Care Quality Commission

Veatreey Development Ltd

Moorland Nursing Home

Inspection report

Moorland Road,
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires Improvement
Is the service responsive?	Inadequate
Is the service well-led?	Inadequate

Overall summary

This inspection was carried out on the 12 and 14 of May 2015 and 03 June 2015 and was unannounced.

We last inspected Moorland Nursing Home in April 2014 and identified no breaches in the regulations we looked at.

The home is situated in a residential area in Poulton-le-Fylde and provides accommodation for up to 22 people. It is a care home that provides nursing and personal care. There are communal and dining areas on the ground floor. Bedrooms are located on the ground floor and the first floor, which is accessible by a lift for the less mobile. Some bedrooms have en-suite facilities.

On the first two days day of the inspection there were 17 people living at the home. After our visits, we received information of concern relating to the care and welfare of people living at the home and leadership and management at the home. This resulted in us visiting the home again on 03 June 2015. On the third day of the inspection there were 19 people living at the home.

Summary of findings

The home does not have a manager who is registered with the Care Quality Commission. 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.

We found processes to ensure that people's freedom were not inappropriately restricted were not always followed. The Provider did not have systems in place to ensure that people were not unlawfully deprived of their liberty. Staff had not received training to understand and carry out the principles of the Mental Capacity Act 2005 (MCA) code of practice.

During the inspection we found people were not always referred to other health professionals in a prompt manner and documentation did not always reflect their needs. We also found people's health needs were not assessed to ensure the care provided met their needs.

People told us staff were rushed and we observed a lack of social activities taking place at Moorland Nursing Home. Interactions with people who lived at the home were task focussed and staff did not interact with people unless they were delivering care and support. We found the staffing provision at the home was inadequate to ensure people received person centred care that met their needs and preferences.

People told us they felt safe, however we noted risk assessments were not completed or were not reviewed in a timely way. We saw staff did not always respond to naturally occurring risk.

The staff we spoke with were knowledgeable of the reporting processes in place if they suspected people were at risk of harm or abuse, however we found these were not always followed in practice.

There were insufficient systems in place to monitor the quality of care and risks to people who lived at the home. Systems in place did not always identify errors in documentation and medicines management. We found medicines were not managed safely as records were incomplete, suitable reference material was not available to staff and medicines were not stored safely.

People were not supported by competent staff as training specific to the needs of individuals had not been provided. Supervisions and appraisals were not carried out consistently to enable competence to be assessed and training needs identified. There were no systems in place to ensure people received care from staff who were qualified to do so.

People were supported to eat and drink sufficient to meet their needs and were offered alternative choices if they declined a meal.

It is a requirement of the Care Quality Commission (Registration) Regulations 2009 that the provider must notify the Commission without delay of the death of a person who lived at the home and also of any abuse or allegation of abuse relating to people who live at the home. This is so we can monitor services effectively and carry out our regulatory responsibilities. During the inspection we found that the required notifications had not been submitted to us.

We found that there were a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example cancel their registration.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to

Summary of findings

varying the terms of their registration within six months if they do not improve. The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risk assessments were not completed in a timely manner. This meant people could not be assured of safe care and treatment.

Staffing was not sufficient to ensure people's needs and preferences were met promptly and there were no systems in place to ensure people received care from appropriately qualified staff.

Medicines were not managed safely. Records were incomplete and fridge temperature monitoring was not carried out.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. However this was not always applied in practice.

Is the service effective?

Inadequate

The service was not effective.

Processes to ensure that people's freedom was not inappropriately restricted were not followed and staff had not received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.

People were enabled to make choices in relation to their food and drink and were supported to eat and drink sufficient amounts to meet their needs.

People's health needs were not always assessed and appropriate referrals to other health professionals were not always carried out.

Training and development activities had not been identified or arranged to ensure staff could meet the needs of people who lived at the home.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us they felt cared for however we observed people were not always treated with dignity and respect.

Documentation was not always written in a way that upheld people's dignity or demonstrated respect.

Is the service responsive?

Inadequate

The service was not responsive.

People were not always provided with activities that were meaningful to them.

The provider did not record and review comments or concerns raised to improve the service provided.

Summary of findings

People told us they were involved in their care planning and staff took their wishes into account.

Is the service well-led?

Inadequate 

The service was not well–led.

The arrangements for management responsibilities at the home were insufficient and there was no clear leadership within the home.

The provider had not fulfilled their regulatory responsibilities and submitted the required notifications to the Care Quality Commission.

There were insufficient monitoring checks being carried out to ensure any areas of required improvement were identified and actioned and existing monitoring checks did not always identify the improvements required.

Moorland Nursing 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 was carried out on the 12 and 14 of May 2015 by one adult social care inspector. On the 03 June 2015 two adult social care inspectors continued the inspection. This was because we had received information of concern relating to the management of the home and the care and welfare of people who lived at the home. On the final day we were accompanied by 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.

Prior to the inspection we reviewed information the Care Quality Commission (CQC) holds about the home. This included any statutory notifications, adult safeguarding information and comments and concerns. This helped us plan the inspection effectively. We also contacted a member of the local commissioning authority to gain further information about the home. We received no negative feedback.

During the inspection we spoke with nine people who lived at Moorland Nursing Home, ten relatives, three qualified nurses, four care staff, the housekeeper and the cook. We also spoke with the acting manager and the provider.

We looked at all areas of the home, for example we viewed lounges, people's bedrooms and a communal bathroom. On the first and second day of the inspection there were 17 people resident at the home. On the third day of the inspection there were 19 people resident at Moorland Nursing Home.

We looked at a range of documentation which included six care records and 15 staff files. We also looked at a medicines audit, care records audits, a health and safety audit and a sample of medication and administration records.

Inadequate

Is the service safe?

Our findings

We asked people if they felt safe. Comments we received included, "Definitely, staff are really kind." And, "I've always felt safe here." The relatives we spoke with also told us they felt their family members were safe, however this was not always reflected in our observations and findings during the inspection.

The care records we viewed showed us individual risk assessments were carried out, but these were not always reviewed regularly. The acting manager told us the risk assessments should be reviewed monthly, however we found this did not always take place. In one care file we saw skin integrity assessments, falls assessments, nutritional assessments and moving and handling assessments had been carried out in January 2015. These were next carried out in May 2015. In a further file we saw skin integrity assessments, falls assessments and moving and handling assessments had been carried out in December 2014 and were next carried out in April 2015. In a third file we saw falls assessments were completed in November 2014 and were next reviewed in May 2015. We saw the same care file contained a skin integrity assessment that had been completed in January 2015 and was next reviewed in April 2015. This placed people at risk of harm as assessments should be reviewed to ensure any risks to people's health and wellbeing are identified and control measures are put in place to minimise these.

We looked at two care records and saw they instructed bed rails should be used. Bedrails are used to help maintain people's safety; however the use of these should be risk assessed to ensure that they are an appropriate care intervention for individuals. This helps ensure that any further risks are identified and managed to maintain people's safety and wellbeing. On the day of the inspection we saw that the bedrails were in use with no documented risk assessments to help ensure people's safety and wellbeing were maintained. On the third day of the inspection we saw these had been partially completed but had not been signed to confirm they were an accurate reflection of the risks and control measures required to maintain people's safety.

On the second day of the inspection we saw both the first floor and ground floor windows opened freely. This posed a risk as people could access these and fall from them which may result in injury. It also posed a risk from unauthorised people entering the home. We discussed this with the provider who told us they had commissioned a specialist health and safety inspection which had taken place on the 13 May 2015 and this had been identified as a risk. They told us they had been advised that the windows could be locked until appropriate window restrictors were fitted. On the third day of the inspection we saw this had not been done and windows still opened freely. This demonstrated that the advice given by the health and safety advisor had not been acted upon.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as reasonable practical measures had not been taken to mitigate the risks identified.

Staff did not respond to naturally occurring risk. We saw two people who lived at the home were having a disagreement and observed a staff member walk past them without intervening. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the lack of intervention by staff could have resulted in the harm occurring to either person.

We asked staff to give examples of abuse and they were able to describe the types of abuse that may occur, identify the signs and symptoms of abuse and how they would report these. They told us they had received training in this area and would immediately report any concerns they had to the registered manager, or to the local safeguarding authorities if this was required. Staff told us, "I'd report straight away to the [manager]." And, I'd report immediately to the [manager]." However during the inspection we noted that safeguarding processes were not consistently followed and we referred an injury to the local authority safeguarding team. We discussed the injury with the acting manager and the owner and were told they would investigate this internally. Unexplained injuries should be referred to the appropriate safeguarding authorities to allow collaborative working between agencies and ensure sufficient and appropriate investigations are carried out to protect people who may be vulnerable.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities 2014) as systems were not operated effectively to prevent the abuse of service users.

Inadequate

Is the service safe?

During the first two days of the inspection people gave us positive feedback regarding the response from staff if they required support. We were told, "Generally they're very good and come straight away. Obviously if there's an emergency that's different but usually they're quite quick." We also spoke with four relatives who gave us conflicting information regarding the staffing provision at the home. Two relatives told us they had no concerns with the response from staff and two told us there were times when they felt staff were not prompt.

We discussed the staffing provision with the acting manager and provider. We were told that individual dependency assessments were carried out and these informed the number of staff required to support people, however the acting manager could not explain how the dependency assessments informed the number of staff required.

On the first day of the inspection we were told the staffing levels were one registered nurse and three care staff during the day and one registered nurse and one care staff at night. This had been changed due to reduction in the number of people who lived at the home. At the time of the inspection carried out on 12 and 14 May 2015 there were 17 people resident at Moorland Nursing Home and we were informed nine people required support from two members of staff. The home had bedrooms on the first and second floor and staff carried out laundry duties and activities.

On the third day of inspection we were informed by the acting manager that 19 people were resident, 12 of whom required support from two staff members with care. We spoke with eight people who used the service and four relatives. When asked, three of the people who lived at the home said they did not think there were enough staff on duty at the home. Staff were described as "overworked" and "rushed". Five relatives we spoke with also said they felt the home was understaffed.

One person described their experience of waiting for support from staff. From their description we concluded staff had not responded in a quick manner to maintain the person's dignity and relieve discomfort. We discussed our concerns with the acting manager who told us they would increase the number of staff available to support people from the next day. At the time of the inspection, the feedback we received from people, their relatives and our observations showed us the staffing provision at the home was insufficient to meet peoples' needs. This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We asked the acting manager how they ensured care was provided by consistent staff who knew the needs of people who lived at the home. The acting manager told us they were currently recruiting staff but until positions were filled, they booked agency and bank staff in advance to ensure consistent staff were available to support people. We saw rotas which confirmed this.

We asked the acting manager and provider how they ensured the qualified nurses who were permanently employed by the home, were registered with the National Midwifery Council (NMC). The (NMC) is the nursing and midwifery regulator for qualified nurses and in order to practise, all nurses must be registered with this body and have their registration renewed annually. The acting manager and owner could not explain what systems were in place to ensure qualified nurses remained registered with the NMC. We viewed the personnel file of one qualified staff which did not contain evidence of their current registration status with the NMC. We spoke with the qualified staff who told us they had never been asked to provide evidence of their current registration status to either the acting manager or the registered manager who had previously managed the home. We discussed this with the acting manager who told us they would ensure formal checks were carried out to ensure qualified staff were appropriately registered.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as the provider had not ensured that persons employed by the home to provide care and treatment had the qualifications to do so safely.

We reviewed three personnel files that showed us a process was in place to ensure safe recruitment checks were carried out before a person started to work at the home. All the staff we spoke with told us they had completed a disclosure and barring check (DBS) prior to being employed. This is a check that helps ensure unsuitable people are not employed by the provider.

During this inspection we checked to see if medicines were managed safely. We looked at a sample of Medicine and

Inadequate

Is the service safe?

Administration Records (MAR) and saw the record and amount of medicines at the home matched. This showed us medicines were available and had been administered as prescribed.

We observed medicines being given and saw the administering staff explained to people what the medicine was for and asked if they were ready to receive it. They were patient with people and helped people understand what their medication was for. This is important as it helps ensure people receive their medicines when they require it.

We discussed the arrangements for ordering and disposal of medicines with the administering staff. They told us the night staff at the home ordered the medicines and we saw medicines were disposed of appropriately by returning them to the pharmacist who supplied them. The staff member told us they had received training to enable them to administer medicines safely; however we saw no evidence in the staff file that we viewed that on-going competency was assessed.

We viewed one MAR record and saw the medicines the person required were handwritten onto it. The MAR record had not been signed to evidence the number of medicines received from the pharmacist. Medicine records should be signed to evidence the number of medicines received as this helps ensure medicines are managed safely. We discussed our concerns with the acting manager who assured us they would investigate this.

We saw there were no protocols in place for PRN medicines. PRN medications are given on an "as needed" basis for specific signs & symptoms of illness and should instruct staff when and how PRN medicines should be given. In addition we looked at the British National Formula (BNF). This is a nationally recognised medical reference book which provides up to date information about medicines. The book we viewed was dated 2010 and therefore would not have provided current information to administering nurses. We discussed this with acting manager and owner who told us they had provided an up to date BNF to the previous manager. However on the day of the inspection this could not be located.

We checked to see that people who received medicines were identifiable by administering staff. The qualified staff told us photographs were used to help staff identify people who lived at the home. We looked at 15 medicines and administration records and saw seven people did not have photographs with the medicines and administration records to support staff to identify people safely. This is particularly important when bank and agency staff administer medicines as they may be unfamiliar with people who live at the home.

We saw a fridge was in place to ensure medicines that required cold storage were stored at the correct temperature. We observed the temperature had not been recorded for two weeks prior to our inspection. Not storing medicines at the recommended temperature can affect the effectiveness of the medicines.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 as medicines were not managed safely.

Inadequate

Is the service effective?

Our findings

Two people who lived at the home told us they did not think staff received enough training. One person said, "In my opinion they are a bit short of staff here and short of staff who know what they are doing. They use a hoist to move me and, sometimes, they are not very good at it."

We asked staff to describe the training and support they received to enable them to provide safe and effective care to people who lived at the home. All the staff told us they had received training in areas such as safeguarding, moving and handling and first aid. We were informed the training was primarily theory based with practical training in moving and handling and first aid. We asked if staff if they had received training in behaviours that may challenge. The staff employed by Moorland Nursing Home told us they had not, and the acting manager confirmed this. This was a concern to us as during the inspection we saw entries in a persons' care record which showed us the person displayed behaviours that may challenge. In addition we asked a qualified nurse if they had received training in pain management. They told us they had not. The provider had failed to identify training to meet the needs of people living at the home.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities 2014) because people were not supported by competent staff as training specific to the needs of individuals had not been provided.

When asked, staff could not recall when they had last received an appraisal. An appraisal is a one to one meeting with a line manager to discuss performance, aims and objectives of the service and identify and plan any training that is required. We looked at 15 personnel files and the documentation we viewed showed us two staff had not received an appraisal since 2008, five staff had not received an appraisal since 2013 and there was no evidence that three staff had received an appraisal.

We also saw that both care staff and qualified nurses had not received regular supervision. Supervisions are important as they enable staff to review their performance and identify if improvements are required. We discussed this with the acting manager who informed us that they had identified this and as a result had held individual supervisions with staff. We saw documentation that evidenced this. The acting manager told us supervisions should be held four times a year and appraisals should be held annually. However, at the time of the inspection we considered improvements were required as supervisions and appraisal were not carried out consistently to enable competence to be assessed and training needs identified. The lack of supervision and appraisal was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

On the 03 June 2015 we spoke to a bank staff who told us they had received an induction when they started at the home. Bank staff are employed to cover shortfalls in staffing and as such may not be familiar with the service provided or the needs of people at the home. They told us the induction consisted of a tour of the home when they were introduced to staff and people who used the service. They also told us they received a handover and were informed of the fire procedures. This was not documented.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations as accurate records of staff development should be maintained to inform the supervision and appraisal process and enable accurate review of learning needs.

We asked people who lived at Moorland Nursing Home their opinion of the food provided. We were told, "If I want anything different I can have it. The cook asks every day what I want and I can change my mind anytime." And, "Not bad." Also, "Passable." During the inspection we saw the cook asked people to select from a menu and at lunchtime we saw people's preferred choices were provided. We saw people could choose where they wanted to eat their meal. One person chose to eat in their bedroom and their meal was presented to them on a tray with a drink, napkins and cutlery. We saw staff checked that they were happy with the meal before leaving.

We observed people being supported to eat and saw this was done with respect. People were shown their meal and offered protection for their clothing. We saw people who chose to eat in the dining room were waiting from 12:30 until 12:50 when the first course arrived. The main course arrived at 1:20pm and the dessert arrived at 1:40pm. It is important people receive their meals in a timely way as this encourages people to eat and drink sufficient to meet their needs.

We checked to see if people who had specific dietary needs were catered for. One of the care plans we reviewed

showed us the person required specific equipment to meet their individual needs. During the inspection we saw this was provided to them. This helped ensure their nutritional needs were met effectively, whilst promoting their independence. We also observed a staff member supporting someone to eat their meal in accordance with a health professional's instruction. This minimised the risk of harm to the person and enabled their nutritional needs to be met.

The people we spoke with told us that if they needed to see a doctor, this was arranged and relatives confirmed this. We saw evidence that if recommendations were made by other health professionals, the instructions from the health professional were included in the care file but these were not always documented within the persons care plan. In one file we viewed we saw there was no care plan in place for this person's particular need. In a further person's care file we saw there was no care plan to instruct staff with regard to a change in their treatment plan. In a further two care files we saw specific instructions from other health professionals had not been included within the care plans for these people.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as absence of care plans and the lack of accurate information within individual care plans placed people at risk of inappropriate care and treatment that did not meet their needs.

Although we had seen some evidence of referrals to other health professionals we saw one occasion when this had not been carried out. In a further care file we saw a decision had been made to support a person in their bed and we spoke with the person who told us they did not like staying in bed. We discussed this with the qualified staff and the care staff and asked if a referral had been made to other appropriate health professionals, for example a physiotherapist. We were told it had not. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people should be referred to other appropriate health professionals to ensure the care and treatment is appropriate and meets their needs.

The care documentation we reviewed showed us peoples' health needs were not always assessed. We saw evidence in one care file that a person's behaviour had changed and there were no evidence based assessments in place to monitor the person's condition and behaviour or assess if the care and treatment provided was effective. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were no assessments in place to ensure the care and treatment provided was effective and met the persons' needs.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the registered manager. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivations of Liberty Safeguards (DoLS) are part of this legislation and ensure where someone may be deprived of their liberty, the least restrictive option is taken. We spoke with the acting manager to assess their understanding of their responsibilities regarding making appropriate applications if they considered a person was being deprived of their liberty. The acting manager failed to demonstrate a robust understanding of the processes in place. We were informed that no applications had been made to the supervisory bodies and there were no DoLS authorisations in place.

We asked staff to describe their understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and how this related to the day to day practice in the home. Staff could give examples of practices that may be considered restrictive and said it was the acting managers responsibility to discuss this with family members and arrange Best Interests meetings if required. When we asked care staff to explain their understanding of the purpose of best interests meetings, they told us they didn't know. We viewed a training matrix that showed us staff had not received training in this area. The acting manager confirmed this and told us this was being planned. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not supported by competent staff as training specific to the needs of individuals had not been provided.

During the inspection we saw a care record instructed in the use of bedrails. Although this is an item of safety equipment, it can also be considered as form of restraint or restriction under the Mental Capacity Act (2005) (MCA).

Inadequate

Is the service effective?

Where a person lacks capacity to consent to the use of bedrails, the guidelines of the MCA should be followed. In the record we viewed we saw it stated "with consent" and this had been completed in 2013. There was no evidence to show how the decision had been reached, who was involved or if consideration had been given to the MCA. We could see no documentation to demonstrate if this had been reviewed with consideration to people's mental capacity. We viewed a further person's care record which also instructed bedrails could be used. This also stated "with consent" and had been completed in 2014. There was no evidence to show how the decision had been reached, who was involved or if consideration had been given to the MCA. We asked the acting manager how the service ensured people's rights were upheld and the acting manager told us they would review the use of bedrails within the service and ensure the guidelines of the MCA were followed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the principles of the Mental Capacity Act 2005 had not been consistently applied.

Requires Improvement

Is the service caring?

Our findings

We asked the people who lived at Moorland Nursing Home to describe the staff who worked there. We were told, "Staff are lovely, they go out of their way to help us." And, "mostly kind and compassionate." Relatives told us, "The staff are very good with my [family member]" and another relative said, "Some are caring."

We carried out observations to see if staff were caring. We saw some positive interactions. For example if people were supported to eat or drink staff spoke with them politely and respectfully. We also saw if people were supported to mobilise, staff explained to people what they intended to do and offered reassurance to people as they provided support. We saw a staff member noticed a person appeared uncomfortable and supported them to sit comfortably. The person appeared happier following this. However interactions were task focused and we did not observe care staff sitting with people or engaging with them if they were not providing support. There were no group activities provided on any of the days we visited. The staff we spoke with told us these were provided, however this was dependent on how busy they were.

During our visit, we spent time in all areas of the home, including the lounge and the dining areas. This helped us to observe daily routines and gain an insight into how people's care and support was managed. During our visit we saw evidence of poor practice. We observed one person speaking directly to a staff member and the staff member did not answer them. The person spoke to them twice more and asked, "why are you not talking to me?" as the staff member walked past them. We observed the staff member said, "I am talking to you" as they walked away from them. We also saw one person was supported to sit in an armchair but was offered no support for their feet which did not reach the floor. The staff member then left the lounge. We intervened to ensure the person's comfort was maintained.

We saw staff knocked on people's bedroom doors before entering and bedroom and bathroom doors were closed to ensure people's privacy and dignity was upheld when personal care was delivered.

However, the documentation we viewed did not always uphold peoples' dignity. In one care file we saw a person was described as "bad tempered". A further entry in the same care file stated "rude as usual…" We saw one bedroom door had a sign upon it detailing the care and support the person needed with regard to their dietary needs this did not uphold the person's dignity or demonstrate respect towards them.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as staff did not uphold people's dignity or treat them with respect.

We saw details of an advocacy service were displayed in the main reception of the home. The acting manager told us that there were no people accessing advocacy services at the time of the inspection. They told us they would support people to access advocacy services if this was requested.

Inadequate

Is the service responsive?

Our findings

People told us some internal activities took place at Moorland Nursing Home. One person told us, "They help me with my knitting and I like the puzzles we play in the afternoons." We received mixed feedback from the relatives we spoke with regarding the availability of activities.

During the inspection we did not observe any group activities taking place. We saw an individual activity where one person was asked if they wanted a manicure and this was done with them. We saw they enjoyed this and were pleased with the result.

We saw there was an activities planner in place and board games, knitting and shopping were listed as activities provided by the home. One person told us, "There are not many activities arranged so I get bored. I would like to do things such as help the staff if possible, they need it. Oh, we do have a singer sometimes." A further person said, "I'd like to go and have tea out." And one person told us they would welcome the opportunity to do some shopping. They said, "I just want to be able to go and do a bit of shopping sometimes but that never happens."

We asked the acting manager and staff what external activities were provided. We were told that people were supported to go out if they wished. We asked to see evidence of activities and were provided with a folder with people's individual names and the dates and types of activities they had taken part in. We saw no evidence that people were supported to engage in the community, unless they were supported to do so by their family member. We were told there were social external events provided by the home and these included trips to local places of interest. We saw no evidence of this during the inspection. It is important people are enabled to participate in activities that are important to them as this helps minimise the risk of social isolation and encourages independence and autonomy.

The lack of social meaningful activities was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure appropriate meaningful activities were available for people who lived at Moorland Nursing Home. This did not ensure people's independence and autonomy was encouraged and maintained.

The records we viewed did not contain any documentary evidence to show that people had been involved in the planning of their care. We discussed this with the acting manager who agreed to review the documentation in place. We asked people if they were involved in the care planning process. They all told us that staff discussed their needs and wishes with them and these were taken into account. One person told us how staff had suggested some individual equipment might benefit them. They told us they had initially had reservations regarding this, however with explanation from staff they had agreed to trial this and found this was helpful to them. All the people we spoke with told us they felt staff knew them well and all but one relative told us they were consulted in their family members care.

We asked relatives if they were aware of the complaints procedure in place. All the relatives we spoke with told us they were not. When asked, people who lived at Moorland Nursing Home told us they would discuss any concerns with some staff.

We checked to see if a complaints policy was in place and saw there was. We noted it contained a description of the timescale and people responsible for investigating complaints. We viewed the homes complaints file and saw there were no complaints recorded within it. The acting manager told us they were not aware of any complaints. They told us that if a complaint was received they would record this and carry out investigations as appropriate and we saw there was a format in place to enable this to be done.

During the inspection we became aware that a complaint had been submitted to the acting manager. We clarified with the owner and the acting manager that the complaint had been received. We were also informed by two relatives they had raised concerns with the management at the home and did not feel their concerns had been adequately addressed. We asked the owner and acting manager if records were kept of concerns and comments raised by people and relatives and if these were reviewed to identify reoccurring trends. We were told they were not. Comments, concerns and complaints should be identified, addressed and reviewed to improve the service provided.

The acting manager and the provider told us they offered people who lived at the home, and their relatives the opportunity to give feedback. They told us they held "residents and relatives" meetings but people had not

Inadequate

Is the service responsive?

attended. When we spoke with people who lived at the home they told us that they were not informed of the meetings and did not know that they occurred. We asked if surveys and questionnaires were provided to people who used the service and their relatives. We were told these had not been carried out. People who use the service and those that are important to them should be empowered to give feedback to enable shortfalls to be identified and changes made to improve the experiences of people who live at Moorland Nursing Home.

The above examples were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as there were inadequate systems in place assess, monitor and improve the quality of the service.

Inadequate

Is the service well-led?

Our findings

We asked people to describe the atmosphere within the home. One person told us, "It is not what it was." Two relatives said they considered the leadership at Moorland Nursing Home was good, and the other relatives felt it was poor. One relative told us, "This place has not run right since [the previous manager] left. They just don't seem organised, especially with the laundry." A further relative commented, "I don't know who the manager is."

We asked staff who was responsible for the management of the home. We received conflicting information. We were told, "It's [the owner]." And, "It's [acting manager] when they're here. When they're not…I don't know." Also, "The nurse in charge." This showed us that roles and responsibilities of the management were not clear and staff were unsure who was accountable for the management of the home.

At the time of the inspection the home did not have a manager in place who was registered with the Care Quality Commission. The acting manager told us that the registered manager had left the service and that they had been providing support and guidance prior to the registered manager leaving. They also said they had been working at the home for approximately nine days and had started to prioritise areas of improvement within the home.

We asked the acting manager and the provider what audits had been carried out at the home to ensure any areas of improvement were identified and actioned. For example, safeguarding audits, care records audits and medicines audits and accident audits. The acting manager told us they were currently introducing a system of checks and audits and this had commenced in January 2015. We asked to see audits and checks completed prior to this and were told by the owner they did not think these had been carried out. The acting manager said they had looked for evidence of these and could not locate any historical audits.

We asked the provider if they received feedback on the performance of the home, or the results of completed audits. The provider told us they had visited the home in the past and sought verbal feedback from the registered manager but they hadn't viewed any audits. They told us they were currently designing a provider's audit which they would complete on visits to the home, and they were also addition they were planning to introduce a system to ensure they received the results of completed audits.

We viewed the audits introduced by the acting manager. We saw medicines, care records and infection control practices were checked to ensure they were up to date and accurate. However it was a concern to us that we had identified areas that required improvement within the medicines management at the home and care records. In addition we saw no evidence that the audit systems in place had improved the quality of care for people who lived at the home. We asked the acting manager if areas such as safe guarding events, comments, complaints or audits of accidents were carried out. We were told they were not.

We considered the lack of historical systems in place and the effectiveness of the audit system at the time of the inspection was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

It is a legal requirement that providers notify us of certain events that occur within homes regulated by the Care Quality Commission (CQC.) We reviewed the notifications file provided to us and saw an event which occurred in 2014 had not been notified to us. Following the inspection we requested further information from the provider relating to events that had occurred within the home. This was provided and we saw a further eight events had occurred. On reviewing the information we hold about the service we could not see evidence that these had been notified to us as required. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We reviewed the information the Care Quality Commission (CQC) holds about the home and saw we had been informed by the local safeguarding authorities of four concerns that had been raised to them. We saw these had been investigated and concluded by the appropriate safeguarding authorities. It is a legal requirement that providers notify the CQC without delay of any allegations of abuse, however there was no evidence to demonstrate this had been done. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We asked to see evidence of staff meetings and were told that prior to the acting manager coming to the service; there were no records of staff meetings available. We asked

Inadequate

Is the service well-led?

staff if they had attended staff meetings prior to the acting manager starting. They told us these had not been frequent and could not recall how often they took place. The acting manager told us, and staff confirmed that they had attended a staff meeting held with the acting manager on their appointment. Regular and productive staff meetings are important as they encourage teamwork, ensure essential information is cascaded and help increase morale. The above were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as accurate records were not maintained in relation to the management of the regulated activity.

During the inspection we observed the office door to be unlocked on three occasions with no staff present. We noted that peoples' care records were stored on open shelving within the office. Records should be stored securely in order to maintain people's confidentiality and uphold their dignity. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the acting manager and the provider what plans were in place to ensure there was a registered manager in place. We were informed recruitment had started and interviews were planned. The provider told us the previous manager had worked for eight hours within a management role and the remainder of their working hours as a qualified nurse. We discussed this with the provider as the evidence within this report demonstrates the provision of eight managerial hours was insufficient to ensure the home was well-led. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because the provider had failed to ensure that there were suitable resources available to fulfil the managerial responsibilities at the service.