The Moorings Care Limited

The Moorings Retirement Home

Inspection report

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Ratings

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

Overall summary

This inspection took place on 26 and 29 June 2015 and was unannounced. The Moorings Retirement Home provides accommodation for up to 39 people, including people living with dementia care needs. There were 32 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.

We found people received most of their medicines as prescribed. However, there was insufficient information about 'as required' medicines to make sure people

Summary of findings

received the correct dose. Arrangements to make sure creams were used within their 'use by' date were not being followed by staff and entries in a medicines register were not always signed.

Staff sought verbal consent from people before providing care, but staff did not follow legislation designed to protect people's rights when making decisions on behalf of people who lacked the capacity to make their own decisions.

Staff developed caring and positive relationships with people by treating them with kindness and compassion. However, people's dignity was not always protected when they were being supported to use the toilet.

A comprehensive quality assurance system was in place, although this had not picked up the above concerns that we identified.

People felt safe at the home and staff knew how to identify, prevent and report abuse. Individual risks to people were assessed and managed effectively. There were plans in place to deal with foreseeable emergencies and staff knew what action to take in the event of a fire.

The provider determined staffing levels by assessing people's needs and seeking feedback from people, families and staff. People said they were usually attended to quickly, although two family members said there could be occasional delays in the evenings. Staff recruitment processes were safe and effective.

The provider followed legislation designed to ensure people were not deprived of their liberty unlawfully. People's independence was promoted and they were involved in planning and reviewed their care as their needs changed.

Staff were competent and skilled in caring for people living with dementia. They received comprehensive training and used their knowledge to provide effective care to people. Staff were supported appropriately in their role and felt valued by management, who they described as supportive and approachable.

Care and support were personalised and staff were responsive to people's needs. Staff knew people's backgrounds and interests and used this information to design suitable activities. The environment was designed to meet the needs of people living with dementia and people had access to safe outdoor area.

Most people were satisfied with the quality of the food. They were encouraged to eat and drink enough and received appropriate support when needed. Staff worked closely with other professionals to make sure people's healthcare needs were met.

People felt the home was well run. There was a clear management structure in place and all staff understood their roles. The provider had clear objectives and staff shared a common goal to provide care to the best of their abilities at all times.

Feedback from people, families and staff was sought and used to improve the quality of the service. People knew how to complain and complaints were managed in accordance with the provider's policy.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Medicines were not always managed safely.

Risks to people were assessed and managed effective and staff knew how to keep people safe. People were protected from the risk of abuse.

There were enough staff to meet people's needs. Recruitment processes were safe.

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not always follow legislation designed to protect people's rights.

Staff had the knowledge and skills to meet people's needs and were supported appropriately in their work.

People were supported to eat and drink enough. Action was taken promptly if they started to lose weight.

People had access to healthcare when needed. The environment helped people find their way around the home safely.

Requires improvement

Is the service caring?
The service was not always caring.

People's dignity was not always protected when they used the toilet.

Staff treated people with kindness and compassion.

People were encouraged to remain as independent as possible and were involved in planning their care.

Requires improvement

Is the service responsive?
The service was responsive.

Care plans were comprehensive and people received personalised care. People had access to a range of activities suited to their interests.

The provider sought and acted on feedback from people, families and staff.

Good

Is the service well-led?
The service was not always well-led.

The quality assurance system had not identified concerns that had led to breaches of regulations.

Requires improvement

Summary of findings

There was an open and transparent culture within the home. A clear management structure was in place and all staff understood their roles.

The registered manager notified CQC of all significant events.

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 26 and 29 June 2015 and was unannounced. The inspection team consisted of an inspector, a specialist advisor in the care of older people, 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, we reviewed information we held about the home 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 nine people living at the home and four friends or family members. We also spoke with a senior representative of the provider, the registered manager, two deputy managers, eight care staff, two members of kitchen staff and a housekeeper. We looked at care plans and associated records for six people and records relating to the management of the service. These included staff duty records, staff recruitment files, records of complaints, accidents and incidents, and quality assurance records. We also received feedback from the local authority commissioning unit and a community nurse.

We observed care and support being delivered in communal areas. 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.

At our last inspection, on18 June 2014, we did not identify any concerns.

Requires improvement

Is the service safe?

Our findings

Medicines were not always managed safely. The process to make sure creams and ointments were not used beyond their 'use by' date relied on staff writing the dates of opening on them. Staff were not doing this, so there was a risk creams and ointments would be used beyond their 'use-by' date and would not be safe or effective. Medicines that were subject to additional controls by law were recorded in a register. However, not all new entries of these medicines had been signed by the staff member receiving them, and the entries for new medicines were not always checked or signed by a second member of staff to make sure they were accurate. This was contrary to guidance issued by the National Institute for Health and Clinical Excellence (NICE) on the safe management of medicines. One medicine, which should be given before food, was often given with or after food, so may not have been effective. Some people were prescribed medicines on an "as required" (PRN) basis. Detailed information was available for staff to know when, and in what circumstances, these medicines should be given. However, when there was an option to give a variable dose, for example one or two tablets, there was no information about which dose should be given. This meant people may not have received suitable doses of PRN medicines in a consistent way. There were appropriate arrangements in place for obtaining, safe handling and disposing of medicines.

The failure to manage all medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at the home. On person told us "I feel happy and safe here. It's my home." A family member said of the staff, "They do everything for her. She's safe; that's the main thing." Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. The provider followed local safeguarding processes and responded appropriately to any allegation of abuse by reporting incidents to relevant bodies and conducting investigations. Staff were encouraged to raise concerns with the registered manager and were confident appropriate action would be taken.

Action was not always taken promptly when people showed signs of developing pressure injuries. Staff monitored the condition of people's skin for signs of pressure injuries. When these were identified, staff recorded them on body maps and took photographs. However, they did not print the photos or use them for comparison purposes to help assess whether the injuries were healing or deteriorating. We found two instances where care records indicated the person's skin was deteriorating, but there was then a delay of two to three days before the person was referred to community nurses for advice and treatment. We discussed this with the registered manager who put new procedures in place to help ensure any deterioration in skin condition was identified and referred to community nurses quickly.

The risks of people falling were managed effectively. Assessments were conducted and appropriate equipment, such as walking aids, provided. This was in people's reach at all times and staff encouraged people to use it safely. When staff used hoists and stand-aids, they did so in pairs and in accordance with best practice guidance. Where people had experienced falls, senior staff reviewed the risks and took appropriate action to reduce the likelihood of further falls. A system is also in place to capture details of all accidents and incidents in the home, so any patterns could be identified and action taken to reduce the level of risk.

People told us there were enough staff to meet their needs and we observed people being attended to quickly. One person told us staff "always respond quickly". Family members had mixed views about this. While some felt staffing levels were adequate, others reported occasional delays in their relatives receiving support on some evenings. Care staff told us they felt there were enough staff to meet people's needs, other than on when people received a lot of visitors in the evenings, which happened occasionally. When this occurred, the home could be "very busy" and staff had to spend time responding to queries from relatives and controlling their entry and exit to the home. The registered manager and the deputy manager told us they had recently worked evening shifts to assess the staffing levels and had observed people being attended to appropriately.

A senior representative of the provider told us there was no formal process in place for calculating staffing levels. They determined these by assessing people's needs and seeking feedback from people, families and staff. They said the staffing levels in the evening had been reduced from five to four care staff recently as the number of people and their

Requires improvement

Is the service safe?

level of need had reduced. However, they said this was constantly reviewed, and staffing levels would revert to five care staff in the evenings if people's needs changed or the number of people living at the home increased.

Records showed the process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Staff confirmed this process was followed before they started working at the home. However, we noted that the application form for two staff members did not include details of their full employment history. A full employment history is required to help providers check that staff have the necessary background, skills and experience for their role and that their conduct in previous employment was satisfactory. We discussed this with the registered manager who amended the process to make sure this information was always recorded in the future.

There were plans in place to deal with foreseeable emergencies. Staff had undertaken first aid and fire awareness training. They were aware of the action they should take in emergency situations. Personal evacuation plans were available for all people. These included details of the support each person would need if they had to be evacuated. They were kept in the office, so may not have been readily available in an emergency. However, the registered manager told us they were waiting for a lockable cabinet to arrive so they could be kept in a more accessible place. Essential checks on the environment, such as fire detection, gas, electricity were up to date. Equipment, such as hoists and lifts, were serviced regularly to make sure they continued to be safe to use.

Requires improvement

Is the service effective?

Our findings

Staff sought verbal consent from people before providing care by using simple questions and giving them time to respond. However, they did not always follow the Mental Capacity Act, 2005 (MCA) or its code of practice. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Assessments had been completed which showed some people did not have the capacity to make decisions relating to the delivery of personal care, the administration of medicines and the use of bed rails to stop them falling out of bed. Staff had, therefore, made these decisions for people. However, in some cases they had not consulted with family members and had not documented the specific decisions they had made. We brought this to the attention of the registered manager. On the second day of the inspection they showed us new forms they had introduced to help staff make and record best interest decisions taken on behalf of people. They had started the process of completing these and consulting with family members which would help them to comply with the requirements of the MCA.

The failure to follow the MCA and its code of practice was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. DoLS authorisations were in place for three people and the registered manager was waiting for the local authority to complete assessments of other people for whom applications had been made. Staff understood the significance of these authorisations and the support people needed as a result.

People felt staff were competent and skilled in their roles. One person said, "There's good food and I'm well looked after." A family member said of the staff, "I think they are stunning here. They do a great job."

Staff had completed a wide range of training relevant to their roles and responsibilities. Staff praised the range and quality of the training and told us they were supported to complete any additional training they requested. One staff member told us "We get fantastic training here." Staff were up to date with all of the provider's essential training, which was refreshed regularly. In addition a high proportion of staff had completed, or were undertaking, vocational qualifications in health and social care. Staff used their training, knowledge and skills to provide effective care and support to people. For example, they demonstrated an understanding of their dementia training in the way they spoke with people, by asking simple questions and giving people time to process the information and respond.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. One staff member told us "I was able to learn at my own pace, which was good. We had meetings to discuss my progress and [management] gradually let me do things I was comfortable with." Arrangements had been put in place for new staff to complete the Care Certificate. This is awarded to staff new to care work who complete a learning programme designed to enable them to provide safe and compassionate care.

Staff were supported appropriately in their role and felt valued. They received regular supervisions and yearly appraisals. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. Staff members told us they each had a training and development plan. One staff member said, "We can talk about anything [during supervisions] and if I ask for more training I get it." Another staff member told us the registered manager was "great at encouraging [staff] to develop".

Most people were satisfied with the quality of the food. One person said, "The food's good and there's always something different if you don't like what you're given." A family member confirmed this, saying, "The food is good and [my relative] eats well". However, another person described the food as "average at best".

People who chose to eat in the dining rooms sat in small groups at tables laid with tablecloths, flowers and cutlery. This helped create a pleasant meal time experience for people. People were offered varied and nutritious meals appropriate to the seasons, including cooked breakfasts

Requires improvement

Is the service effective?

daily. Alternatives were offered if people did not like the menu options of the day. Drinks were available and in reach throughout the day and staff prompted people to drink often. People were encouraged to eat and staff provided appropriate support where needed, for example by offering to help people cut up their food or by supporting people on a one-to-one basis. Special diets, including fortified meals and high calorie supplements were available for people who required them. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration and took prompt action when people started to lose weight.

People were supported to maintain good health and had access to appropriate healthcare services. Healthcare professionals such as GPs, community nurses and speech therapists were involved in people's care where necessary. Records were kept of their visits as well as any instructions they gave regarding people's care. A community nurse told us staff always followed any advice or instructions given.

Guidance from the National Institute for Health and Care Excellence (NICE) had been followed in the design of the home. Passenger lifts had been installed to assist people to move around the home. Good lighting levels, bright colour schemes and pictures placed at appropriate heights were used to create an environment suitable for people living with dementia. This helped people navigate their way around the home safely. A variety of seating areas were provided for people to choose from and chairs in one lounge were arranged in clusters to promote conversation. Bedrooms had been personalised with furniture, photos and items important to people; these also provided memory prompts which staff used to promote conversation with people. The garden had been re-designed and provided level access from the ground floor. Raised flower beds and a range of benches created a pleasant, secure, outdoor area for people to spend time in and enjoy views of the sea. This area was also used for events to which friends and families were invited in the summer.

Requires improvement

Is the service caring?

Our findings

Staff did not always respect people's privacy and dignity. On the first morning of our inspection we noticed two people using the toilet in view of other people. On the first occasion a member of staff was supporting a person to use the toilet and had not closed the door. On the second occasion a staff member was exiting the toilet having assisted a person on to it. As the door opened the person was in full view of people walking along the adjacent corridor. We brought this to the attention of the registered manager who took immediate action to make sure this did not occur again.

For the remainder of the inspection we observed people's dignity was respected at all times. Staff knocked and waited for a response before entering people's rooms. When personal care was provided, staff ensured bedroom doors were closed and curtains pulled. Confidential information, such as care records, was kept securely and could not be accessed by people who were not authorised to see it. People had been asked whether they had a preference for male or female care staff; their preferences were known to staff and respected.

Staff developed caring and positive relationships with people by treating them with kindness and compassion. One person said, "I've quickly settled in; all staff are very kind." Another person told us staff gave them "a birthday cake and a small party" on their birthday, which they enjoyed. A family member said of the staff, "Nothing is too much trouble for them. They're all so caring. They always respond to the residents' questions, even when they're repeated many times." Another family member told us "[My relative] is so much happier and out-going since she moved here."

We observed warm interactions between staff and people. Staff were attentive and conversations were not limited to care tasks. They spent time kneeling, so they could engage with people at eye level. When people, for example those living with dementia, became anxious or confused staff remained calm and used supportive prompts and gentle reminders to reassure them. One person had difficulty expressing themselves verbally, but staff were able to identify the person's needs by observing their gestures and body language. This showed staff understood people and their needs well. We heard staff talking to people about their lives, families and interests. One staff member visited the home on their day off to show their very young grandchild to people. From the smiles and comments we saw and heard, people clearly enjoyed this.

People were encouraged to remain as independent as possible in line with their abilities. One person said, "When they take me for a shower they help me wash but let me do what I can." Another person was able to come and go as they wished and needed minimal support. They told us "I know [the staff] are there if I need them, but I like to do my own thing." Comments in their care plan showed staff respected this and encouraged the person to attend to as much of their personal care as they were able to.

Prior to moving to the home, people (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Care plans were then developed to meet their individual needs. Comments in care plans showed people were continually involved in this process and family members were kept up to date with any changes to their relative's needs. A family member told us "We've discussed [my relative's] care; I've seen the care plan and everything I ask for [the staff] show me." Another family member said, "I phone daily and am kept fully informed."

Good

Is the service responsive?

Our findings

People received personalised care from staff who supported them to make choices and were responsive to their needs. One person said, "I can choose when I get up and where I have my meals." Another person told us "Staff have asked if I wish to go out or join activities but at the moment I prefer to stay in my room." A family member told us "[My relative] is so much happier since she came here. They've encouraged her to be involved in the social group and she's settled in really well." The friend of a person said, "Staff make sure residents' needs are met and good communication between staff."

Care plans were created using a computer program. This guided staff to complete a wide range of assessments and helped make sure all essential aspects of a person's care needs were considered. Hard copies of the latest versions of the plans were then printed to provide easy access for staff. The care plans provided comprehensive information about how each person wished to receive care and support. For example, they gave detailed instructions about how staff should support people with personal care, how they liked to dress and where they preferred to spend their day. People were asked about their likes and dislikes and staff respected people's preferences, remembering, for example, how people liked to take their medicines and whether they preferred a bath or a shower. Continence care plans had been developed and provided detailed information about people's individual continence needs and how they should be met. Pain protocols had also been created to help staff identify when people were in pain and to monitor the effectiveness of any pain relief given.

People whose needs caused them to behave in a way that challenged staff were supported appropriately without immediately resorting to the use of medicines. For example, when one person became distressed, staff tried to reassure and distract the person in line with guidance recorded in their care record. Only when these strategies failed to calm the person did staff then administer a medicine to help relax them. Staff then monitored the person over a period of time in case further support was needed. One person could become distressed when receiving personal care and staff knew how to keep them calm and relaxed by using specific techniques that worked well with that person and helped make sure they received essential care.

Reviews of care were conducted regularly by nominated key workers. A key worker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. As people's needs changed, their care plans were developed to ensure they remained up to date and reflected people's current needs. People and their relatives were consulted as part of the review process and their views were recorded. Records of daily care confirmed people received care in a flexible and personalised way in accordance with their individual needs. For example, we saw one person was supported to get up later than usual after having been up late the night before.

Care plans included details about people's backgrounds, interests and life histories. This information was used to develop appropriate activity plans to suit to people's individual needs. The activity coordinator had developed a wide range of activities, including trips out, tea parties in the garden, quizzes and musical entertainment. We observed a music session a singer sang songs people were familiar with and could join in with. Some people had been given simple percussion instruments which they clearly enjoyed playing. One to one activities were also provided for people who preferred not to engage in group activities. A family member told us their relative was "kept as busy as she wishes to be."

The provider conducted quality assurance surveys each year to obtain the views of people and their relatives about the service. Comments from the latest survey were mostly positive, such as: "[My relative] is very happy and that gives me great peace of mind"; "I cannot see how you could improve the care and ambience of the home"; and "Well looked after by caring staff and in comfortable surroundings. Staff look smart and always have time to talk." Where comments indicated improvements could be made, these were identified and acted on. For example, some people were concerned about the laundry arrangements. The registered manager responded to this by discussing it at recent staff meetings and introducing a book for people to record laundry issues, such as missing clothing, on a daily basis. This allowed staff to rectify any problems more quickly. Feedback also showed that family members were not aware of what their relatives had eaten and how they had spent their day, because those living with dementia were often unable to remember. To resolve this, the provider had started posting the day's menu and

Good

Is the service responsive?

activity programme in the reception area, for the information of visiting family members. This provided a topic of conversation for them to talk about with their relatives, which helped build and maintain relationships.

'Residents meetings' were held every three months to provide additional opportunities for people to provide feedback about the service. Minutes of the meetings showed people often discussed menu options. There were no records to confirm whether their requests had been actioned, although most people told us they were satisfied with the current menu.

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. Records showed complaints had been dealt with promptly and investigated in accordance with the provider's policy. The findings of the investigation were documented and the outcome shared with the complainant.

Requires improvement

Is the service well-led?

Our findings

A senior representative of the provider conducted a comprehensive range of audits on a weekly, monthly or yearly basis, depending on their nature. These included audits of medicines, infection control, the environment and care plans. In addition, the registered manager conducted daily checks of care records and staff administering medicines checked the MAR charts each shift. A further audit of medicines by the supplying pharmacy identified remedial actions and we found these had been addressed. However, the medicine audits had not picked up that staff were not dating creams and ointments when opened or that entries in the controlled drug register had not been signed. This, and a lack of understanding of the Mental Capacity Act, had led to breaches of two regulations.

People felt the home was well-led and had a positive atmosphere. One person told us "The home is managed well by [the registered manager] and her team." A family member described the registered manager as "very competent". A visitor said, "The home's got a good feel and a nice outlook."

There was an open and transparent culture within the home. There were good working relationships with external professionals and visitors were welcomed. A whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior person in the organisation, or directly to external organisations. Staff meetings were held regularly to update staff on developments and seek their view about the service. The views of staff were also sought as part of the supervision and appraisal process and the provider used this feedback to help drive improvement.

The provider's objective was to provide high quality training to staff and deliver consistently good quality care to people. Staff understood this aim. They were keen to access developmental training and shared a common goal of providing care to the best of their abilities at all times. The provider had recruited an additional deputy manager with experience in mentoring staff, to help develop staff further and provide additional support to the registered manager. New technology was also being introduced to help staff perform their roles more effectively. This included handheld computers to make it easier for staff to record the care provided and to prompt them when people needed support, such as regular turning to prevent pressure injuries.

There was a clear management structure in place and all staff understood their roles. They told us the registered manager was approachable, effective in their role and encouraged staff to raise any issues or concerns. One member of staff told us "Things are better since [the registered manager] came. She's really hands on and looks after the residents'" Another staff member said, "There's an open door policy and things get sorted out."

The registered manager and deputy managers worked a range of shifts, including occasional night shifts, to provide support and guidance to staff and monitor the effectiveness of each team. The registered manager also conducted unannounced spot checks to make sure people were receiving the care and support they needed.

The registered manager told us they received a high level of support from the provider and had access to advice and support from the local care homes association and trade bodies which circulated information about best practice. They were familiar with the new regulations introduced in April 2015 and were about to start a level five diploma course to further develop their management skills.

The registered manager understood the responsibilities of their registration with us. They notified us of significant events, such as safety incidents, in accordance with the requirements of their registration.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider was not following the Mental Capacity Act, 2005 in ensuring service users were only treated with consent.** Regulation 11(1)(2) & (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider was not ensuring that medicines were managed safely.** Regulation 12(1) & (2)(g)