Moors Park (Bishopsteignton) Limited

Moors Park House

Inspection report

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

Summary of findings

Overall summary

About the service
Moors Park House is a residential care home providing personal care and accommodation to up to 37 people. The service provides support to older people, the majority of whom are living with dementia. At the time of our inspection there were 34 people using the service. Accommodation is provided over two floors in an adapted and extended building. There were spacious communal areas for people to use including a lounge, conservatory, large dining room and library area.

People's experience of using this service and what we found
Systems and processes were not operated effectively to protect people from the risk of abuse. The registered manager and provider consistently failed to share allegations of abuse and neglect with the local authority safeguarding team and failed to effectively investigate allegations of abuse, or act in line with their own safeguarding policy. Staff told us they did not feel confident safeguarding concerns were appropriately addressed.

Risks were not always safely monitored or managed, for example risks relating to bed rails, falls and eating and drinking. A lack of information and inconsistencies across people's care plans meant people were at risk of harm. Medicines administrations systems were not well managed, and we identified a significant number of areas for improvement. Systems to ensure staff were recruited safely were not operated effectively and there were not always enough staff to meet people's needs.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

We found at least 14 people were living at Moors Park House without the capacity to consent to care and treatment. Capacity assessments had not been completed, and Deprivation of Liberty Safeguards applications had not been made. This meant people were being deprived of their liberty without legal authorisation.

Staff had not received sufficient training to meet people's needs and there was a very low completion rate of core mandatory training including safeguarding and moving and handling. Staff had not completed sufficient training in meeting people's specific individual needs such as dysphagia, diabetes and catheter care. Staff did not receive regular supervision.

People's needs and choices were not always assessed. Some people's care plans contained limited detail about their individual needs and choices, or how care should be provided in their best interest. People's end of life care plans did not reflect their personal preferences. Some care plan's contained good information to help staff communicate with people, for example by reducing background noise and maintaining good eye contact.

People gave negative feedback about a minority of staff and often received support in line with staff routine and preference, rather than their own choice. Staff routinely used institutionalised language such as "singles" and "doubles" to describe the level of assistance people needed, and some concerns were raised about the way staff spoke with people. People and their relatives were not always involved in their care planning or their health monitoring.

Complaints were not recorded, and no regular reviews took place to ensure improvements were made following receipt of a complaint. Staff told us they had raised concerns, but they had not been addressed.

Quality assurance systems were not effective. Whilst some regular audits were being completed, they did not identify any of the concerns found at this inspection. No care plan audits were being completed. There were also no effective checks at provider level. Notifications were not made to CQC in line with legal requirements and there were no systems in place to ensure continuous learning.

We received mixed feedback about the culture of the service from staff and from people's relatives. Staff told us they did not feel listened to, and this impacted upon the care people received because concerns were not addressed. Some people's relatives told us they found communications received from the home hostile at times and concerns were not addressed. Other people's relatives were more positive. One said, "The manager is very approachable. The culture is open and welcoming."

Whilst some relatives had raised concerns with CQC, other's felt confident their relative was safe. One relative said, "It's comfortable and safe, I'm impressed." Another relative said, "I think [relative] is safe. The staff are good, the manager is good, I've no concerns." Some people's care plans contained good information about how staff should use equipment to support them. Some staff were experienced in care and had completed training either some time ago at Moors Park House or in other care settings. This meant some staff did have enough knowledge to ensure people received safe care.

People were supported to eat and drink enough. One person told us, "The food is always good, I enjoy most of it." Staff supported people to access healthcare services and people's relatives felt confident staff sought input from other professionals in a timely way. One said, "I think staff would act on health needs promptly."

Most people gave positive feedback about staff. One person told us, "The staff are all respectful". Another person told us, "It's pleasant here, the staff are all pleasant too." We saw and heard kind, caring and supportive interactions between staff and people. People were supported to be active and to maintain relationships. On the second day of inspection, we saw an exercise session taking place in the lounge. We observed people were engaged with the activity and enjoyed taking part.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (15 March 2019)

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding people, the quality of care, communication, and the management of the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

You can see what action we have asked the provider to take at the end of this full report.

The provider told us they were committed to addressing the concerns identified during this inspection. Prior to the end of this inspection, they had booked safeguarding and Mental Capacity Act training, and were taking action to update their policies and procedures.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Moors Park House on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safeguarding people, safe care and treatment, person-centred care, consent, receiving and acting on complaints, staffing, fit and proper persons employed and good governance at this inspection. We issued 7 Warning Notices.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe.	**Inadequate**
Is the service effective? The service was not effective.	**Inadequate**
Is the service caring? The service was not always caring.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**
Is the service well-led? The service was not well led.	**Inadequate**

Moors Park House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by 1 inspector and 2 Experts 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.

Service and service type
Moors Park House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Moors Park House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information held in our systems and the information of concern we had received. We asked the local authority for feedback. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 6 people at length and spent time talking to people and observing care delivery in communal areas over the 3-day site visit, including breakfast and lunch time observations. We spoke with 3 relatives, one visiting professional and 10 staff members including the registered manager and provider. We looked at 5 people's care records in detail, sampled a further 11 people's care records and looked at 19 people's medicine records. We looked at records relating to safeguarding, accidents and incidents, quality assurance systems, recruitment and safety records, including records relating to premises and equipment.

Following our site visits we spoke with a further 9 relatives and 6 staff by telephone. We requested feedback from 11 health care professionals by email. We did not receive any responses.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- Systems and processes were not operated effectively to protect people from the risk of abuse.
- The registered manager and provider consistently failed to share allegations of abuse and neglect with the local authority safeguarding team.
- Concerns staff raised with the registered manager and provider included people being neglected, the use of restraint, unexplained bruising and staff causing distress to people by shouting. Some people living at the service had also told staff they had suffered harm, including physical assault, verbal abuse, and intimidating behaviour.
- The registered manager and provider consistently failed to effectively investigate allegations of abuse, or act in line with their own safeguarding policy.
- Where the registered manager and provider did address concerns raised with them, they did not always take appropriate action to safeguard people. For example, it was common practice to stop staff providing care to an individual person when an allegation of abuse had been made. In doing so they considered the matter resolved and failed to effectively investigate the allegation itself, or to consider the potential risk to other people.
- Staff told us they did not feel confident safeguarding concerns were appropriately addressed. On more than one occasion, members of staff had taken photographs to evidence their concerns, however, the provider did not view photographic evidence as sufficient 'proof' of the concerns raised.
- Shortly before this inspection, a visitor to the service raised concerns with CQC after they saw markings on one person's face. The markings were consistent with an allegation of abuse the person had made. During this inspection we found no record of the injury in the person's care record and the existence of the injury had not been shared with the local authority.
- Only 9 staff, out of a team of 36, had completed safeguarding training in the past 12 months.
- We raised 6 individual safeguarding concerns with the local authority during this inspection.

Systems and processes were not operated effectively to protect people from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some members of staff raised concerns with the registered manager, and escalated to the provider when they were not satisfied with the response. These staff were committed to ensuring people were safeguarded.

- Whilst they had not all completed safeguarding training, staff had raised concerns appropriately. One said, "I just think about how I'd like my own grandparents to be treated."
- Whilst some relatives had raised concerns with CQC, other's felt confident their relative was safe. One

relative said, "It's comfortable and safe, I'm impressed." Another relative said, "I think [relative] is safe. The staff are good, the manager is good, I've no concerns."

Assessing risk, safety monitoring and management

● Risks were not always safely monitored or managed.

● On the first day of our inspection we saw one person with their arms wrapped around their bed rails. This put them at risk of entrapment, and pressure damage. Their risk assessment said the bed rails should have bumpers attached, but staff had not followed this direction. There had been 6 incidents in the past 12 months relating to the bed rails, including the person becoming trapped upside down between the bed and the wall. Staff failed to reassess the risks associated with the use of bed rails after these incidents, which meant the person was still at risk.

● Falls risk assessments did not always accurately reflect people's level of risk. For example, one person's risk assessment assessed their falls risk level as low. Records showed they had fallen 18 times in the past 12 months, and we observed them needing staff intervention to reduce the risk of them falling.

● Inconsistencies across people's risk assessments and care plans meant people were at risk of harm. For example, health professionals had recommended one person have bite sized food following a choking episode. This information was not in their care plan. Another person's care plan contained inconsistent information about their modified diet with 5 different stages of diet detailed across different parts of the care plan, 4 of which would have been unsafe for them. Care records showed them being offered inappropriate foods. This put them at risk of choking.

● People's care plans were not always updated when their level of need changed. For example, when their mobility declined, and they needed more support from staff. This meant staff who did not know them well would not know how to assist them.

● Care plans lacked information about how staff should safely assist people with medical equipment such as catheters.

● Records showed people who required regular re-positioning were not being assisted in line with their care plan.

● 11 people living at the service on the first day of our inspection had no personal evacuation plans in place (PEEPS). This put people at risk in the event of an evacuation.

People's risks were not always safely monitored or managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Kitchen staff were pro-active in making sure they provided food at a safe consistency. Meeting minutes showed they asked care staff to tell them as soon a referral for a swallowing assessment was made, so they could make immediate changes to minimise the risk whilst waiting for an assessment.

● Some people's care plans contained good information about how staff should use equipment to support them, with specific detail such as which coloured loops to use on the sling when being assisted with a hoist.

Using medicines safely

● Medicines administrations systems were not well managed.

● A significant number of people did not have identification information within their medicines administration records. This meant staff did not have a photograph to identify the correct person when administering medicines and did not have information about their allergies easily available. 6 of the people with no identification records had allergies recorded within their care plans. This put people at risk of harm.

● 'As required' (PRN) medicines protocols were not always in place, and those that were in place did not contain sufficient information. For example, one person was prescribed medicine to alleviate anxiety. There was no information to direct staff as to when they should administer it, what the spaces between doses

should be and what the potential side effects were.
● Administration times were not being recorded for time sensitive medicines, such as antibiotics. This meant people were at risk of not having sufficient time between each dose.
● Where people were prescribed variable doses, staff did not always record how many tablets had been administered.
● One person was prescribed a medicine which required their heart rate to be checked prior to administration. Staff did not always record they had done so, and there was no information in the person's care plan to tell staff what range their heart rate should be within, or what action to take if it was out of range.
● Medicine administration records did not follow best practice guidelines. For example, handwritten entries were not always signed by two members of staff, and some were not signed at all.
● Topical cream administration records showed staff were not applying people's creams in line with the prescribed directions. Some people's topical cream records contained no directions for staff, and others had no records at all. This put people's skin integrity at risk.
● Training records showed only 3 staff had completed medicines training in the past 12 months, and some staff competencies were out of date.

Medicines administrations systems were not well managed. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Systems to ensure staff were recruited safely were not operated effectively.
● Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions. Whilst DBS checks were undertaken, they were not always properly checked and where DBS disclosures contained information of concern, no risk assessments were completed to ensure staff posed no risk to people.
● Full employment histories were not always obtained as part of the application process, and gaps between previous employments were not always explored.
● Appropriate references were not always sought. For example, for some staff references had been obtained from friends or previous work colleagues, not their former employers.

Systems to ensure staff were recruited safely were not operated effectively. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not always enough staff to meet people's needs.
● Whilst the provider used a dependency tool to assess how many care hours each person required, they did not use this to influence staffing levels.
● There were 3 members of staff on duty from 8pm to 8am, regardless of how many people were living at the service or what their level of need was. One staff member told us this was particularly difficult if there was an incident, or somebody was nearing the end of their life, because it meant they did not have time to spend time with them.
● One member of staff told us people who required assistance from 2 staff to go to bed needed to be assisted before 8pm, or they would wait until after 10pm because there were not enough staff available.
● Another member of staff said, "[night staff] like us to have as many ready for bed as possible, we start about 6.30pm." A third member of staff said, "The mornings are very busy, around 5-6am all the bells are ringing and there's only 3 staff."
● One member of staff had recently raised a formal written complaint with the provider. They said on one

night shift there had been 19 people needing assistance from 3 staff, which was 'ridiculous'. However, when we asked the provider, they said no one had raised any concerns about staffing levels with them.
● A second staff member had recently raised a written complaint with the provider. They told them people were being forced to get ready for bed and/or go to bed against their will. The provider responded to the complaint, but did not consider staffing levels might be impacting staff's decision making about what was in people's best interests.
● We received mixed feedback from people's relatives. One said, "There's always staff around, but there's been agency staff and a high turnover." Another relative said, "They're run ragged when we go, sometimes buzzers are constant'.

There were not always enough staff to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During the day, there were 6 or 7 members of care staff on duty with the support of managers, domestic and kitchen staff. One person's relative told us, "Some staff have been there quite a while and they all seem to know [relative]".

Learning lessons when things go wrong
● There were not always systems in place to ensure lessons were learnt when things went wrong, and where systems were in place, action was not always taken to mitigate the risk of the same thing happening again.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

Visiting in care homes
● People's relatives were requested to book an appointment to visit and the number of visitors at any one time was being restricted. One relative told us, "There's confusion over the rules, you get different messages from different staff. We ring before we go".
● On the second and third days of inspection we saw visitors, including children, spending time with their relatives.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance
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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA.

- The service was not working within the principles of the MCA.
- We found at least 14 people were living at Moors Park House without the capacity to consent to care and treatment. Capacity assessments had not been completed, and DoLS applications had not been made. This meant people were being deprived of their liberty without legal authorisation.
- People's care records said they had consented to care, and to specific restrictions such as alarm sensor mats, when they did not have the capacity to do so.
- Some capacity assessments were completed following the first day of inspection in response to our feedback, however assessments were also completed for people who had capacity, which were not required.
- A DoLS application had been made for one person in November 2020. No capacity assessment had been completed in respect of the decision at the time, and the person's care records showed they had capacity to consent to care, so an application should not have been necessary.
- There was widespread use of pressure alarm mats for both people with and without capacity to consent to their movement being monitored. Staff did not consider if an alarm mat was the least restrictive option, or if it was in the person's best interest. One member of staff said, "It's always been that way."

The service was not working within the principles of the MCA. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
● Staff had not received sufficient training to meet people's needs.
● Staff responsible for completing capacity assessments and making decisions to deprive people of their liberty had not completed any training and did not have the knowledge to do so.
● Only 4 staff had completed moving and handling training in the past 12 months. This meant there were significant gaps in staff's knowledge and understanding of how to safely assist people using equipment. One senior member of staff told us the lack of training put pressure onto senior staff, who had to support them.
● Other mandatory training had very low rates of completion, and very few staff had completed any training in meeting people's specific individual needs such as dysphagia, diabetes and catheter care.
● The majority of people living at Moors Park House were living with dementia. 17 members of staff had not completed any dementia training.
● New staff worked without completing basic mandatory training such as infection control, moving and handling and safeguarding. This included staff who had never worked in care before.
● Staff did not receive regular supervision. Records showed that most staff had no formal supervision since June 2022. When we asked staff when they had last had a supervision, they all responded they couldn't remember.

Staff had not received sufficient training to meet people's needs. This was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Some staff were experienced in care and had completed training either some time ago at Moors Park House, or in other care settings. This meant some staff did have enough knowledge to ensure people received safe care.
● The provider told us they had booked safeguarding and MCA training following our feedback.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs and choices were not always assessed.
● Some people's care plans contained limited detail about their individual needs and choices, or how care should be provided in their best interest. For example, we saw staff using a communication aid to support one person, however there was no detail about this in their care plan.
● Other people's care plans did contain information about their preferences, but care records showed care was not delivered in line with them. For example, one person had a preference for showers over a bed bath. Records showed they had only had 4 showers since December 2022.
● People were often assisted in line with staff preferences, rather than their own choice or best interest. The registered manager told us, "Night staff at the moment insist everyone has to be in bed by 10.30pm." A staff member told us the evening routine was based around which members of staff are on duty, and said, "Some staff will just put people to bed not to get the night staff annoyed."
● People's relatives were not always involved in the care planning process. One relative told us they had requested a copy of the care plan in place for their relatives but had to wait several months to receive it.

People's needs and choices were not always assessed in line with standards, guidance and the law. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet
● People were supported to eat and drink enough.
● One person told us, "The food is always good, I enjoy most of it." Another said, "There's always enough for me. They give me a fried egg; you can have what you want."
● We saw people being offered choices at mealtime and being supported to eat appropriately when needed.

● On the first day of inspection we saw people enjoying leisurely breakfasts throughout the morning as they were ready to. People were offered a choice of breakfasts including cooked food.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● Staff supported people to access healthcare services.

● One person told us their medical needs were well managed, they said, "My pain is well managed, I'm fine today."

● People's relatives felt confident staff sought input from other professionals in a timely way. One said, "I think staff would act on health needs promptly." Another relative said, "Staff pick up quickly if there are any health problems and tell me the treatment."

Adapting service, design, decoration to meet people's needs

● The building was well adapted to meet people's needs.

● The layout of the building meant people could walk in a continuous circle on the ground floor. This suited people living with dementia who liked to walk continuously.

● Décor such as road signs and reminiscence materials gave points of interest and helped people navigate around the home. People's bedrooms had name plates on the door to help people identify their own room.

● There were large communal spaces including a conservatory which we saw people enjoying using.

● There was a pleasant, safe and accessible outside space in the centre of the building, which staff told us was well used in warmer weather.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People were not always well supported or treated with dignity and respect.
- People gave negative feedback about a minority of staff. One person said, "The carers are very good, normally, but there's one who's not."
- People often received support in line with staff routine and preference, rather than their own choice. Because people's care plans lacked detail about their personal preferences, staff had no guidance as to how to best support the person. This led to conflict between staff when they disagreed about what was in people's best interest.
- During this inspection staff raised concerns about how a minority of staff treated people, including shouting at them and using bed rails to prevent them getting out of bed, when this was not in line with their care plan.
- Staff routinely used institutionalised language such as "singles" and "doubles" to describe the level of assistance people needed. All the staff, including the registered manager, referred to people as room numbers, rather than names.
- Some people's relative's raised concerns about the quality of care. One said, "My [relative] is happy, but is not always clean. They don't wash their hands. Sometimes they have the wrong clothes on, and slippers that don't fit." Another relative told us, "Their nightie was on for 3 days, it was dirty, and they looked unkempt."

People were not always well supported or treated with dignity and respect. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Some people gave positive feedback about staff. One person told us, "The staff are all respectful. The lady who puts [name] to bed is very good." Another person told us, "It's pleasant here, the staff are all pleasant too, you've got to have a joke." A third person told us, "I'm very happy [living at Moors Park House]. They [staff] are a nice crowd, they're very friendly and helpful."
- We saw and heard kind, caring and supportive interactions between staff and people. For example, we heard staff supporting people with comments such as, "I am here to support you" and "There's no rush, take your time".
- One person's relative told us, "Staff are lovely, kind, caring and friendly." Another said, "They have a really good relationship with my [relative]. They speak to them nicely." A third told us, "There's some fabulous carers."
- Some relatives commented on how well they felt their relative was cared for. One said their relative was

"always clean and well presented".
● Staff generally felt people were well cared for. One staff member said, "I think they are very well taken care of. The seniors are amazing with the residents." Another staff member said, "The residents are looked after how they should be."

Supporting people to express their views and be involved in making decisions about their care
● People and their relatives were not always involved in their care planning or their health monitoring.
● One person told us, "I've been weighed loads of times, but they never tell me [my weight]."
● We asked people's relatives if they had been involved in or seen their relatives care plan, one said, "I honestly don't know about that." Other relatives told us they had asked to see their relative's care plan but had to wait several weeks before it was shared with them.
● We observed people being supported to express their views about their day-to-day care needs, including where they wanted to spend their time.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to Requires Improvement. This meant people's needs were not always met.

Improving care quality in response to complaints or concerns
● Complaints were not recorded, and no regular reviews took place to ensure improvements were made following receipt of a complaint.
● Appropriate action was not always taken in response to complaints. For example, disciplinary processes were not used to address issues around staff conduct or quality of care.
● Staff told us they had raised concerns, but they had not been addressed. One said, "I made a complaint to [registered manager] but didn't feel it was dealt with properly. They said they would pass it to the provider, but that was 4 months ago."

Complaints were not recorded or reviewed. This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support
● Care plans were not always personalised.
● People's care plans contained limited information about their personal preferences, for example what time they liked to get up or how they liked to spend their time.
● People's end of life care plans did not reflect their personal preferences. Whilst some people's care plans contained information about their medical choices and any advanced decisions around funeral care, none contained any information about how people wished to be cared for in the final weeks of their life, or what was important to them. The registered manager told us people's relatives "didn't want to discuss it".

Care plans were not always personalised. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Efforts had been made to obtain life histories for some people, and the majority of care plans contained information about what people liked to eat and drink.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them
● Whilst there was activity provision within the home, people were not always supported to follow their individual interests. One person told us, "It was absolutely beautiful yesterday, I don't know why we couldn't go outside." We saw this person ask to go outside several times during the day, but they were not assisted to do so.
● People were supported to be active and to maintain relationships.

● On the second day of inspection we saw an exercise session taking place in the lounge. We observed people were engaged with the activity and enjoyed taking part.
● Other activities included a local church choir singing hymns and social events to celebrate special occasions.
● The registered manager told us one person's pet lamb had been bought into visit them, and other people had enjoyed seeing it. They also said they had an egg hatchery arranged so people could enjoy watching chicks hatch.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● We saw people being supported to communicate. For example, two people used a microphone and headphones to help them hear more clearly.
● Some care plan's contained good information to help staff communicate with people, for example by reducing background noise and maintaining good eye contact.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Quality assurance systems were not effective in identifying where regulatory requirements were not met.
- Despite medicines systems being audited daily and weekly by senior staff, and monthly by the registered manager, none of the concerns identified during this inspection had been identified.
- There were no care plan audits in place. The registered manager had failed to identify people had not had capacity assessments or DoLS applications where required because they did not understand their regulatory responsibility.
- There was no training matrix in place which meant the registered manager did not have an overview of what training staff had completed. In August 2022 the provider recommended one be put in place, but this had not been addressed at the time of this inspection.
- Routine safety checks did not always identify issues. For example, fire exit signs had been removed in December 2022 whilst decorating work was carried out. No one had identified they had not been replaced.
- There were no effective quality checks at provider level. Whilst the provider had undertaken two quality compliance visits in the previous 12 months, they had not identified the concerns identified at this inspection. For example, they had looked at medicines management during a quality compliance visit a few days before this inspection began. They noted PRN protocols were in place and being followed and medicine administration records were correct. We found this was not the case.
- There was no service improvement plan in place which meant the provider and registered manager could not easily monitor improvements required, or actions taken. For example, a fire risk assessment completed in November 2022 made a number of recommendations to ensure compliance. At the time of this inspection at least one had not been completed, and neither the registered manager nor provider were aware of this.

Quality assurance systems were not effective. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Notifications were not made to CQC in line with legal requirements. We identified in excess of 10 notifiable incidents which were not notified to CQC.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) regulations 2009.

Continuous learning and improving care

- No systems were in place to ensure continuous learning.

● In 2022 there was an incident concerning agency staff living on site which potentially put people at risk of harm. Despite this, bedrooms directly next to people were still being used to accommodate agency staff. No risk assessments had been completed and no agreements signed regarding expectations of behaviour, prior to the start of this inspection.
● Because complaints and concerns were not effectively addressed, there was no learning and care did not improve as a result.
● Several relatives told us they had raised concerns about their email addresses being disclosed to other relatives in group emails. Despite contacting the registered manager about this on several occasions, it continued to happen.
● The provider and registered manager did not keep their own skills and knowledge up to date and were therefore unable to identify where care provision required improvement.

No systems were in place to ensure continuous learning. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We received mixed feedback about the culture of the service.
● Several members of staff told us they had raised complaints about bullying, and there was a toxic culture amongst some of the staff team. This had resulted in a high turnover of staff towards the end of 2022.
● Staff told us they did not feel listened to, and this impacted upon the care people received because concerns were not addressed. One staff member said, "It's always been like that, night staff moan if there's not enough people in bed and day staff moan if there's not enough up. We have staff meetings, but it keeps happening."
● One staff member said, "Morale feels very low at the moment, because nothing gets done about anything.' Another staff member said, 'I made management aware [of their concerns] but they didn't seem to do a lot." A third staff member told us they had raised concerns with the registered manager about the lack of training provision but did not feel they had been addressed.
● Some people's relatives told us they found communications received from the home hostile at times. For example, one email sent to 6 relatives requesting money for expenses said, 'If we do not receive this money your [relative] will not receive Care from the Chiropodist / Hairdresser, get newspapers or anything else they may need. This can be a form of abuse not just from Moors Park but also yourselves.' More than one relative told us this approach caused them distress.

● Other people's relatives were more positive. One said, "The manager is very approachable. The culture is open and welcoming." Another relative said, "The home is welcoming, everybody is friendly, and they treat me as an equal."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● We were not aware of any incidents reportable under the duty of candour; however, we saw the provider had not always informed people's relatives when something went wrong. For example, when staff had raised safeguarding concerns.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● There were no formal systems in place to gather feedback from people living at the service, or alternatives in place for people who were not able to express their views, such as observations.

● Questionnaires were used to gather feedback from people's relatives and there were regular staff meetings.
● Records showed staff made referrals to health professionals, however we were unable to obtain any feedback from health professionals about the effectiveness of partnership working.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's needs and choices were not always assessed in line with standards, guidance and the law. People were not always well supported or treated with dignity and respect. Care plans were not always personalised.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service was not working within the principles of the MCA.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's risks were not always safely monitored or managed. Medicines administrations systems were not well managed.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not operated effectively to protect people from abuse.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not recorded or reviewed.

The enforcement action we took:

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Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were not effective. No systems were in place to ensure continuous learning.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Systems to ensure staff were recruited safely were not operated effectively.

The enforcement action we took:

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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to meet people's needs. Staff had not received sufficient training to meet people's needs.

The enforcement action we took:

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