the case of an emergency, such as a fire. A back gate was kept locked. There were no restrictions on people's movements within the building, with the only exceptions being to areas where it may not be safe, such as the laundry and kitchen.

When we spoke with staff they showed a good understanding of how to protect people from harm, and were able to tell us what they would do if they suspected a person was at risk of abuse. The manager forwarded a log of any safeguarding incidents to the local authority on a monthly basis, but since our last inspection there had been no reported incidents of suspected abuse. Where accidents or incidents had occurred, we saw that these were looked into and action taken to minimise risk of reoccurrence. For example, following a fall, a referral was made to the Falls Co-ordinator, a safety mat put in place and the risk assessment reviewed.

The service had a whistleblowing policy and we saw in staff records that where issues of poor conduct had been raised either by other staff or people who used the service, these were dealt with appropriately through the whistleblowing and disciplinary procedures. A whistle blowing policy allows staff to report genuine concerns with no recriminations.

We looked at the care and treatment records for four people and saw that risks were assessed and if necessary appropriate measures were put into place to minimise any harm which might occur, such as risk of poor nutrition or risk of falls. In addition we saw specific risks assessments such as emotional risk due to poor mental health. For instance one risk assessment noted, 'Confusion so needs assurance at all times'. Where risk was identified, a corresponding care plan instructed staff how to minimise the risk. For example, one person was at risk from visual hallucinations, and a care plan told staff to provide ongoing reassurance and explain their interventions. This also noted a referral to the mental health liaison team. Another person was at risk due to poor balance; their care plan instructed staff to ensure that the call bell and other items were within easy reach to avoid overstretching. A subsequent review of this care plan noted some improvement, but action was still required to minimise the risk.

Some people who used the service required assistance with moving and handling using mechanical aids, such as hoists or stand aids. We saw that equipment was clean and well maintained. Staff were able to use this equipment effectively, and took care to ensure that transfers were safe.

We found systems were in place to enable staff to respond effectively in the event of an emergency. There was a fire risk assessment in place, and we saw that personal emergency evacuation plans (PEEPs) had been developed for the people who used the service, and updated regularly. These plans explain how a person is to be evacuated from a building in the event of an emergency evacuation and take into consideration a person's individual mobility and support needs. A copy of each personal evacuation plan was kept in each person's room and in a file close to the main entrance to the building. A Fire book included the evacuation procedures, record of fire tests, location of equipment and a map of the building. A monthly fire check was

carried out with a visual check of extinguishers, blankets and emergency lighting, and a recent inspection was carried out by an external contractor. The service also had a business continuity plan in place. The plan contained details of what needed to be done in the event of an emergency or incident occurring such as a fire or utility failures.

Records showed that equipment and services within the home were serviced and maintained in accordance with the manufacturers' instructions. This included checks in areas such as gas safety, portable appliance testing, fire detection and emergency lighting. This helped to ensure the safety and well-being of everybody living, working and visiting the home. The registered manager kept a maintenance file which showed when servicing was required for the call system, lift, fire extinguishers and alarms and boiler and gas cooker; and when full checks were needed for water temperatures and legionella testing. Other equipment used to support care staff with people's personal care, such as hoists, and profiling beds had been serviced to ensure safe operation. At our last inspection we saw that bed rails in use for some people were unsafe. At this inspection we saw that safety checks had been carried out on all bed rails in use.

We saw that there were appropriate systems in place for the effective ordering, control, management and administration of medicines at Moorhaven. The registered manager was responsible for ordering medication and would complete a weekly check of all medicines and reorder any stock required. Any unused medicines were returned to the pharmacy which meant that there were no excessive stocks kept on the premises.

We saw that there were systems in place to minimise risk of medicine errors, including weekly stock checks and regular audits by the manager and assistant director. Medicines were provided using a monitored dosage system. This minimised the risk of giving the wrong dose to people and provided an efficient system of storing and accounting for medicines.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, in order to ensure medicines were stored at the correct temperature. If medicines are stored at the wrong temperature they can lose their potency and become ineffective. Controlled Drugs were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. We checked the balance of controlled drugs for two people and found them to be correct. Nursing staff administered medicines, and the nurse on duty would keep the keys to the medicine cupboard and trolleys on their person throughout their shift.

Each person requiring medicines had a Medication Administration Record (MAR). This is a form that records the details of any medicines prescribed, when they are taken, and if they are refused. Staff recorded all newly delivered medicines on the MAR, which also included details of the medication and dose required; details of the general practitioner (GP),medical conditions, and any known allergies. We looked at the Medication Administration Record sheets (MARs) for four people who received medication from staff and found these were fully completed.

Where topical medicines, such as skin creams and ointments were required these were kept in people's rooms, and applied by care staff. Guidelines and a body map would indicate how and where the creams needed to be applied. A separate chart was used to indicate that the creams had been dispensed, but this was signed by the nurse on duty. We were assured by the nurse on duty that they checked with the person who administered the cream that it had been applied but this system did not allow for full accountability or assurance that the creams had been administered appropriately. We spoke to the registered manager about this, who agreed that care staff who administered creams would sign the records.

We observed one medication round during our inspection. The nurse checked the dosage and that they were for the right person before placing the tablets into a small pot. They approached the person, addressed them by name and explained what they were doing. They then checked the person had a drink to help them take the medicines. Where a person was unable to take the tablets from the pot, the senior care worker placed them in the person's hand, and watched them swallow. One person had been prescribed a medicine to be taken 'as required'. The nurse checked the MAR sheet to see when they had last had their medicine, and checked with the person to see if they needed it that morning. All medicines were given in a calm and friendly manner.

When we toured the building there were no unpleasant odours. One relative we spoke to said, "There are no bad smells. The home always smells nice, bright and fresh". Communal areas were clean; rooms and corridors were free from clutter or obstacles which might cause an obstruction. Bedrooms were kept clean and tidy, with evidence of personal belongings such as pictures and photographs. Another visitor remarked, "My relative has a hospital bed but you wouldn't know it going into the room, its personal and tasteful". Call bells were conveniently placed near the bed to allow people who used the service to call for assistance when required. We saw staff used protective equipment such as disposable gloves and aprons when dealing with personal hygiene or serving food. The staff we spoke with told us that they had received training around infection control and basic hygiene. Communal toilets and bathrooms had a supply of liquid hand wash and paper towels and each had foot operated pedal bins to prevent the spread of infection. However, on the first day of our inspection we noticed that the position of a bin in one downstairs toilet could only be opened by manually lifting the lid. We showed this to the registered manager who moved the bin, but on the following day it had been put back in its original position. The manager agreed to instruct staff to ensure the bin remained in a position where it could be operated correctly.

The home had recently undergone some refurbishment and communal areas had been redecorated. A visiting relative commented, "It's all been done up nicely, isn't it great? I love the wallpaper, it makes it calm and peaceful". However, a visual inspection of the outside of the building showed rotting window frames and fasciae with flaking paint, loose slates and broken guttering, with work required to maintain the structure of the building and prevent leaks. We saw condensation had built up where double glazed windows had blown. We raised these issues with the assistant director who agreed to look into arranging repairs.

Good

Is the service effective?

Our findings

When we last inspected Moorhaven in September 2016 we found that staff did not always have up to date training, were not supported through regular appraisal, and staff with professional qualifications did not receive clinical supervision. This was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014 regulations which relate to staffing.

We looked at the training matrix, which mapped out the training needs of all staff and noted when each person had completed their training. We saw that all staff had completed mandatory training for moving and handling, fire safety, safeguarding vulnerable adults, mental capacity, infection control , control of substances hazardous to health (COSHH), and food hygiene. The registered manager told us that all staff had completed or were enrolled at level 2 or higher of the National Vocational Certificate (NVQ) in Care, and one senior care worker was currently completing level 5.

Refresher training was provided along with other courses such as meeting nutritional needs, dementia care, life after stroke, dysphagia awareness and end of life care. When we looked in staff files we saw records showed the level of training reached including relevant certificates gained before starting work at Moorhaven, and copies of certificates where staff had successfully completed courses or workshops. We also saw that nurses employed at Moorhaven had recently completed a two day revalidation workshop to ensure that their knowledge was up to date, and we saw that one nurse had recently completed a four week dementia course ratified by University College London. However, in one file we saw that an in house assessment of competency to administer medication had not been completed since August 2015. When we raised this with the registered manager she informed us that this observation had been scheduled for the following week.

People who lived at Moorhaven told us that they believed the staff were competent. One person told us, "Being here has given me a new lease of life. I've made lots of friends and I'm well looked after by people who know how to look after me."

After our last inspection the registered manager had completed formal supervision sessions for each member of staff. This included nursing staff, who received clinical supervision from the registered manager who was herself a trained nurse. Supervision provides an opportunity to monitor the performance of individual staff members or for allowing collective understanding of issues or concerns and allows the person being supervised the chance to raise any work related concerns, or identify new opportunities. We were informed by the registered manager that she was now providing supervision every three months, but at the time of our inspection, dates had not been set for supervision in the following quarters.
When we spoke to staff they told us that they found their individual supervision useful, one person said, "I find supervision useful. I have learnt a lot. [My supervisor] doesn't always take my side but will listen and instruct. I accept this and incorporate it into my work". When we reviewed supervision notes we found that there was opportunity for staff to raise concerns, for example we saw that a member of staff had raised an issue regarding the correct use of moving equipment which led to a review of moving and handling training for staff.

We saw notes in staff files to evidence that staff had received a yearly appraisal. A staff appraisal gives the manager an opportunity to discuss progress over the preceding months and consider areas of strength, areas of improvement and opportunities for development. At Moorhaven, appraisal included ratings of performance in key work areas, and notes recorded discussion and outcomes. Training needs were identified, for instance in one record a member of staff requested further training in wound care. When we spoke to this person they informed us that a training opportunity had been identified and that their name had been forwarded to attend the session.
Our last inspection identified a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the service did not assess people's mental capacity where required, nor did it ensure best interest decisions were made on behalf of people who lacked capacity.
At this inspection we found that the service was meeting this requirement. When we looked in care files we saw that each included a consent form signed by the person to indicate that they agreed to their care and treatment. Where they were unable to sign, for example if they had dexterity problems, verbal agreement and the reason why they had not signed was noted. We saw that this was audited on a monthly basis,

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.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called Deprivation of Liberty Safeguards (DoLS). By law, the Care Quality Commission must monitor the operation of any deprivations and report on what we find. 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.

The registered manager told us and we saw information to show that nine applications to deprive people of their liberty had been made, and when these had been authorised by the supervisory body (local authority), we had been notified of these authorisations. Where these were due to expire there was evidence of requests for a review. When a DoLS had been requested or authorised the information was stored within the person's care records, along with details of why the DoLS had been agreed, and any conditions relating to the restriction. We saw that the registered manager kept a separate record to show when a request had been made, authorised, or due to expire. This reduced the risk that the authorisation could expire without the knowledge of the registered manager, and allowed a quick check to determine if the deprivation made was legally permissible.

Capacity assessments had been completed to determine why people needed a DoLS authorisation. When we looked at the care records we saw evidence of best interest decisions which indicated why the service was applying for a deprivation of liberty in the person's best interest. This helped to make sure that people who were not able to make decisions for themselves were protected.

When we asked the people who lived at Moorhaven if they were asked for consent, they told us they were and that they were always offered choices. For example, one person told us, "Oh yes, they always ask me, for instance, they'll always ask what clothes I want to wear." Where people were unable to consent we asked the staff what this meant to them. They told us that they needed to ensure that any care was given in accordance with the person's wishes, and that whilst some interpretation was needed they would consider and chose what was in the person's best interest. The register manager told us that the staff at Moorhaven had a good basic understanding of capacity and consent issues but did not always have a good grasp of the finer parts of this issue. She told us that the service was working closely with the local authority DoLS Co-

ordinator, and was arranging for further training for some staff to improve their knowledge.

The care files we looked at showed that attention was given to people's nutritional needs. We saw that Malnutrition Universal Screening Tool (MUST) charts were used. People were weighed on a monthly basis to ensure that they were maintaining weight. We noted that where there were concerns about a person's weight they had been referred to the dietician for further advice and support and their weight was then monitored on a weekly or fortnightly basis.

One person told us, "The food is good but they don't over face us. It's the type of food I like. I look forward to mealtimes." Mealtimes were a relaxed and social occasion with good interaction between people. The menu was prominently displayed on a large chalkboard in the dining room and at lunchtime on the first day of our inspection we observed a person who lived at Moorhaven reading this out and discussing the options with their peers. On hearing the choices we overheard one person remark, "Oh good, I like liver and I like chips!" The main meal was served at lunchtime and at teatime there was a choice of hot meals, such as chicken Kiev or beef and onion soup, or cold snacks for people with smaller appetites. Breakfast was as requested, for instance, we saw one person had porridge; another poached egg on toast, and a third had cereal with toast and jam. Meals looked and smelled appetising with good colour including green vegetables. Some people had coloured plates to provide good visual contrast for people with dementia. Most people chose to eat their meals in the dining area, but some had meals in their rooms or in the lounge. We observed one tray being taken to a room and this was well presented. People were supported to be as independent as possible to eat their meal and adapted equipment was available to help people with this. Staff provided one to one assistance for people who were unable to feed themselves, sitting with the person, talking with them, establishing eye contact and helping them to eat and drink at their own pace.

The kitchen staff knew the people who lived at Moorhaven well, and assisted serving and supporting the care staff at mealtimes. The kitchen staff we spoke with demonstrated a good knowledge about people's preferences and needs. We saw written information in the kitchen area detailing people's preferences, food allergies and specialised diets. Those people who needed food to be presented in a softened or liquidised form had this prepared for them and we saw softened diets were presented in an attractive way. Where people needed their food to be fortified using specialist supplements these were in place. Specific dietary requirements such as sugar free or soft foods were available as required, with specific diets followed and monitored with evidence of food and fluid charts where necessary. Staff were aware of people's dietary needs and preferences, which were taken into account on the menu. The cook told us that whilst most of the people at Moorhaven liked traditional meals, they were gradually introducing meals such as sweet and sour chicken, which they told us were going down well.

Throughout the days of our inspection drinks were served, and on the second day which was particularly warm there was a continuous supply of ice-lollies and cold drinks provided to keep people refreshed and maintain hydration.

People had good access to healthcare and staff monitored their physical and mental health needs. Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. We saw evidence in care files and case notes of referrals, for example to mental health liaison officers, with records of advice taken and implemented by care staff. Where specific needs, such as eye care or concerns about pressure care were identified specific care plans were drawn up to meet any needs identified. This meant that people were receiving care and support to access additional health care services to meet their specific health needs.

Good

Is the service caring?

Our findings

People told us that they were well cared for at Moorhaven. One person who lived there told us, "They look after me as well as they can. I can sit back and enjoy it. It's nice to be looked after. One or two can be a bit strict but that's just their way. They are all good and care for us." Visitors to the home were keen to pass on their high opinion of the service. They said, "The staff are on the ball with everything, and take on board any changes in need". Another told us, "[My relative] is growing older, and they see that, and how it affects her from day to day. They always go at her pace".

Relatives also told us that they were made welcome when visiting the home. They informed us, and we saw that staff knew them and were always welcoming. "It's brilliant," one told us. "They know me, and support me too. Staff are enthusiastic, caring and everything is open. They are always available, friendly and knowledgeable". They told us that if they wanted to speak with their relatives in private they had access to a quiet room or could go to the person's bedroom where their privacy was respected.

Throughout our visit we heard good, friendly and familiar interaction between staff and people who lived at Moorhaven. For instance, when a person checked the activity board to see what activity was on, they stated, "Bingo! I'm not a one for that," to which a care worker humorously retorted, "You will be when you win a bottle of wine!" People were referred to by their preferred name including pet names and nicknames.

When we asked, people who lived at Moorhaven told us that they thought the care staff made an effort to get to know them, and we saw that staff would spend time with people sitting and talking with them either individually or in groups. For instance, we observed a care worker talking to a person who used the service about an upcoming football match and helped to draw in opinions from others. This led to a lively conversation amongst the people present. We overheard a quiet discussion between a care worker and a person who lived at Moorhaven. A question, "How did you know that?" led on to local reminiscence and discourse about shops in the local area and how they had changed.

Staff agreed that it was important to get to know people and to spend time with them. One member of staff told us, "I love my job. The best part is when you can have a laugh and a joke with the residents". Another agreed, stating, "There is no hanging about, we are kept busy but there is always time to talk. You always have five minutes or so for a resident". They told us they felt rewarded when they chatted to people, "I got a real kick out of a chat when assisting a person to bed recently when they told me, 'I've enjoyed that conversation'."

We saw people were clean, tidy and well groomed. One member of staff told us, "I like people to look good, especially when they take pride in appearance. It's important that they are well dressed and washed, and I ensure they have clean clothes each day. I think, 'If it was my mother or father, how would they want their care delivered?"

We observed that when staff interacted with people they were caring, compassionate and respectful to people's needs and wishes. For example, at lunchtime people were given sufficient time to eat at their own

pace and were not rushed. When transferring a person using lifting equipment, we saw staff took care to ensure that they explained each step, watched, and were mindful of the person's dignity, treating them with courtesy and respect. Care was taken when people were being transferred in wheelchairs. For instance, we saw staff check that footrests and lap belts were applied, and any obstructions which may cause knocks or bumps were moved out of the way. On the second day of our inspection one person was going to hospital for an out-patient appointment. The care staff ensured that this person understood the nature of the appointment, was dressed appropriately and had all relevant documentation before the ambulance arrived. The caring attitude of staff towards people who used the service was not restricted to nursing and care workers. We saw that kitchen staff and domestics assistants knew the people who used the service and would listen and talk to them.

Care records for people documented their interests and what they enjoyed doing, and included any spiritual or religious needs. People and their representatives told us that they were offered choice in the delivery of their care and support, and these wishes were reflected in care plans. One person told us, "I am always given choices, what to wear, what I want to eat, or when I want to go to bed." We were told that there were no set times for people to get up or go to bed.

The staff engendered a caring attitude amongst the people who lived at Moorhaven. For example, at lunchtime when one person asked for some vinegar a person on the next table asked them if they would also like ketchup. One member of staff brought in newspapers each day for people to read. We saw when one person had finished reading their paper, they took it over to another person to look at. We saw when one person who lived at Moorhaven asked a question of another and received no response, staff gently explained that the person was extremely hard of hearing and not being rude.

There was evidence that people's wishes for their end of life care had been considered. When we looked in care files we saw that where necessary a DNAR (do not attempt resuscitation) form was in place and reviewed by the registered manager on a monthly basis. A DNAR form is a document issued and signed by a doctor, which advises medical teams not to attempt cardiopulmonary resuscitation (CPR). All staff had recently received training on the Six Steps Care Pathway. This is a programme designed to provide quality care to people who are at the end of their lives. Staff told us that they benefitted from this training, and had taken steps to put the learning into practice. One member of staff we spoke to told us that this helped them to support people to have a dignified death, and to remain professional in their dealings with the person and their relatives. They told us that following a recent death, "I felt better for saying goodbye properly, then I could go off and weep quietly to myself in a corner."

Information held about people, including all care records was securely stored in the manager's office when not in use. This helped to protect the personal information held about people who used the service. Staff had access to the notes and we saw that they regularly consulted care plans and assessment to ensure that they were providing appropriate care and support.

Good

Is the service responsive?

Our findings

When we inspected Moorhaven in September 2016 we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the assessments carried out prior to a person moving into the service did not record the person centred detail known by staff around how a person would like their support to be delivered, and because care plans were not always written in a way which ensured people's preferences, likes and dislikes were captured.

At this inspection we asked the registered manager how they determined if the service could meet the needs of people who enquired about moving to the service. She told us that when there was an enquiry about occupancy, she sought background information about the person and their condition from the relatives and sought information from any professionals involved in their care, such as social workers or nursing and medical staff. This was followed up with a home or hospital visit to the person. She told us, "There is no point in doing half a care plan, so I try to get as much information as possible and discuss how to best meet needs with the person and their relatives, who assist in drawing up the initial care plan. We do a full assessment and review this on admission, and revise accordingly".

We looked at a recent pre-admission assessment to see if there had been any improvement since our last inspection. We saw that the registered manager had visited the person prior to their admission and completed a thorough assessment of their needs, including details of the person, their medical and social needs and included their likes and dislikes. Information included details about how they would like their care needs to be addressed, and included daytime and night-time routines, which would ensure that any disruption to the person's daily patterns was kept to a minimum on admission.

When we looked at care files we saw that they contained a 'resident's profile' which gave some details about the person, their background and the reason for their admission into Moorhaven, and a one page document provided a simple breakdown of the tasks required to maintain the person's independence. This was followed by more detailed care plans to provide instruction on how the care was to be delivered. Twenty one separate care plans contained detailed information to guide staff on how to provide care and support. They also showed that risks to people's health and well-being had been identified, such as the risk of poor nutrition and the risk of injury. Where a risk had been noted action to reduce or eliminate any identified risk was recorded. We saw that specific specialist information and guidance from the relevant professionals involved in their care was contained within the care records, with notes of visits and consultations. The records were reviewed regularly to ensure the information was fully reflective of the person's current support needs.

We saw that within some care files there was a document entitled "This Is Me" which provided a short biography of the person and helped to give a greater understanding of the person and recognise their individuality. However, they were not easy to locate in the care files. When we spoke to the registered manager about this she agreed that greater prominence in the files would help staff who were unfamiliar with the person to provide a more person centred approach to care. Not all care files contained a 'This Is Me'

document, but the registered manager informed us that this was a work in progress, and that staff were talking to people and their relatives to develop a full picture of the person that could be incorporated in the person's file.

When we spoke with staff they were able tell us about the people who lived at Moorhaven in a way that showed that they knew them well, and we saw that interactions with the people who used the service were warm, friendly and person centred. People and their relatives told us that they had helped to draw up their care plans so that they had a say in how their care was delivered, and that they were involved when their care was reviewed. We saw staff were attentive to need and noticed when people were in difficulty. For example, a person who lived at Moorhaven told us that after their family had purchased a new chair for them, staff noticed that the person was uncomfortable, the chair appeared too low and the person was struggling to get out. They liaised with an occupational therapist who arranged for adaptations to the chair height.

Following our last inspection the service had included information in care files which recorded the activities people took part in. People who lived at Moorhaven told us that they received enough stimulation and social activity. One said to us, "There is usually enough to do. I don't like twiddling my thumbs, and we don't here." The service employed an activities co-ordinator who organised special events such as parties or visiting entertainers, and provided activity for people either individually or in groups. People told us that she would take them out shopping, and on the second day of our inspection she took a group out to the local park, ensuring before she left that all were appropriately covered and dressed for the warm weather. From the activities board which was displayed in the dining room we saw there were a variety of activities planned for each day. We were told that all staff had a responsibility to arrange an activity on a rotating basis. On the first day of our inspection we saw a member of staff had arranged a bingo session; people were asked if they would like to join in, and we saw five of the people who used the service were enjoying the session. All won a prize. We saw constant interaction between people and that the people who lived at Moorhaven had developed friendship groups. One remarked, "It's a good community. People talk to us all the time and don't leave us. There are a lot of comings and goings. It's a bit noisy sometimes, but lots of chatter".

The people we spoke to told us that if they had a complaint they would speak to the manager. The service had a complaints policy which explained who to contact if people wished to make a complaint and gave timescales for action. However, this policy was not prominently displayed or easily accessible to people who used the service or their visitors. When we mentioned this to the registered manager she agreed to leave a copy in the entrance area. There had been no complaints made since before our last inspection. One visiting relative told us, "I have nothing to complain about; I can always ask if I have any issues." Another told us that although they had no complaints about the quality of the service they had raised concerns about the funding arrangements for their relative, and that the service had been supportive and advocated on their behalf.

Good

Is the service well-led?

Our findings

There was a manager in post at the time of our inspection who had been registered as the manager of Moorhaven with the Care Quality Commission (CQC) since October 2010. People spoke highly of the registered manager, for instance, a person who lived at Moorhaven said, "She's busy, but always has time for us and I think she knows us all really well", and a visiting relative told us, "If I find a problem, I'd go straight to the [the registered manager]. I know she would deal with it".

Staff told us that they were well supported by the manager. One care worker told us, "[The registered manager] is really supportive and understanding even with personal issues. For example she will rearrange the rotas if necessary or give set days off for us to support our families." In addition to formal supervision, we observed the registered manager instructing staff as they were going about their duties, and we saw in staff files that following a period of absence staff were given a 'return to work interview' with recorded notes to show that their ability to undertake tasks following sickness was assessed and monitored.

We saw that there was a friendly and open atmosphere; staff got on well together. One care worker told us, "I enjoy working here. I like working with people and getting to know them. Staff get on well generally but I don't like when staff don't pull their weight, but that rarely happens." Staff were aware of their roles and responsibilities. The manager had established a routine where care workers were allocated to work either on the ground or first floor, rotating on a daily basis. Senior Care workers would alternate between floors week by week. This meant that staff would work with different staff each day and get to know all the people who lived at Moorhaven well. When we asked, the staff we spoke with told us that they liked this variety. One told us, "Here, you get to work with everybody, and get to know them. It is also good because they are all so different, so we can learn from them as well as about them".

When we last inspected Moorhaven we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014, because the registered manager had been rostered as a nurse on a number of occasions over the previous months, which meant that she would be unable to undertake her duties as the registered manager for the service. At this inspection we reviewed the rotas for the previous two months and saw that a nurse was on duty at each shift, leaving the manager to undertake her management role.

We saw other improvements from our last inspection and action had been taken to resolve the issues we had identified. There was an on-going action plan to improve the standards of care and support. For example, when we last looked at the quality assurance system we found that this did not ensure safety and quality for the people who lived at Moorhaven which we identified as a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection we found that the service had reviewed its quality assurance framework and implemented systems to monitor the service to ensure the delivery of safe care and treatment of people. For example, care files were checked on a weekly basis to ensure that they contained all relevant information. A more generic and person centred audit was undertaken monthly to check that information in care files was up to date and still relevant. A more thorough audit would check that any areas of risk were noted, monitored and

reassessed. Each care file was thoroughly audited at least yearly. We looked at one audit and saw that where a person had had a small number of falls the risk assessment was reviewed and a referral made to the falls co-ordinator. The audit cross referenced the accident and incident reports. In addition the registered manager and assistant director undertook random audits to check that care plans were responsive; these checked that risks were identified, especially in relation to skin integrity, mobility and weight; if any referrals to external professionals were required, and to check that consent had been given for care and treatment.

Further audits were carried out covering, infection control, moving and handling, medicines management, and the general environment. All staff were observed carrying out their duties every six months. The assistant director also visited the home on a six weekly basis to carry out a comprehensive audit, which included checks on maintenance, cleanliness, staffing levels and training, and produced an action plan, which demonstrated on-going improvement.

Staff told us that they were involved in discussions about issues in service provision during team meetings, and that if they had any concerns they could approach the registered manager. Minutes of the most recent meeting showed staff were able to contribute their thoughts and ideas, with evidence of discussion and agreement on service provision. People who lived at Moorhaven told us that they were invited to provide feedback about the service, and that there were regular residents meetings. We reviewed the minutes of the most recent meeting held in April 2017. Items discussed included the quality and variety of the food, environment, activities, daily routines and the positive attitude of staff.

The manager was aware of the importance of maintaining regular contact with people using the service and their families. The service conducted an annual survey, and produced a report outlining the results. The outcome of the most recent survey was positive, but where issues were identified there was evidence that the information was used to improve the service on both an individual and general level. For example, where people had been less than enthusiastic about the quality of the food the menus had been reviewed and appropriate changes made. The following residents meeting noted improvements.

We asked a visiting relative if they were invited to relatives meetings. They replied, "Why would we need one? We know what's going on and they always keep us informed." They told us that the staff encouraged their questions and would call them if there was anything out of the ordinary regarding their relative's care. The service produced a newsletter every three months and a copy was sent to relatives of all the people who lived at Moorhaven. The last newsletter provided information about end of life care at Moorhaven and outlined planned and recent activities. It also included a statement which reflected the vision and values we found during our inspection: "It isn't all about personal care; we also look after your loved ones' social needs and we try to make the day as entertaining and comfortable as possible".

Before our inspection we checked our records to see if any accidents or incidents that CQC needed to be informed about had been notified to us by the registered manager. This meant that we were able to see if appropriate action had been taken by management to ensure people were kept safe. We saw that the registered manager reported incidents to us and gave us information about actions taken to respond to the issue. We had also received a detailed provider information return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make.

From 1 April 2015 it has been a legal requirement of all services that have been inspected by the CQC and awarded a rating to display the rating at the premises and on the service's website, if they have one. Ratings must be displayed legibly and conspicuously to enable the public and people who use the service to see them. During this inspection we saw that the rating and a summary of the report from our last inspection

were displayed in the entrance hall.