The Moorings Care Limited

The Moorings Retirement Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 7 September 2016 and was unannounced. The Moorings Retirement Home provides accommodation for up to 39 people, including people living with dementia care needs. There were 37 people living at the home when we visited.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our previous inspection on 26 & 29 June 2015, we found medicines were not always managed safely and staff were not following legislation designed to protect people's human rights. The provider sent us an action plan detailing steps they would take to become compliant with the regulations. At this inspection we found action had been taken, but further improvement was required.

There were appropriate arrangements in place for the ordering, storing and disposing of medicines. However, there was a lack of information available to help staff know when to administer some medicines that were prescribed on an 'as required' basis. Staff were unable to confirm that hand written entries on people's medication administration records were checked by a second member of staff and this had led to some discrepancies. The deputy manager had already identified these concerns and was taking action to address them. Time is needed for these improvements to be fully implemented and sustained over time.

There were not always enough staff in the evenings to meet people's needs. The registered manager was in the process of recruiting additional staff to support people more effectively at this time. Time is needed for this work to be completed.

Risks to people were not always managed effectively. Special mattresses designed to reduce the risk of pressure injuries were not always set correctly. Staff did not monitor the fluid output of a person's catheter to check it was operating properly. However, the registered manager took immediate action to rectify these issues.

The risks of people falling were managed effectively and appropriate action was taken when people had fallen. People were supported to take risks that helped maintain their independence.

People said they felt safe at The Moorings and staff knew how to identify, prevent and report incidents of abuse. The process used to recruit staff helped ensure only suitable people were employed. Staff knew how to deal with foreseeable emergencies, such as a fire, and had been trained to deliver first aid.

Staff sought consent from people before providing care and support. The ability of people to make decisions was assessed in line with legal requirements to ensure their rights were protected and their liberty was not

restricted unlawfully. Decisions were taken in the best interests of people.

People were satisfied with the meals and were supported appropriately to eat and drink enough. They were supported to access healthcare services and were referred to doctors and nurses when needed.

Staff were knowledgeable about people's needs. They had received relevant training and were supported in their work through one-to-one sessions of supervision and appraisal.

People were cared for with kindness, patience and compassion. We observed positive interactions between people and staff. People's privacy and dignity were protected at all times. They could choose the gender of the staff who supported them with personal care. Staff encouraged people to remain as independent as possible and involved them and their families (where appropriate) in planning the care and support they received.

People needs were met in a personalised way. Staff knew how people preferred to receive care and tailored their approach to suit people's individual needs. They recognised that people's needs varied from day to day and accommodated them accordingly.

Care plans provided comprehensive information and were reviewed regularly to help ensure they remained up to date. They included information about people's interests and this had been used to arrange suitable activities. Links had been developed with the community, including with a local school, whose children visited regularly. This benefitted people, who enjoyed interacting with the children.

People felt the service was run well. There was a clear management structure in place and staff understood their roles. Staff spoke positively about the management of the home and worked well as a team.

There was an open transparent culture. Visitors were welcomed and there were good working relationships with external professionals. The provider notified CQC of significant events and they had clearly displayed the previous inspection rating for visitors to view.

There was an appropriate quality assurance process in place. This used a series of audits and spot checks to assess, monitor and improve the service. The provider sought and acted on feedback from people, and were continuing to develop the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely. There was a lack of information to advise staff when to administer 'as required' medicines and hand-written records were not checked in accordance with best practice guidance. However, action was being taken to address this.

There were not always enough staff to meet people's needs in the evenings, although the registered manager had plans in place to improve these.

People were not always protected from the risk of harm. Special mattresses were not adjusted correctly and one person's catheter was not monitored appropriately. Action was taken to address these issues, but time is needed for them to become embedded in practice and sustained over time.

Other risks to people were managed effectively. People felt safe at the home and staff knew how to identify, prevent and report abuse. The process used to recruit staff was safe and suitable plans were in place to deal with foreseeable emergencies.

Is the service effective?

Good

The service was effective.

Staff followed legislation designed to protect people's rights and freedoms. They sought consent from people before providing care and support.

People were offered a choice of suitably nutritious meals and received support to eat and drink when needed. People could access healthcare services including doctors and specialist nurses.

People's needs were met by staff who were suitably trained. Staff were supported appropriately in their role and could gain recognised qualifications.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They protected people's privacy and dignity at all times.

People were encouraged to remain as independent as possible and were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. They had access to outdoor space and a range of activities.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Good

The service was well-led.

People enjoyed living at the home. There was a clear management structure in place. Staff were positive about the management and felt supported in their work.

There was an open and transparent culture. Positive links had been made with the community.

An appropriate quality assurance process was in place. Areas for improvement had been identified and were being addressed; and the provider was continuing to develop the service.

The Moorings Retirement Home

Detailed findings

Background to this inspection

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

This inspection took place on 7 September 2016 and was unannounced. It was conducted by an inspector and an expert by experience in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 12 people living at the home, two visiting friends and a visiting community nurse. We also spoke with the registered manager, two of the three deputy managers, four care staff and a housekeeper. We looked at care plans and associated records for five people, staff duty records, recruitment files, records of complaints, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At our last inspection we identified that medicines were not always managed safely. At this inspection we found action had been taken but further improvement was needed.

Some people were prescribed medicines on an "as required" (PRN) basis. These included pain control and medicines to reduce people's anxiety levels. Detailed information was available for staff to know when, and in what circumstances, to give some of these medicines to people, but there was no information available for two of these medicines. For example, information in the medication administration records (MAR) about one medicine instructed staff to administer 'one tablet when required', but there was no further information detailing how many could be taken over a 24 hour period or the recommended time interval between doses. However, whilst there was a risk that the person might be given too many tablets, this had not occurred.

Guidance issued by the National Institute for Health and Clinical Excellence (NICE) on the safe management of medicines recommends that hand written entries in medication administration records (MAR) should be checked by a second member of staff to help ensure they are accurate. Staff were unable to confirm whether this was done as hand written entries were not always signed. For example, hand-written entries had been made to add four medicines to one person's MAR chart, together with the number of tablets present. No details were recorded of which staff member had made the entries or whether they had been checked. When we checked the tablets, we found the number present did not tally with the number recorded. The senior staff member with us was unable to explain the discrepancy and commented, "That's exactly why they should be double-signed." The discrepancy indicated that three additional tablets were present, which meant the person may not have received these as prescribed.

We discussed these concerns with the deputy manager who had recently been appointed to take the lead on medicines management. They told us they had already identified these issues and were taking action to address them. Time is needed for these improvements to be fully implemented and sustained over time.

There were appropriate arrangements in place for the ordering, storing and disposing of medicines. One person told us, "[Staff] look after my medicines. They're very good like that." Staff were suitably trained to administer medicines and the registered manager had recently introduced a process to check the competence of staff authorised to administer medicines by observing their practice. Since the last inspection, an additional medicines round had been introduced in the early morning to administer medicines that people needed to take before breakfast. A new process had also been introduced to help ensure that topical creams were not used beyond their 'use by' date. In addition, body maps were used to help staff understand where and when to apply creams to people.

There were not always enough staff to meet people's needs. People had mixed views about whether there were enough staff to meet their needs. Whilst some felt there were sufficient staff and said they were attended to promptly, others told us this was not always the case. For example, one person said, "There aren't enough of them [staff]; you have to keep calling for them." Another person said they sometimes waited up to 45 minutes for support in the evenings and a visitor told us there were "sometimes staff

shortages", although they said this had not caused them any difficulties. For most of our inspection we found there were sufficient staff to support people appropriately and call bells were answered promptly. However, in the early evening, several people became anxious and restless, pacing up and down the main corridors. Whilst staff attempted to provide reassurance, they were sometimes distracted by other people who were calling for their support at the same time.

Whilst some staff felt there were enough of them to attend to people promptly, other staff felt this was not always the case in the evenings. One staff member told us, "The 5-8[pm] shift is really tough. There's normally only four of us and it's very busy. We have to get suppers and put people to bed. Lots of people become restless and wander and we have to watch them or they could fall. Then three people will want to go to the toilet and we have to prioritise and choose who to take first." Another staff member said, "There's a lack of staff on the 5-8 shift. There's a very diverse mix of people and needs. When we're short, they get frustrated as they don't get the attention or we don't have time for them."

The registered manager told us staffing levels were based on the number of people using the service and their needs. They said they had recognised the need to increase staffing levels in the evening and were in the process of recruiting additional staff to achieve this. They said they always made sure there were at least four staff in the evening and were aiming to increase this. Time is needed for this to be fully implemented and sustained over time.

People were not always protected from the risk of developing pressure injuries. Staff demonstrated an understanding of pressure area care and used a nationally recognised tool to assess individual risks to people. Preventive equipment, such as pressure relieving cushions and mattresses were in use. However, the mattresses were not always adjusted correctly according to the person's weight. We checked three mattresses and found two were not at the right setting, and there was no process in place to check they were adjusted correctly. This meant the mattresses may not have been effective in reducing the risk of pressure injuries. We discussed this with the registered manager, who took immediate steps to address this and implement a system of regular checks.

The risks associated with one person's catheter were not managed effectively. A catheter is a device used to drain a person's bladder through a flexible tube linked to an external bag. Catheters can be prone to becoming blocked if good fluid input and output is not maintained. Staff were not clear about how or when the person's output was monitored and did not keep records to help them assess and identify when a blockage may have occurred. This could put the person at risk of fluid retention, which would require prompt medical intervention. We discussed this with the registered manager, who took immediate action to improve the way staff monitored the person's input and output.

The risks of people's falling were managed effectively. Fall saving equipment, such as walking sticks and frames, were in people's reach at all times and staff encouraged people to use them correctly. When equipment, such as hoists, was needed to support people to transfer between chairs, we saw this was used safely and in accordance with best practice guidance.

Where people had fallen, the person's risk assessment was reviewed and staff considered any additional measures that could be put in place to protect the person from harm. These included reviewing the layout of their rooms; installing bed rails or devices to monitor people's movements; and referring them to falls prevention specialists. One person had sustained a head injury during a fall and staff had sought immediate medical advice and conducted appropriate checks for the following 24 hours to monitor their health.

People were supported to take risks that helped them retain their independence and avoid unnecessary

restrictions. For example, staff encouraged people to mobilise using their walking frames; they remained close by, in case the person needed additional support, but allowed them to travel at their own pace and retain their independence

People told us they felt safe at the home. One person said, "Nothing concerns me here." Staff had the knowledge and confidence to identify and report safeguarding concerns, and acted on these to keep people safe. One staff member told us, "I would have no hesitation [raising concerns] if needed; I've never had to but I would." Staff had received appropriate training and were aware of people who were at particular risk of abuse; for example, one person could be over-familiar with visitors and staff told us they monitored interactions closely. Another person was potentially at risk from a friend and suitable precautions had been put in place to protect the person while still allowing them appropriate contact with the friend. The registered manager conducted thorough investigations in response to allegations of abuse and worked with the local safeguarding authority to keep people safe from harm.

The process used to recruit staff was safe and helped ensure staff were suitable for their role. The registered manager carried out relevant checks to make sure staff were of good character with the relevant skills and experience needed to support people effectively. Staff confirmed this process was followed before they started working at the home.

There were plans in place to deal with foreseeable emergencies. Staff were aware of the action to take in the event of a fire. Fire safety equipment was maintained and tested regularly. An emergency bag and file had been prepared, containing contact details for staff and management out of hours, together with personal evacuation plans for people. These included details of the support people would need if they had to be evacuated in an emergency. Staff had been trained to administer first aid.

Good

Is the service effective?

Our findings

At our last inspection we identified that staff did not always follow the Mental Capacity Act, 2005 (MCA) or its code of practice. At this inspection we found action had been taken. Staff followed the MCA and people's rights were protected.

The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Care records confirmed that where people lacked capacity to make decisions, staff completed thorough assessments using the recommended two-stage test. They consulted with family members and made decisions in the best interests of people. These included decisions relating to the administration of people's medicines and the delivery of personal care.

We observed staff seeking verbal consent from people before providing them with care or support, such as offering to help them mobilise or to use the bathroom. A staff member told us, "We always follow [people's] wishes. For example, if they ask for tea, we make sure they get tea; and we always ask if they are happy to receive personal care." Another staff member said, "If someone [declines] care, we come away and try again later or try a new [staff member]." People had been invited to give their consent before having their photograph taken. Their agreement for it to be used for particular purposes had been recorded. For example, one person was happy for their photograph to be used on their bedroom door, but not for it to be used on the provider's website. A check of the provider's website confirmed this decision had been respected.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found the provider was following the necessary requirements. DoLS authorisation had been approved for two people and applications had been made for a further four people. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way. One person had a condition attached to their DoLS authorisation, requiring them to have access to activities and outside space, which we confirmed were being provided.

Most people were satisfied with the quality of the food. One person said, "The food is very nice." Another person told us, "We eat well here." However, some people who took their meals in their rooms said the meals were not always warm by the time they reached them. We discussed this with the registered manager, who agreed to address the concern.

People were offered a choice of suitably nutritious meals. Some people had chosen to take the main meal of the day in the evening and this was catered for. A staff member told us, "Some people now have sandwiches

at lunchtime and we're quite flexible with times. It's their choice."
However, we found that people living with dementia were not always offered choice in a meaningful way. They were invited to make their meal selection the day before, which they were unlikely to remember, and visual prompts were not used to help people understand the options. Staff told us people could change their mind when the meals were served and we saw alternatives were offered to people when they did this. Following the inspection, the registered manager informed us they had improved the process by offering meal choices closer to the meal times in order to support people more effectively.

People were given appropriate support to eat and drink. For example, one person needed full support to eat and was given this on a one-to-one basis in a calm environment. Another person was at risk of choking and was supervised closely during meals. Other people were given adapted plates, cups and cutlery to help maintain their independence. Staff were aware of people who needed special diets or their food preparing in a particular way. Three people needed their meals pureed and we saw these were presented in an appetising way that allowed people to distinguish the individual food items. Staff monitored the food and fluid intake of people who were at risk of malnutrition or dehydration and took action if people started to lose unplanned weight. This included fortifying their meals and drinks, to increase the calories they received, or referring the person to their GP for advice.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. A community nurse said of the staff, "They call us when needed and follow our advice. I have no concerns. If anything, they are over-cautious."

People's needs were met by staff who were skilled and suitably trained. Staff were positive about the training they received and said they could ask for any additional training they felt would benefit people. For example, some staff and the registered manager had attended extended dementia awareness courses. The registered manager had used the course as a model for rolling out bespoke dementia training to other staff, together with training aids to help staff understand the sensory perceptions of people living with dementia and the challenges they face. Written feedback from staff showed they had gained valuable learning from the training. Comments included: "[I've learnt] that the little things can be so big for people with dementia" and "I will re-evaluate the way I assist someone. I need to be patient". A staff member told us, "We try to speak clearly and find short explanations work best [for people living with dementia]."

People were cared for by staff who were appropriately supported in their role. New staff were assigned a mentor to support them and completed a comprehensive induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, a high proportion of experienced staff had been supported to gain vocational qualifications in health and social care. Senior staff told us they were supported to undertake leadership courses and gain management qualifications to enhance their skills.

All staff received one-to-one sessions of supervision. These provided an opportunity for one of the managers to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal with one of the management team, to assess their performance and identify development objectives. Staff told us these sessions were helpful and spoke positively about the support they received from management on a day to day basis.

Good

Is the service caring?

Our findings

People told us they were cared for with kindness and compassion. One person said, "Everyone's friendly, they're helpful and kind. The staff here are brilliant. I've no complaints about this place at all. They treat you as if you're a human being." Another person told us staff were "very good" to them and a further person described staff as "rather nice". Staff had received many cards and letters from family members after their relatives had passed on showing they had appreciated the way their loved ones had been cared for. These included, "Thanks for your patient and kind care" and "We appreciate all the care and attention you gave [our relative]. It was wonderful to know she was so happy for the time she was with you."

We observed positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. At lunchtime, staff spent 10 minutes with one person, encouraging them to stand, so they could walk through to the dining room for lunch, which was their preference. With patience and good humour, they eventually succeeded. The staff member told us, "It's a challenge, but you can't just leave [the person]. It's important to try and get them up and moving around."

When people, for example those living with dementia, struggled to express themselves, staff observed the person's body language and facial expressions and were able to understand their needs from their knowledge of the person. They also spent time kneeling next to people, so they could engage with them at eye level. One person suddenly became anxious and was responded to immediately by a member of staff who sat with the person for some time in an effort to find out what was troubling them.

People's privacy and dignity were protected. Since the last inspection, the provider had altered the design and layout of the toilets to help ensure people's dignity was not compromised. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. When a person's blouse started to become unbuttoned, a staff member swiftly intervened and did the buttons up again to protect the person's modesty. In addition, confidential care records were kept securely and only accessed by staff authorised to view them.

People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed. For example, two people had requested female only care staff for personal care and male care staff confirmed that they did not support these people.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, staff described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach or by gently reminding them when they lost track of where they had and hadn't washed. A staff member told us, "We allow [one person] to manage [drinks] on their own, but if they start to struggle we will help them. It encourages their

independence. It's the same with meals; they can manage some days, but other days we have to prompt."

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives. Each person had been assigned a key worker. A key worker is a named member of staff who took responsibility for supporting a person and liaising with family members. Key workers held monthly meetings with people to discuss their care and make any changes they requested. In addition, they conducted comprehensive reviews every three months, to which the person and family members were invited.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their needs. One person said, "I get all the help I need. [Staff] are always there for me and help me with whatever I need."

Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support. For example, which people drank well and which people needed to be encouraged; when people liked to get up and go to bed; and where people chose to spend their day. They recognised that people's needs varied from day to day and were able to assess and accommodate the level of support they needed at a particular time. For example, one person was able to eat independently some days, but needed prompting or some support on other days. Another person's mobility varied and staff told us they had access to alternative pieces of equipment to support the person, depending on how tired they were.

Care plans were comprehensive and covered a wide variety of topics, including: the person's normal daily routine, mobility, medicines, continence, hobbies and personal preferences. They detailed whether people preferred baths or showers, how often and when they liked to receive them. A staff member told us, "We keep this flexible and take a person-centred approach. If someone doesn't want a bath one day, we swap it for another. I wouldn't want to be told when to bath."

The provider was in the process of transferring care plans from paper records to computer records. This had proved challenging for staff as the information on the computer system could not always be relied upon, which meant they sometimes had to check the old paper records to obtain accurate information. We discussed this with the registered manager, who told us they were prioritising the updating of information to the computer system so that staff had access to current information. Once completed, this would provide staff with more efficient access to information about people's needs.

Reviews of care were conducted regularly by nominated key workers. They looked at all aspects of the person's care, including their personal care needs, their activity preferences and their dietary needs. Any identified changes were updated in the person's care plan, and communicated to other staff, to help ensure people's current needs were met. People and their relatives were consulted as part of the review process and their views were recorded. Records of daily care provided confirmed that people received care in a personalised way in accordance with their individual needs.

Care plans also included details about people's backgrounds, interests and life histories. This information was used to develop appropriate activity plans to suit people's individual interests. The activity coordinator had developed a range of activities, including trips to local attractions, tea parties in the garden, quizzes and musical entertainment. One person was an avid knitter and told us staff supported them to make jumpers for an overseas charity. Another person enjoyed baking and had made some cupcakes.

Activities also included quizzes and discussions about a daily newsletter produced to support people living

with dementia. Staff had developed links with a local school, whose students visited to sing and chat with people living at the home and join in activities, such as board games. The registered manager told us people "absolutely love" interacting with the children. The activities coordinator was absent on the day of our inspection, so other staff members ran ad hoc activities with people, such as nail care. In addition, a staff member offered therapies, such as body and hand massage to people in a purpose-built treatment room. People also had level access to the garden, from the ground floor and this provided a safe, pleasant environment, where people could get fresh air and enjoy views of the sea. The garden contained raised flower beds, which people had used to grow produce.

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. A staff member told us, "[One person] struggles to choose clothes, but what works with her is to show her a small selection of clothes and compliment her. She used to paint, so she understands colours." Care records showed that two people had declined to go to bed and had spent the night before our inspection awake in the lounge. Night staff had respected their right to make this choice and day staff showed consideration by not disturbing them when they dozed in their chairs during the morning.

The provider sought and acted on feedback from people. They conducted regular questionnaire surveys of people and their families to assess and monitor the quality of the service. Where improvements were identified, action was taken and communicated to people through the use of notice boards entitled "Things we could change" and "Things we will do". For example, following feedback, staff now offered visitors a quiet area in which to meet their relatives. They also advised family members when reviews of their relatives' care were due to be conducted. Key workers used their reviews as an opportunity to seek feedback from people about the service. In addition, the activity coordinator spoke with people regularly on a one-to-one basis to help identify any concerns or issues they wished to raise.

People knew how to complain about the service and the complaints procedure was prominently displayed. People and family members felt senior staff were approachable and that any concerns or complaints would be listened to and addressed effectively. One complaint had been received in the past year about a Christmas present that had not been passed on to a person from their relative. The complaint had been responded to promptly and in accordance with the provider's policy. The registered manager explained how they had learnt from the incident and were planning to take extra care this year to make sure people received their Christmas presents on time.

Good

Is the service well-led?

Our findings

People told us they were happy living at The Moorings and felt it was run well. One person said, "Everyone seems to know what they are doing."

There was a clear management structure in place. This comprised of the registered manager, three deputy managers and senior care staff. One of the deputy managers stepped up to manage the home when the registered manager was not available; they also took part in an on-call rota to be available to provide advice and support to staff out of hours. Each manager had responsibility for taking the lead on an aspect of the home, such as medicines or infection control. This spread responsibilities and allowed the registered manager more time to spend with people and visiting relatives. The registered manager was a member of the local care homes association and belonged to a managers' network. This helped them keep up to date with best practice guidance, as did their close working relationship with the registered manager of another home operated by the provider.

Staff enjoyed working at the home and spoke positively about the management, who they described as "approachable" and "supportive". Comments from staff included, "Management has improved and things have settled down"; "The registered manager listens to staff and has matured into the role"; and "I am happy here. I love the clients and know them well". Staff worked well as a team and shared information with one another at the start of each shift to help ensure they understood people's current health and care needs

There was an open and transparent culture at the home. Visitors were welcomed at any time and could stay as long as they wished. There were good working relationships with external professionals. Notifications about significant events were reported to CQC as required and the previous rating of the service was displayed in the entrance lobby for visitors to view. The provider had a duty of candour policy in place to ensure staff acted in an open way when people were harmed and we saw the registered manager had followed this when a person experienced a fall.

Links had been established with the community to the benefit of people. These included a local primary school, whose children visited and a pet retailer, who brought unusual pets to the home for people to see and interact with. Feedback from people indicated that enjoyed these sessions.

An appropriate quality assurance process was in place. Senior staff conducted a range of audits to assess and monitor the service. These included reviews of the arrangements for infection control, the management of medicines and care planning. Following the audits, improvement actions were identified and implemented. For example, a cleaning audit had identified the need for more robust checks to be completed by the night staff and we saw these had been put in place. Audits also included inspections of empty rooms to help ensure they were ready and suitable for people at short notice.

The registered manager also conducted unannounced spot checks at varying times of the day and night to monitor the performance of staff and observe the delivery of care to people. These had identified areas for improvement which had been addressed, such as changes to the way drinks were provided to people

throughout the day.

The quality assurance processes had identified the need to improve the arrangements for managing medicines and to increase staffing levels in the evenings. The registered manager was taking action to address these issues. They were also responsive to areas of improvement identified during the inspection and took immediate action to address areas of concern.

The provider was continuing to develop the service. They had invested in upgrading the computer system, which linked to hand-held computers to support staff in their work. Although there had been teething problems, staff told us the system was proving useful as they could keep people's daily care records up to date throughout the day, which had improved the accuracy of recording. The registered manager told us they had found that some new staff left after a short period of time. To address this, they had introduced a more thorough selection and recruitment process to check applicants were suitable for the role. They had also increased the support available to new start once they had started. This had led to improved staff retention staff and meant people were cared for by a more consistent team.