Veatreey Development Ltd

Moorland Nursing Home

Inspection report

Moorland Road
Poulton Le Fylde
Lancashire
FY6 7EU

Tel: 01253883457

Date of inspection visit:
12 June 2017
13 June 2017
14 June 2017
17 June 2017
22 June 2017
27 June 2017

Date of publication:
03 August 2017

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection visit at Moorland Nursing Home took place on the 12, 13, 14 17 22 and 27 June 2017. The inspection was unannounced on the first day with the following visits being announced.

Prior to the inspection taking place, we received several concerns about people's safety and the management of the service. We carried out this inspection to check people were not at risk of receiving unsafe care.

Moorland Nursing Home is situated in a residential area in Poulton-le-Fylde. The service provides accommodation for up to 22 people. It is a care home that provides nursing and personal care. All areas of the home are accessible and there are aids to assist people with their mobility. Some rooms have en-suite facilities. There were 13 people residing at the home.

There was no registered manager at the time of the inspection. There had been no registered manager in place since May 2015. We were made aware by the registered provider an application had been submitted to register a new 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 this inspection visit carried out in June 2017, we found breaches in the regulations relating to safe care and treatment, person centred care, dignity and respect and safeguarding service users from abuse and improper treatment. We also found breaches in the regulations related to meeting nutritional and hydration needs, premises and equipment and good governance. There were further breaches in the regulations related to staffing, fit and proper persons employed, requirement as to display of performance assessments and notification of other incidents.

We looked at how the registered provider managed risk. The registered provider had failed to ensure risks were appropriately addressed to mitigate and manage risk. During the inspection process, we were informed one person who was living with dementia, left Moorland Nursing Home unsupported and the environment was not secured to prevent a reoccurrence of the incident.

Moorland Nursing Home had not been well led. There was no visible leadership and there was a lack of continuity in managerial and clinical oversight. The registered provider did not have robust arrangements to take appropriate timely action if there was a clinical or medical emergency.

We looked at how medicines were managed. We observed medicines being administered and noted the nurses did not follow good practice. They handled tablets and signed medicine administration forms before

administering medicines. Documentation in relation to medicines was not robust and did not clearly guide staff about the administration of medicines, creams and powders.

Concerns related to a nurses clinical skills were disclosed during this inspection. They stated the nurse on shift failed to complete a clinical task safely. They raised additional concerns that the correct dressings were not available to manage people's ongoing care requirements.

We looked at how the registered provider recruited staff. They had not documented staff members' full employment histories, or gathered written explanations of any gaps in employment. One staff member's application form was not in their file and the provider was unable to supply this during our inspection. We could not find information related to their Disclosure and Barring Home check (DBS) for one member of staff.

The systems the registered provider had in place to monitor and improve the quality of the service, were ineffective. The registered provider had failed to ensure all nurses working at Moorland Nursing Home maintained their professional registration with the nursing and midwifery council (NMC).

Staff actions meant people were not protected from malnutrition and dehydration. People were not always presented with food in a way that was easy to eat safely.

We found people's dignity was not always respected and promoted. One person was provided with continence aids designed for an animal. The registered provider failed to ensure people were free from inhuman or degrading treatment (protected by Article 3 in the Human Rights Act).

Feedback from people who lived at the home indicated they were not always treated with dignity and respect. One person had their independence restricted preventing them from using the toilet independently. People expressed concern staff who spoke English, as a second language did not fully comprehend English. This affected how they engaged with people and hindered people's ability to express their views.

We looked at staffing levels at Moorland Nursing Home. The registered provider did not continuously review staffing levels to respond to the changing needs and circumstances of people living at Moorland Nursing Home.

As part of our inspection, we had a walk around the home. We witnessed bedroom doors were lodged open with wooden wedges. Wedging or propping open a fire door can prove devastating as it allows fire to spread unchecked, putting lives and buildings at risk. We noted fire exits had had their alarms disabled.

As part of this inspection, we looked at audits. We noted some audits did take place, however, the information did not reflect our findings. Effective auditing systems were not consistently carried out to ensure care delivered was safe and person centred.

During the inspection visit, we were made aware of an incident whereby police had been called to the home to provide assistance. This was a notifiable incident, which should have been reported to CQC. This had not been completed.

As part of the inspection, process we looked to ensure the registered provider was meeting their statutory requirements in displaying their CQC rating. They did not have this on full display on the website as stated within the guidance.

Staff received training related to their role and told us they were knowledgeable about their responsibilities. However, staff failed in their responsibilities to identify, report and prevent abusive care practices taking place

We received mixed feedback on how the service managed complaints. It took one person seven requests before the manager met with them regarding a complaint. We also noted one person's complaint had been documented and investigated in line with Moorland Nursing Home's policy and procedures.

Staff had received abuse training and understood their responsibilities to report any unsafe care or abusive practices related to the safeguarding of vulnerable adults. Staff we spoke with told us they were aware of the safeguarding procedure.

We found people had access to healthcare professionals. There were established links with community based healthcare professionals.

People who lived at Moorland Nursing home had their favourite staff. Caring relationships had been established with these staff members.

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. Full information about CQC's regulatory response can be found at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

The registered provider had failed to ensure risks were appropriately addressed and managed.

Fire exits were not alarmed. Fire doors were wedged open. The premises were not maintained to allow people to remain safe.

The provider did not maintain comprehensive and up-to-date records about medicines and topical creams for each person. People were at risk due to the unsafe management of their medicines and powders.

There were not enough staff available to meet people's needs. Recruitment procedures were not safe as they failed to ensure appropriate checks were made to ensure people employed were of suitable character.

Staff had been trained in safeguarding and were knowledgeable about abuse and the ways to recognise and report it. However, based on our findings, this did not occur.

Is the service effective?

Inadequate

The service was not effective.

People were not always protected against the risks of dehydration and malnutrition. People's food was not offered in a way that was easy to eat safely.

The management team were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and had knowledge of the process to follow. However, they failed to take into account the assessment of a person's needs and their capacity to consent to such treatment.

Care staff had the appropriate training relevant to their role but did not always put these principles into practice.

Is the service caring?

Inadequate

The service was not consistently caring.

The registered provider failed to ensure people were free from inhuman or degrading treatment (protected by Article 3 in the Human Rights Act).

Language used by staff did not always promote and protect people's dignity.

People told us they had developed positive caring relationships with staff.

Is the service responsive?

Inadequate

The service was not responsive.

The registered provider had failed to ensure care and treatment was appropriate and met people's needs.

People were not always supported to take part in meaningful individual or group activities.

One person told us they waited two months before they met the manager to complain despite requesting a meeting on several occasions.

Is the service well-led?

Inadequate

The service was not well led.

The registered provider did not have robust arrangements to take appropriate timely action if there was a clinical or medical emergency.

The registered provider did not ensure persons providing care and treatment to people had the qualifications, competence, skills and experience to do so safely. They did not ensure persons employed were registered with the relevant professional body.

Auditing of the service was not comprehensively carried out. The lack of effective governance failed to highlight poor widespread practice.

The registered provider failed to ensure they met all their CQC statutory requirements.

Moorland Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place over five days on 12, 13, 14, 17 and 21 June 2017. The first day of the inspection visit was unannounced.

One adult social care inspection manager and two adult social care inspectors carried out the inspection.

Prior to our inspection, we reviewed all the information we held about the service. This included notifications the registered provider had sent us. We also reviewed information provided by the safeguarding authorities. Concerns had been raised that people at Moorland Nursing Home were not safe.

To ensure people who lived at Moorland Nursing Home were not exposed to the risk of harm, the local authority deployed social care staff and managers and the Commissioning Group (CCG) sourced agency trained nurses to work alongside Moorland Nursing Home staff.

During the inspection process, we spoke with three managers and two care staff from Lancashire County Council and two agency nurses. We were in regular communication with staff and management from the local authority and the local Clinical Commissioning Groups (NHS Blackpool CCG and NHS Fylde and Wyre CCG). We also spoke with two visiting professionals.

During our inspection visits, we spoke with seven people who lived at Moorland Nursing Home and nine relatives to seek their opinion of the service. Not everyone who lived at the home was able to tell us about their experiences of life at the home. We therefore carried out observations of how the staff interacted with people who lived at the home and how people were supported during meal times and during individual tasks.

We spoke with a range of staff at the home. This included the director of the company, the area manager,

seven nurses employed at the home and six staff members.

To gather information, we looked at a variety of records. This included care plan files related to six people who lived at the home. We also looked at medicine administration records related to people who received support from staff to administer their medicines.

We viewed recruitment files belonging to three staff members and other documentation relevant to the management of the service. This included health and safety certification, training records, team meeting minutes, accidents and incidents records and findings from monthly audits.

We looked around the home in both communal and private areas to assess the environment to ensure it met the needs of people who lived there.

Inadequate

Is the service safe?

Our findings

We looked at how the service was staffed. We did this to make sure there was enough staff on duty at all times, to support people who lived at the home.

We spoke with people who lived at the home and their relatives about staffing levels. We received mixed feedback about this. One relative we spoke with thought staffing levels were appropriate. One person who lived at the home told us, "They need one more carer in the morning." A second person told us, "It started going wrong when they cut staff."

We asked staff their opinion on staffing levels. Staff told us they did not always have time to complete allocated tasks. One staff member told us, "We haven't got time to do activities." Another staff member told us, "Since January, people's needs have started to change, we were told we could have an extra staff member at 16 [people living at the home]. It's not needs led."

On the first day of our inspection visit, 13 people lived at Moorland Nursing Home. Staff informed us that eight of the 13 people who lived at the home needed two care staff to attend to all their needs. This included personal care and assistance moving, for example from their bed to a wheelchair.

We looked at the staff rota for the first day of our visit. There was one nurse on duty from 8am until 8pm and another nurse on duty from 8pm until 8am the following morning. There were two care staff on duty from 8am until 8pm. This decreased to one care staff during the night from 8pm until 8am the following morning. There was a cook on duty from 9am until 2pm and a domestic on duty 9am until 12pm. The maintenance person was recorded on the rota as on leave and the area manager was recorded as on call.

We observed two separate shift change handover meetings between nurses and staff where any changes in people's care needs were discussed. We did not see any evidence that staff were deployed effectively in a planned way to meet people's needs.

On the first morning of inspection, we arrived at 07:00 am and noted all people who lived at the home were in their bedrooms. There was one nurse on duty and one care staff. The day staff did not start until 08:00am and the cook did not start until 09:00am. We spoke with the nurse who confirmed staff were on duty as per the rota and the rota reflected the normal staffing levels for the home. This meant staff were responsible for making breakfast and supporting people with their medicines, meals and personal care. As eight people needed two care staff to attend to all their needs, the staffing levels were inadequate to meet people's needs.

We reviewed the rota for the previous week, week commencing 05 June 2017. The printed rota was written on to record hours worked. One nurse had worked 72 hours and another nurse had worked on one day from 2pm until 8pm and then continued working from 8pm until 8am on the night shift. This level of work was unsafe and does not meet The Working Time Regulations (1998). We have informed the appropriate authorities to investigate this.

During our inspection, we noted contracted staff were guided by local authority staff to meet people's needs safely. At the beginning of our inspection, the cook started work at 9 am, which meant staff were responsible for making breakfast and supporting people with their meals. After concerns were raised with the registered provider around staffing levels in the morning, the cook's hours changed to an 8 am start to allow staff to focus on supporting people with their morning routines.

Low staffing levels meant staff did not always have time to complete allocated tasks. We observed no activities taking place. One staff member said, "We haven't got time to do activities." We spoke with the quality assurance manager about quality auditing systems. They told us they were often deployed through the week as a nurse so they did not have time to carry out the quality assurance processes. We looked at rotas that confirmed there was no suitably qualified staff consistently employed at Moorland Nursing Home to make sure they could meet people's care and treatment needs.

This was a breach of Regulation 18 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing) as the registered provider did not continuously review staffing levels to respond to the changing needs and circumstances of people living at Moorland Nursing Home.

We looked at recruitment procedures to ensure people were supported by suitably qualified and experienced staff. To do this we reviewed three staff files. One staff file did not have an application form present. We spoke with the staff member who told us they had completed an application form on the day of their interview. Two of the three files had application forms, which had not been correctly completed, as they did not show the applicants full employment history. These checks were required to ensure that new staff were suitable for the role for which they had been employed.

We could not find information related to their Disclosure and Barring Home check (DBS) for one member of staff. A DBS check reviews the person's past history and identifies any criminal convictions or cautions the person may have received. A valid DBS check is a statutory requirement for people providing a personal care service supporting vulnerable people.

This showed the provider had not fully carried out systems in place to keep people safe. We were unable to speak with the manager about our findings on this topic, as they were unavailable.

We checked that staff were suitably qualified, competent, skilled and experienced. Staff are required where relevant for them to meet the professional standards which are a condition of their ability to practice and a requirement of their role. One member of staff did not have the required registration. We raised our concerns with the area manager and informed the appropriate authorities.

This was a breach of Regulation 19 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Fit and proper persons employed because the provider did not have recruitment procedures in place to ensure persons employed were of good character.

At this inspection visit, we looked at how the registered provider managed risk. We looked at the management of accident and incidents at Moorland Nursing Home. Information in regards to accidents and incidents was reviewed on a monthly basis. However, we did not see any evidence to show that risks had been addressed and systems implemented to prevent re-occurring risk. For example, one person had fallen ten times in a three-month period. We spoke with a family member they told us the person had a history of falls. From the evidence we reviewed we observed that no referrals had been made to the specialist falls team for advice and support. We asked the manager about the protocols for managing people at risk of falls. They confirmed there was no protocol in place. This meant the lack of a robust data management system

failed to deliver clinical oversight, improve quality and keep people safe.

During our inspection visit we were made aware that one person had left the home unsupported by staff. Their preadmission assessment stated they were living with vascular dementia. Entries in the daily log the day before they left the home identified the person was agitated and 'does have a tendency to wander.' The registered provider failed to do all that was reasonable to manage the identified risk.

After the incident, the registered provider did not secure the building. This meant they did not take timely action. This placed the person at risk of continued harm, as people were able to leave the home unsupported, unmonitored and were vulnerable to unwanted, unannounced visitors entering the home.

This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safe care and treatment) as the registered provider had failed to ensure risks were appropriately addressed to mitigate and manage risk.

As part of the inspection visit, we reviewed the environment in which people lived. We reviewed the security of the building to ensure it was safe and secure. On investigation, we noted two fire exits were not alarmed. The side access gate was unlocked and remained unlocked after the incident where someone living at the home had left the home unattended when they did not have capacity and were unsafe to do so. We spoke with the registered provider and shared our concerns about the gate being unlocked. They secured the gate on the day we raised our concerns, five days after the incident took place. However, the two fire exits remained disabled and were not alarmed.

During our walk around the home, we were made aware that the water temperature in the bathrooms was warm but too cold for people to bathe comfortably. We observed the repair person and outside contractors visit the home to rectify the problem. The fridge also required attention during our inspection visit. We also witnessed bedroom doors lodged open with wooden wedges. Wedging or propping open a fire door can prove devastating as it allows fire to spread unchecked, putting lives and buildings at risk. We highlighted our concerns to the nurse on duty who told us they would remove all the wedges.

During our inspection, we were made aware one person's mattress was not fit for purpose. We saw the mattress was in poor condition. Once highlighted to the registered provider they agreed it was in poor condition and replaced it.

A nurse employed by the CCG raised concerns that the sharps container was overflowing and had not been replaced in a timely manner. A sharps container is a hard plastic container used to dispose of hypodermic needles and other sharp medical instruments safely. Extreme care must be taken in the management and disposal of sharps waste.

This was a breach of Regulation 15 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Premises and equipment) as the registered provider had failed to ensure premises and equipment were properly used and maintained.

As part of our inspection, we observed medicine administration. During our observation we noted one nurse handled tablets and signed the MAR form prior to administration. We spoke with the manager about this who told us the mistakes had occurred due to additional staff and additional scrutiny taking place at the home, making the nurse stressed. We observed a second nurse leave the medicine trolley open and unattended. Upon observing our presence in the area, they returned to the trolley and locked the trolley. They left it untethered in an unlocked room with the door open.

Good practice guidelines for the storage of medicines were not consistently applied. We observed powder used to thicken drinks was accessible to people living at Moorland Nursing Home. The powder was stored in two bedrooms and in the lounge. NHS England had previously raised a nationwide patient safety alert highlighting the risks of choking related to inappropriate use of these powders. Through not having the thickening powder securely stored, the registered provider failed to manage risk and failed to keep people who may be vulnerable safe.

We found instructions for administering medicines and creams were unclear. We looked at instructions for administering variable doses of medicines. One person was prescribed a tablet to combat anxiety. They could have half or one tablet 'as and when required'. There were no instructions to guide staff on the amount to administer or when to administer the medicine. Regarding the administration of topical creams, records we looked at did not have procedural guidance for staff to follow. For example we noted, 'apply to dry areas' and 'apply as and when required.' There were no body maps to show which part of the body to apply cream. This meant people were at risk of receiving ineffective treatment as there was no clear direction as to where and how to apply the cream.

The relatives of one person had raised concerns about the care of their family member prior to our inspection. Local authority staff whilst working at the home raised concerns related to the dryness of one person's skin. We observed the person's red and flaky skin. We looked at the records for the administration of creams for this person. This indicated the creams had not been consistently applied as directed. We spoke with the manager who told us they were disappointed the care had not been delivered, as these were basic care tasks. They told us they had very recently been absent from work and this could be the reason staff had not completed these tasks.

This was a breach of Regulation 12 HSCA (RA) Regulations 2014 (Safe care and treatment.) as good practice guidelines were not followed to ensure the safe management of medicines.

We looked at how safeguarding procedures were managed by the registered provider. Staff we spoke with told us they had received safeguarding training and were confident they could identify and report abuse. When asked, staff could describe different forms of abuse and said they would report any concerns to management. One staff member said, "If I saw anything, I would report it."
Although staff told us they were aware of what abuse was and how to report it, we found that safeguarding concerns we identified during the inspection process related to restraint and degrading treatment had not been responded and reported appropriately.

This was a breach of Regulation 13 HSCA (RA) Regulations 2014 (Safeguarding service users from abuse and improper treatment.) as staff failed in their responsibilities to identify, report and prevent abusive care practices taking place

During the inspection, we had a walk around the home, including bedrooms, bathrooms, toilets, the kitchens and communal areas of the home. We found these areas were clean. We observed staff made appropriate use of personal protective equipment, such as, wearing gloves when necessary. However, we did observe staff walking in communal areas carrying used continence pads. We shared our concerns with the nurse on duty who told us they would investigate the incident and speak with staff.

Inadequate

Is the service effective?

Our findings

We looked at how people were supported to have sufficient to eat, drink, and maintain a balanced diet.

We looked at systems in place for managing people's weight loss. Records showed a person had lost 5kg in weight in one month. Sudden or rapid weight loss is considered a significant risk factor of ill health. No measures were put in place to manage the weight loss. No medical advice was sought to investigate if there was an underlying medical condition linked to the weight loss. We looked at records maintained for people at risk of malnourishment. One person's care plan stated staff were to monitor the person's nutritional intake. We noted documentation was not always completed in a way that nutritional needs could be monitored. For example, records did not document what the person had eaten. They just stated, "[family member] fed them."

We found that records did not always give an accurate account of fluid intake. For example, when people were at risk of dehydration records did not quantify how much fluid people had consumed. One person's care records stated the person had taken 'sips'. There was no record of the total volume of fluid consumed. Documentation was also inconsistently completed. This prevented any oversight of the amount of fluids taken. Inadequate fluid intake is a major contributor to preventable dehydration. Poorly hydrated people are more likely to develop pressure sores and skin conditions.

We noted one person's care plan stated they were at risk of malnourishment and said they required additional nourishment. Their guidelines recorded they were to have a nourishment powder as part of their fortified diet. We observed the staff member did not follow the documented guidance on how to administer this.

This meant people were not protected against the risk of malnutrition and dehydration. This was a breach of Regulation 14 HSCA (RA) Regulations 2014 (Meeting nutrition and hydration needs.) The provider had failed to maintain a food and drink strategy that addressed the nutritional needs of people using the service.

Observations showed the registered provider failed to make sure people received effective care based on best practice. For example, one person's care notes stated they required fluid to be thickened to a syrup consistency. Staff were to administer the thickened liquid using a teaspoon. A visiting health professional had to intervene when a staff member prepared the person's drink unsafely. They guided the staff member on the correct procedure, which included mixing the liquid with thickener, leaving for five minutes, assessing the consistency then supporting the person to drink. The staff member left the room and never returned to support this person. We observed the health professional seek the staff member and reiterate the required procedure.

Throughout our visit, we observed the person being presented drinks in cups, which was against specialist guidance. Local authority staff had to intervene and remind staff of the person's guidelines. People with difficulty swallowing may find liquids cause coughing, spluttering or even choking and thickening drinks enables them to swallow safely. The registered provider failed to ensure that this person's care and

treatment was delivered in a safe way.

This was a breach of Regulation 12 HSCA (RA) Regulations 2014 (Safe care and treatment.) The provider had failed to maintain a food and drink strategy that addressed the nutritional needs of people using the service. Dangers were not appropriately addressed to manage risk effectively and keep people who were vulnerable safe.

We received mixed comments on the food provided. One person told us they had an arrangement with the cook. The cook offered them alternatives they liked if the meal advertised was not to their taste. For example, if it was spicy or a hot meal in very hot weather.

With their consent, we joined a second person midway through their meal. They told us, "If that's my dinner, roll on tea. There's nowt worth eating, it's alright if you want to lose weight." They explained they did not like what was offered. They further commented they would just wait for the pudding.

We visited the kitchen during the inspection and saw it was clean and tidy. We were told all meals were home cooked. The current food hygiene rating was displayed advertising its rating of five. Services are given their hygiene rating when a food safety officer inspects it. The top rating of five meant the home was found to have very good hygiene standards.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make particular decisions, any decisions 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 interest and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the home was working within the principles of the MCA.

We noted applications had been made for six people who lacked capacity and were awaiting authorisation to deprive them of their liberty lawfully. The MCA states people will continue to make decisions about their own lives whenever possible, or be included in such decisions as much as possible at all other times. However, we saw bed rails were being used for people who lived at Moorland Nursing Home. We did not find any documentation that showed best interest discussions had taken place. This indicated the registered provider had not acted lawfully as directed in the statutory principles laid out in S.1 of the MCA.

Processes for giving consent were not consistently adhered to. For example, one person's bed rail assessment stated, 'use of bed rails declined.' We observed bed rails were being used on the person's bed to restrict their movements. The person requested the bed rails be removed. We relayed this to the nurse in charge who we witnessed document the request. On the second day of our inspection, we visited the person in their room and noted the bed rails were again in place and raised and their movement had been restricted throughout the night.

We told the nurse in charge who questioned the night nurse. They confirmed they had raised the bed rails to protect the person despite the person having capacity and requesting the bed rails not be used. This however was against the wishes of the person, as they had not given consent. Staff in authority at Moorland Nursing Home had a duty of care to offer people support to maintain their independence in line with their

preferences. The registered provider did not ensure staff respected the persons expressed wishes whilst managing the risk. This meant they failed to protect the person from abuse and improper treatment.

This was a breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment) as the registered provider failed to take into account the assessment of a person's needs and their capacity to consent to such treatment.

One person we spoke with told us they were happy living at Moorland Nursing Home. They told us they had lived at the home for nine years and did not want to move. A second person stated in a relatives' meeting we attended, they were happy at the home and had their room just how they liked it. We noted both people mentioned how they liked their bedrooms. However, when speaking with us, they both raised concerns related to the effectiveness of the care they received.

Staff we spoke with told us they had supervision meetings. Supervision is a one-to-one support meeting between individual staff and a member of the management team to review their training needs, role and responsibilities.

We looked at the training records for three staff members and saw they had received training related to their role. Staff had received training in safeguarding adults, respect and dignity, moving and handling, infection control and fire prevention.

We asked people who lived at the home if staff had the knowledge and skills they needed to carry out their roles and responsibilities. One person told us, "They [the carers] do what I ask for. The nurses do their job apart from [named nurse]." A second person told us, "All the carers work really hard." They went on to tell us they had concerns about a nurse's ability to carry out their role.

Staff had documented involvement from several healthcare agencies to manage health and behavioural needs. Records we looked at showed involvement from various health professionals such as GPs and community based nurses. During our inspection, a community based nurse made several visits and a speech and language therapist visited. This confirmed established communication protocols were in place for people to access specialist care and support to manage some of their healthcare needs.

Inadequate

Is the service caring?

Our findings

During our inspection, we spoke with people to assess how their dignity was respected and promoted. We spoke with one person who required care and support whilst remaining in bed. The person required continence aids as part of their ongoing care. Due to the lack of continence pads being available, pads used to train young dogs were purchased and used. These puppy training pads were used for three to four days and applied by several staff during that period. We saw the animal continence pads in the person's bedroom. The person told us they had kept them as evidence to show and discuss with the manager.

We were present when the discussion took place with the manager. The person blamed the use of the animal pads on the deterioration of their skin. They told the manager, "My bottom is still very painful and it is long days sat in bed in pain." The manager stated they were unaware these pads had been purchased and used. They apologised to the person and said would investigate how they came to be in the nursing home and to be used. The registered provider failed to ensure people were free from inhuman or degrading treatment (protected by Article 3 in the Human Rights Act).

This was a breach of Regulation 13 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safeguarding service users from abuse and improper treatment). The registered provider failed to take reasonable steps to ensure people were not subjected to treatment that may be viewed as degrading.

Feedback we received from people we spoke with, indicated people were not always spoken to appropriately. One person told us about a staff member, "She is just miserable, walking round like a zombie. She talks at me." A second person who had limited communication asked us to read their diary in which they had documented their unhappiness at an 'ignorant' staff member. This meant staff were not caring and failed to be compassionate when supporting people who lived at Moorland Nursing Home. We raised our concerns with the registered provider and manager who took immediate action.

People we spoke with expressed concern that staff who spoke English as a second language did not always fully comprehend what was being asked of them. This impacted on how they engaged with people and hindered people's ability to express their views, as they were not understood. For example, one person told us they asked a staff member for a bedpan repeatedly. The staff member sought a second staff member, as they did not understand; the person had to make the request again. This meant the person had to wait for their request to be acted upon and they had to make the sensitive request twice.

We observed interactions between staff and people that were task orientated. Staff supported people with their meals and drinks. They did not use this as an opportunity to chat, listen and engage with people. For example, during moving and handling procedures, staff did not explain and reassure the person about what was happening.

We heard staff use language that did not promote people's personal dignity. For example, staff talked about "feeding" people. In the hall of Moorland Nursing Home on public view, we noted guidance that included, 'Serve Lunch, Feeders at 11.45 am & 12 other.' The language we use can influence how staff treat or view

people who require support and who may be vulnerable. People who are treated as conditions or problems can have their personal dignity threatened. The registered provider had failed to ensure people's individuality was respected and promoted.

One person who, through the use of bed rails, had their movements restricted told us, "I wanted a wee, but couldn't get up, where's the dignity in that." We spoke with the nurse in charge about the person's statement and they took action to remove the bedrails and shared the information with colleagues.

The concerns noted were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Dignity and respect) as the registered provider had failed to ensure people were treated with dignity and respect.

People we spoke with gave mixed feedback on the care and support they received. They shared concerns on their personal and clinical care. We noted they had complained to the manager about the quality of the care and support they received around their intimate personal care. However, they told us there were staff at the home they liked. They told us, "I have a laugh with the staff."

Relatives we spoke with said they were made to feel welcome by everyone. They told us they could visit whenever they liked. Two relatives told us they visited daily. A third relative told us there were no restrictions on when they could visit. This showed the provider maintained relationships with people's loved ones.

We spoke with the management team about access to advocacy services should people require their guidance and support. We noted information regarding advocacy services was advertised publicly within the nursing home. The manager had information on several advocacy services available in the local area that could be provided to people and their families if required. This ensured information was available on additional independent support outside of the home to act on people's behalves if needed.

We saw evidence conversations had taken place with people who lived at the home and family members about their end of life wishes. There was a do not attempt cardiopulmonary resuscitation (DNACPR) register which ensured end of life wishes were valid and current. We noted people had also chosen not to discuss end of life plans. This highlighted the provider had recognised end of life decisions should be part of a person's care plan and had respected their decisions.

Inadequate

Is the service responsive?

Our findings

We noted people's preferences on who provided their care were identified and documented. For example, one person had requested one nurse to attend to one specific medical task but liked a different nurse to provide support for a separate ongoing health condition. This was acknowledged and documented in their care plan. However, the documentation was out of date. Their preferred nurse had left the home. The registered provider had failed to discuss and document alternative arrangements with the person.

We noted one person's wishes and preferences included the refusal of treatment. There was no documentary evidence to show an assessment of capacity had taken place to support this unwise decision. The lack of treatment resulted in ongoing severe health conditions. The family had not been made aware of the extent of damage caused by the lack of treatment. We did not see any documentation that showed the person's decision had been reviewed or capacity reviewed. There was no documentation that indicated information had been presented in different ways that ensured the person fully understood the impact of their decisions. There was no risk management plan and the decision had not been discussed with local health professionals who visited regularly.

Community health professionals were unaware of the extent of damage that had occurred through a prolonged lack of treatment. We observed they were visibly shocked on seeing the extent of the severe bacterial infection. They confirmed they visited the home regularly and no one had asked for their professional opinion in relation to these injuries.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safe care and treatment). The registered provider failed to risk assess the needs of people using the service against their rights and preferences.

We looked at care records of six people to see if their needs had been assessed and consistently met. We found each person had a set of care plans that detailed the support they required.
The plans showed how to support people with washing and bathing, continence, nutrition, mobility and 'dressing and grooming'.

Although care plans were in place we found delivery of care was inconsistent and did not always reflect direction and preferences set out in care plans. For example, we were made aware that one person had not had a bath in all the time they had lived at Moorland Nursing Home. We spoke with the person who told us, "They always want me to have a shower, I don't like a shower. I'd like a bath. I could lie in the bath and have a soak. They did promise me a bath, but it never happened." They told us they had a strip wash every day.

We reviewed the person's care plan this confirmed the person did not like showers. The care plan stated staff were to offer one person the choice of a shower or bath on a daily basis. Staff could not recall when the person last had a bath. We could not find any records that showed the person had ever had a bath or shower. We spoke with the nurse on duty about this who confirmed the person had not bathed or showered for over a year.

We looked at the care plan to see when it was last reviewed. A review had not taken place since August 2015. Consequently, no action had been taken to review the person's preferences.

People were not encouraged to be independent. For example, one person's care plan stated the person could not walk and required full support. It also documented that the person required physical support to eat a meal. With encouragement, we observed the person walking with support. They were also able to eat independently once their meal had been adapted to meet their needs.

We observed people with no health restrictions given soup in a cup with a lid and spout on. We observed one person struggle to eat their meal out of dish provided and lifted it to their mouth to drink.

Within the same care plan carers were informed, 'Carers to ensure [person's] clothes are always cleaned and ironed. During our inspection, we noted the person wore the same clothes continuously for four days. There was no documentation that showed the care plan had been followed and fresh clothes had been offered or provided.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Person-centred care). The registered provider had failed to ensure care and treatment was appropriate and met people's needs and preferences.

At our previous inspection in January 2017, we looked at activities at Moorland Nursing Home. There had been a weekly timetable and people had confirmed the activities advertised took place. We noted photographs of events and activities that had taken place at the home. At the time of this inspection, no activities took place. There were additional staff on site and this may have caused a break in normal routines. However, no staff employed at the home attempted to deliver any organised activities during the four days we were present. One person we spoke with told us there were no activities at the home. The week before our inspection, the local authority had made two unannounced visits to the home. They were concerned everyone who lived at the home were in bed by mid-afternoon. One staff member told us this was the normal routine for people. We looked at the daily notes of six people and could not see any documentary evidence that activities had taken place.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Person-centred care). People were not always supported to take part in meaningful individual or group activities.

During our inspection, we spoke with an agency nurse sent by the CCG to work at Moorland Nursing Home to ensure people received care and support that was responsive to their needs. They raised concerns that the nurse on shift did not follow good practice when attending to a person's pressure wound. They stated they failed to perform the task following good practice guidance to keep the area free from contamination. They also raised concerns that the correct dressings were not available to attend to the pressure wound. We spoke with the registered provider who told us they would speak with the nurse. They assured us there were now suitable dressings available when required.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Safe care and treatment). The registered provider failed to ensure there were sufficient medical dressings available to meet people's needs and keep them safe.

We acquired mixed feedback on how complaints were encouraged and responded to by the registered provider. A complaints policy was on public display. Relatives we spoke with stated they would not have any reservations in making a complaint. One relative told us they had nothing to complain about and a second

relative stated they had thought about making a complaint but their family member wanted to deal with it themselves.

We spoke with the family member who lived at Moorland Nursing Home and who remained in bed 24 hours a day. They told us they had requested seven times, via staff, to speak with the manager. They had documented in their notebook each time they made the request to a staff member. They told us they had not seen the manager for over two months. They commented they had heard her outside the room but the manager had not visited them in their room. Despite this information being relayed to staff, the manager stated they were unaware of any concerns. The manager met with the person during our inspection.

We found documentation that one person who lived at Moorland Nursing Home had visited the manager and made a complaint. The manager had followed their complaints policy. For example, the manager had documented the person's complaint, investigated the concern, interviewed staff and met with the complainant with the outcome.

Inadequate

Is the service well-led?

Our findings

One person told us, "It's never been any good here, since [previous manager] left."

Moorland Nursing Home was not well led. There was no visible leadership and a lack of continuity in managerial and clinical oversight. This had resulted in the quality and safety of the service going unchecked. For example, the clinical lead nurse worked nights and told us they were not always available during the day. This meant the home lacked professional oversight to lead trained staff in effective clinical governance to deliver a quality service and drive improvements.

The manager had recently been absent from work. The registered provider lived out of the area and was at times not able to be contacted. There was no support network in place should guidance be required or an emergency occurred. When concerns on the care being delivered were highlighted, the local authority and CQC were unable to contact any member of the management team. We were unable to speak with anyone who would be able to co-ordinate action to safeguard people. Because of the lack of contingency plan and no timely communication, the local authority and CCG took the decision to temporarily import managers, nurses and care staff into Moorland Nursing Home, to keep people safe.

This was a breach of Regulation 12 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Safe care and treatment) as the registered provider did not have robust arrangements to take appropriate timely action if there was a clinical or medical emergency.

Systems for monitoring and improving the quality of the service were ineffective as people were receiving care that was not safe, effective, caring, responsive or well led. For example, the registered provider had failed to ensure all nurses working at Moorland Nursing Home maintained their professional registration with the nursing and midwifery council (NMC). The NMC sets standards of education, training, conduct and performance so nurses can deliver high quality healthcare. To be able to practice as a nurse you have to be registered with the NMC. This is a mandatory requirement for all practicing nurses.

We spoke with the manager about this who told us they had checked their nurses' registration dates and details. However, these checks had not taken place for over twelve months, in which time one nurse's registration had expired. This meant the unregistered nurse was working illegally in their role and had not met the required nursing standards to work in any healthcare role that required registration.

This was a breach of Regulation 19 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Fit and proper persons employed) as the registered provider did not ensure persons employed were registered with the relevant professional body where such registration is required by the work the person is required to perform.

Documentation maintained by the provider lacked direction. For example, MAR records for variable dose medicines and creams and ointments were not clear as to when medicines were to be applied and to which parts of the body. Records were inconsistently completed. For example, fluid charts and nutritional charts

were not correctly completed to illustrate what people had eaten and drank.

People's care notes at times were difficult to read and lacked relevant information. For example, two people's notes included, 'unremarkable afternoon.' This this did not guide staff on the support delivered or reflect the person physically and emotionally. Daily notes consistently lacked information on the amount of fluids taken per day and if prescribed creams had been applied. Records had not been completed to evidence that creams and ointments had been applied. We found required documentation to show that people's capacity had been assessed and best interest's decision processes had been followed had not been completed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008, (Regulated Activities) 2014 (Good governance) as effective auditing systems were not consistently carried out to ensure care delivered was safe and effective.

During the inspection we were made aware the police had been called upon to help find a person who left the home unsupported. No statutory notification to the CQC to record this event had been submitted. We spoke with the registered provider and manager about this; they told us there had been an oversight.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) as the registered provider failed to make all statutory notifications.

As part of the inspection process, we looked to ensure the registered provider was meeting their statutory requirements in displaying their CQC rating. This has been a legal requirement since April 2015. We found they did not have this on full display on the website as stated within the guidance.

This was a breach of Regulation 20A of the Health and Social Care Act (2008) Regulated Activities 2014.

The services liability insurance was valid and in date. There was a business continuity plan in place. A business continuity plan is a response planning document. It showed how the management team would return to 'business as normal' should an incident or accident take place. However in this situation, when concerns were raised we were unable to make contact with a person of authority and decision maker. This demonstrated their business continuity plan was not a robust effective document.

As part of this inspection, we looked at audits. We noted audits for mattresses, hoists, hand hygiene, maintenance, infection control, sharps storage and housekeeping had been completed. However, these had failed to identify the concerns we identified during the inspection process.

We observed daily handover meetings took place to share knowledge on people living at the home. Nurses and care staff were present at the meeting with the information being shared documented on the handover sheet. We saw minutes, which indicated staff meetings took place. Topics discussed included care plans, teamwork and the people being supported at the home.

We saw safety checks had taken place, which looked at legionella, gas safety, electric safety fire alarms and emergency lighting. Each person living at Moorland nursing Home had a personal evacuation plan to guide emergency services should they be required to support people to leave the home in an emergency.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider failed to make all statutory notifications within a timely manner. 18(1)(2)(f)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure care and treatment is appropriate and meets people's needs. People had not been supported to make informed decisions about their care and treatment. The registered provider had failed in their duty of care to design a care plan that acknowledged their preferences and ensured their needs were met. 9(1)(a)(b)(c)(3)(b)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered provider had failed to ensure people were treated with dignity and respect through staff actions and the language used.

10(1)(2)(b)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had failed to ensure risks were not appropriately addressed to mitigate and manage risk. The registered provider failed to provide care and treatment in a safe way. They failed to consistently follow control measures to make sure the risk is as low as possible The registered provider did not have robust arrangements to take appropriate timely action if there is a clinical or medical emergency 12(1)(2)(b) The registered provider did not ensure persons providing care and treatment to people had the qualifications, competence, skills and experience to do so safely. 12(1)(2)(c) The registered provider failed to ensure there were sufficient medical equipment available to meet people's needs and keep them safe. 12(1)(2)(f) The registered provider did not maintain comprehensive, accurate and up-to-date records about medicines and topical creams for each person receiving medicines support. People were at risk due to the unsafe management of their medicines and powders. 12(1)(2)(g)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers

registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider failed to take into account the assessment of a person's needs and their capacity to consent to such treatment with regards restraint. 13(1)(4)(b) The registered provider failed to take reasonable steps to ensure people were not subjected to treatment that may be viewed as degrading. 13(1)(4)(c)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not maintain a food and drink strategy that addressed the nutritional needs of people using the service. 14 (1)(4)(a)(d)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The registered provider had failed to ensure premises and equipment was properly used. 15(1)(2)(d)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers

registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective auditing systems were not consistently carried out to ensure care delivered was safe and person centred. 17(1)(2)(a)(c)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider did not ensure persons employed were registered with the relevant professional body where such registration is required by the work the person is required to perform. They did not have in place a process to check that staff had appropriate and current registration. 19(1)(b)(4) The registered provider did not document people's full employment history, or gather written explanation of any gaps in employment. 19 (1)(3)(a)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider did not have their most recent CQC rating on full display upon their

	website. 20A(1)(2)(c)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider did not continuously review staffing levels to respond to the changing needs and circumstances of people living at Moorland Nursing Home. 18(1)

The enforcement action we took:

Under Section 31 of the Health and Social Care Act 2008 we varied condition 2 of the service providers registration. They are no longer authorised to carry on regulated activities from Moorland Nursing Home, Moorland Road, Poulton Le Fylde, Lancashire, FY67EU