Buckland Care Limited

Merry Hall Nursing & Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 10 and 11 February 2016 and was unannounced.

Merry Hall Nursing and Residential Care Home provides accommodation, care and nursing support to older people, some of whom are living with dementia. It provides support for up to 32 people; at the time of inspection 28 people lived in the home.

A registered manager was in place. 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.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.
If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

Serious injuries caused by equipment and an unexplained serious injury had not been reported to external bodies. They had not been investigated by the registered manager meaning people may not have been safeguarded. Risk associated with people's care were not always appropriately assessed and action was not taken to reduce the risks of harm to people. Where injuries had occurred, assessments of risk had either not been done or not been reviewed to ensure these did not occur again. Staff had not received training to support them with assessing risk and developing plans of care. Medicines were not managed safely because significant medicines errors were not identified and medicine plans for life threatening conditions were not

always adhered to.

Thorough recruitment checks were not carried out and where concerning information was provided at the time of recruitment, this had not been explored further, meaning people were not protected because safe recruitment practices did not take place. The system for identifying staffing levels was ineffective and at times observation reflected staff were not always present to meet people's needs. Some feedback from people indicated staff response time to them was not always prompt.

People spoke positively about the food they received and the choice they were offered, however unplanned weight loss was not always identified and as such no action was taken to explore why this was happening and take action to address this for people. Where people had an identified need their care had not always been developed to ensure these needs were recognised and met. Care plans were not always personalised, accurate and reflective of people's needs and preferences. Although people could access external healthcare professionals, this relied on prompt staff referrals and good communication which did not always happen.

Observation demonstrated people's consent was sought before staff provided care. Staff and the registered manager demonstrated a limited understanding of the Mental Capacity Act 2005. The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The service had submitted applications for DoLS for some people living in the home to the supervisory body.

Most observations demonstrated staff were compassionate and kind but some also demonstrated staff became easily distracted while providing support which lead to a lack of respect being shown.

A complaints policy was in place but when these were raised we could not see that these were always investigated, addressed promptly and that there was any learning from them. Systems were in place to gather people's views and assess and monitor the quality of the service. These were not always fully effective. Notifications were not being submitted as required.

People and their relatives described staff as kind. They said they felt safe and well looked after. They knew how to make a complaint and felt confident these would be listened to and acted upon. Staff felt supported and received an induction when they first started work which helped them to understand their roles and responsibilities. Supervisions had begun to take place and a plan for future training was in place. Staff demonstrated a good understanding of safeguarding people at risk. They were confident any concerns raised would be acted upon by management.

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

Following our inspection we made a referral to the Local Authority safeguarding team to advise them of concerns we had identified during our inspection. In addition we asked the provider to send an urgent action plan to us outlining how they would address the immediate concerns we had for people. This was submitted promptly and the Local Authority confirmed they were monitoring this action plan.

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.

Safeguarding concerns were not always reported.

Identified risks associated with people's care were not always assessed and plan developed to mitigate such risks.

Recruitment processes did not ensure staff were safe to work with people at risk. Staffing did not always meet the needs of people at all times.

Medicines were not always managed safely.

Is the service effective?

Inadequate

The service was not effective.

Staff had a poor knowledge of the Mental Capacity Act 2005 and the need for best interest's decisions to be made.

Whilst people's nutritional needs were met, weight loss was not always managed effectively.

Access to healthcare professionals relied on staff to do this promptly, with effective communication however this did not always happen.

Staff felt well supported. Supervisions had begun to take place and some training had been planned, however some training needs had not been identified.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always treated people with kindness and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care staff knew people well but the planning of care was not personalised and reflect of people's needs.

A complaints procedure was in place and people knew how to use this. Records of the management of complaints were poor and did not reflect these were addressed promptly or effectively.

Is the service well-led?

Inadequate

The service was not well led.

Systems were in place which monitored the service and gathered people's feedback; however some of these did not identify issues for improvement.

People's records were not always accurate and complete.

Notifications were not always submitted as required.

The manager operated an open door policy and staff were encouraged to share concerns and make suggestions.

Merry Hall Nursing & Residential Care 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.

The inspection took place on 10 and 11 February 2016 and was unannounced.

The inspection team consisted of two inspectors and a specialist nursing advisor. Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications. A notification is information about important events which the service is required to tell us about by law). This Information helped us to identify and address potential areas of concern. Before the inspection, the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home and three relatives. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We also spoke to the registered manager, and 14 staff including nursing, care and ancillary staff. We looked at the care records for 11 people and the medicines administration records for 10 people. We reviewed four staff files in relation to their recruitment and looked at records of supervisions, training and the staff duty rota for the past four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

The service was last inspected on 27 June 2014 and no concerns were identified.

Inadequate

Is the service safe?

Our findings

People spoke positively about the service they received. Comments included "They keep me safe and if I have a fall they are here to look after me", and, "I feel safe here and have no regrets about moving here." Relatives also spoke positively of the service and felt their family members were safe. Our observations and findings did not reflect these comments.

Staff understanding of how to safeguard people at risk was good. We saw that there was a laminated safeguarding quiz describing staff responsibilities, displayed in several areas where staff frequented. Staff were able to explain types of abuse and how they would recognise the signs. They all said they would report any concerns they had to a senior member of staff on duty or the manager for them to take appropriate action. They were confident appropriate action would be taken. Records showed that 13 of 41 staff had not received training about safeguarding but a 2016 plan indicated this would happen this year.

Incidents of safeguarding concerns had mostly been reported to the local authority by the service, including medicine errors. However we found that two serious injuries had not been reported to either the local authority or to the Commission. The registered manager was unable to explain why these incidents had not been reported and confirmed no investigation had taken place. Registered persons are legally required to notify so CQC of incidents such as this so that CQC can determine if the appropriate action has been taken. The failure to report these incidents means people may not have been safeguarded. Following the inspection we reported these incidents to the local authority responsible for safeguarding matters.

This failure to report these incidents of take action based on concerning information was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us how they managed risk day to day, for example, they described how sensor mats were used if people were at risk of falling. However, we found the assessment and management of risk to be unsatisfactory and placed people at risk of harm. For example, one person had an injury caused by an item of equipment. The use of this equipment had not been reassessed following this injury and there was not mention of the risks associated with this, in the person's care records. Prompt and effective action had not been taken following this injury to ensure these risks could be minimised. In addition, records indicated that this person had suffered similar injuries from this equipment before, which meant that the risk of these injuries was known to the service. For a second person we found they had sustained an unexplained injury. The registered manager was unable to demonstrate what action had been taken to identify how this injury may have occurred, to then minimise the risk of any recurrence. Their care records did not reflect the risks that may have caused this injury. For a third person their daily records show they were displaying both verbal and physical behaviours that challenged others. The risks associated with these behaviours had not been assessed. There was no plan developed to identify any triggers to these behaviours or action staff could take to minimise the risk of the behaviours presenting, or minimise the risk of injury should the behaviours occur.

Staff were required to complete incidents and accidents sheets and the registered manager described how

they reviewed these and collated the information. We were concerned about how the registered manager triaged the information collated as they had recorded the injury from the equipment as an injury caused by the person. They said they must have read the accident record wrongly. Triaging this information inaccurately meant the risks associated with the use of this equipment had not been recognised.

The management of medicines was not always safe and the records held were unclear. We found records of a significant medicines error noted by a care worker, in one person's daily notes. This error had occurred approximately one and a half months prior to our inspection. The registered manager and head of care confirmed they were not aware of this error until we pointed it out to them. As a result no action had been taken to ensure this error had not posed any risk to the person and no action had been taken to ensure an error such as this did not reoccur. For another person we saw they were prescribed medicine to help manage a life threatening health condition. The prescription was clearly recorded however we found this was not being adhered to, this placed the person at potential significant risk of harm. A registered nurse was unable to explain why and said it should be followed. The registered manager was unaware of this.

Records of the disposal or destruction of any medicine were unclear. We found for some medicines that required additional levels of recording there were discrepancies in the recording of these medicines being destroyed. The registered nurse on duty could not explain this and the registered manager was unaware until we pointed this out to them. They later told us they had spoken to the registered nurse who disposed of this medicine and they were able to describe what happened. This demonstrated a lack of a robust process for recording and identifying discrepancies in order to avoid any potential mishandling or misappropriation of such medicines.

This failure to effectively assess risks, take action to reduce risk and manage medicines safely was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines in medicine trolleys were stored safely. However medicines that are required to have specific storage facilities were not stored requirement by the Misuse of drugs (Safe Custody) Regulations 1973. No gaps were found in the recording of such medicines administered. Allergy information was clearly recorded. Registered nurses had received competency assessments of their ability to administer medicines.

The provider had a policy in place which detailed the number of staff required to be on duty at any one time. Whilst rotas confirmed the numbers of staff available on each shift met the requirements of this policy, the number of staff available was not always sufficient to meet people's needs. For example, on two occasions we observed people in the communal areas indicating they wanted help and they appeared to be frustrated. No staff were present in the room to respond. On the first occasion we were unable to find a staff member for five minutes. On the second occasion the person waited 10 minutes for staff. We observed that staff often went for their meal breaks together. For example, on one occasion three members of staff were in the dining room with the doors shut, eating their lunch. There were no service users present in this room and these staff could not see any service users with the doors shut. During this time, these staff did not respond to call alarms. This left three care staff available to meet the needs of 28 people during this time and we noted call alarms ringing for prolonged periods before they were answered. Feedback from people about staffing levels was varied. One person said "They come quickly when I press the buzzer", whilst another said, "When I press the buzzer they come quite quickly most of the time." This person also said, "The staff are always busy and don't really have time to sit and chat." The registered manager told us the staffing levels have always been like this and it "just works", however they did not respond when we described the times we had seen people having to wait.

The failure to ensure sufficient staff at all times was a breach of Regulation 18 of the Health and Social Care

Act 2008 (Regulated Activities) 2014.

The recruitment of staff was not undertaken in a way which ensured staff were safe to work with adults at risk. The provider's policy for staff recruitment outlined the process for the registered manager to follow. However, the registered manager was unable to demonstrate that they adhered to this and was unable to demonstrate safe recruitment of staff to the service. We found concerns with three of four staff recruitment records we reviewed. For example, for one staff member, only one reference had been received and this was not from the most recent employer, despite the provider's policy requiring two references, one being from the most recent employer. In addition, according to records, the registered manager was aware of information of concern from an external agency when they recruited this staff member. The lack of sufficient references and information of concern did not demonstrate sufficient information had been gathered to be assured of their good character and conduct. The registered manager confirmed they had not undertaken a risk assessment which demonstrated any potential risks associated with recruiting an applicant, with insufficient references and concerning information had been explored and appropriate measures implemented.

For a second person, two references had been received however one provided dates of employment only and the second reference detailed concerning information which had not been followed up. This did not provide sufficient evidence for the provider to determine someone's conduct in their previous role. In addition, the person had commenced work with a Disclosure and Barring Service check (DBS) from a previous employer while the registered manager said they applied for a new one. The registered manager confirmed they had not undertaken a risk assessment which demonstrated any potential risks associated with unsatisfactory references and no new DBS had been explored and appropriate measures implemented.

The failure to ensure appropriate pre recruitment checks and to ensure the safe recruitment of staff was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

Relatives who had the right to know confirmed staff kept them informed of any changes in the care of their loved ones. People spoke positively of staff and felt they supported them well.

Staff knew the importance of gaining people's consent before undertaking any tasks and giving them choices. We observed staff sought consent before carrying out day to day support tasks with people. They offered choices and gave people time to make these choices. However staff lacked knowledge of the Mental Capacity Act 2005 and told us they wanted training on this.

Care records contained consent forms for a variety of areas including the use of photos, information sharing, personal care and medication. However the majority of these had been signed by the person's relatives and the registered manager did not have evidence that the relatives had the appropriate legal authority to provide this consent.

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 take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. Of six sets of care records all showed the principles of the MCA had not been applied.
For example, one person was receiving one of their medicines covertly. This means medicines were being given to a person without their knowledge or consent. This person did not have the capacity to consent to this care. Health care professional records recorded that their relative had "POA health" and wished for the medicines to be administer covertly. The registered manager said they had a copy of this POA, however when we looked at this allowed the relative to make decisions regarding finance and property, not health and welfare. . This placed the person at risk of receiving their medicines in an inappropriate manner and not in their best interest. For a second person records stated they did not have a cognitive impairment. A relative had signed a consent form regarding the use of bed rails for this person. However there was no evidence this person had the legal authority to make this decision. No assessment of the person's capacity to make this decision had been completed and no best interests discussion recorded around any least restrictive options before the use of bed rails was used.

The lack of robust processes for ensuring that people's rights were protected when consenting to their care was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within this and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood their responsibilities in relation to DoLS. Applications had been submitted

to the local authority responsible for authorising these. The registered manager told us the supervisory body had not yet assessed these applications. They said once a decision was made, the approval and any conditions would be incorporated into people's care plans.

People spoke positively about the meals they were provided with. Comments included "There are very good meals here and I enjoy a glass of sherry before lunch". The chef spoke enthusiastically about their role and how they aimed to meet the needs of people. They had a good understanding of people's preferences, how to offer choices and the types of diets people may need. They described what they did to ensure dietary needs were met and said they relied upon care and nursing staff to keep them informed of any changing needs for people.

Monthly assessments of people's nutritional status were undertaken using the Malnutrition Universal Screening Tool (MUST). 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. Of 11 people's care records we found concerns that for five people, weight loss had not been identified by staff in the home. Whilst people's weight was monitored where this was reducing, the cause had not been explored and no action had been planned or taken. Nutrition care plans made no mention of weight loss, its causes or any plans to address this. For example one person's weight records demonstrated they had lost a significant amount of weight in a period of none month. Their nutrition care plan did not identify if this weight loss was planned or recognise it had occurred for service user A. The registered manager confirmed this was not planned and they were not aware any action had been taken to explore any underlying cause an take action to address this. No plan had been developed to ensure that this person received the care and support required to meet their needs.

People had access to a range of healthcare professionals including GP, dentists, chiropodist and other specialist. Access to these professionals relied heavily on nursing staff making prompt referrals; this was not always done in a timely manner. For example, where we identified weight loss as a concern, there was no evidence of referrals made to specialists. Where care staff had recorded signs of an infection, staff had not promptly contacted external health professionals for support. For example, the daily notes for one person recorded indications of an infection had been reported to a registered nurse. However staff told us contact with a GP surgery had not been made until four days later and was unable to explain why. Care had not been delivered promptly to ensure this persons needs were met, meaning they may have been suffering from an infection for four days before any contact was made with a doctor.

The failure to ensure care is planned and delivered to meet people's needs is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff said they were well supported and felt they worked well together. Records showed new staff received an induction and were required to complete the Care Certificate. The Care Certificate is the standard employees working in adult social care should meet before they can safely work unsupervised. The registered manager confirmed supervisions had not previously been happening regularly and they had a plan to undertake these on a three monthly basis in the future. Records confirmed all staff had received at least one session of formal supervision in the two months prior to our inspection and these allowed staff to discuss any issues they may have, their role, updates regarding safeguarding and team work. Actions were set following these. The registered manager confirmed no appraisal had been undertaken but they intended on doing these this year.

Feedback from staff about training they had received was positive. One staff member told us "We have face to face training mostly, the quality is good and you learn things all the time. We can put up ideas for extra training and if there are enough people interested the manager organises it". Staff confirmed they were

supported to undertake vocational qualifications in health and social care. A staff training database was in place, which recorded training undertaken by all staff. Training was provided in a number of areas including infection control, moving and handling, safeguarding and end of life care. In addition staff had the opportunity to undertake specific training relevant to their roles. From the training records we saw that courses completed recently included dementia awareness, end of life care, use of syringe driver, catheter training, anaphylactic shock and attendance at the moving and positioning and falls conference. These training courses were recorded in individuals file they were not recorded on the training matrix.

However, we identified areas of concerns that effective training would have supported staff's understanding and practice. For example, we found care plans were not always person centred, they did not always cover peoples need and risks had not been effectively assessed. The registered manager confirmed that staff did not received training in care planning or risk assessment.

Requires Improvement

Is the service caring?

Our findings

People's feedback was generally positive. They described staff as kind and caring. One person told us they felt, "The staff are excellent, very dedicated and we are looked after very well". However one person said, "The staff are always busy and don't really have time to sit and chat". A relative told us, "The care in general is pretty good and they treat my relative with respect. I've never noticed them treat anyone in any other way". Our observations did not consistently reflect the positive feedback we received.

Staff were seen to be kind and affectionate, laughing and joking with people. There was a friendly and relaxed atmosphere throughout the two days of our inspection. Staff were able to describe the importance of respecting people's privacy and dignity. They were able to tell us some of the things they did to ensure this, such as knock on doors and make sure curtains and doors were closed when delivering personal care. Staff used a butterfly emblem to indicate when a person had passed away. Staff said this was to ensure staff were aware and to ensure that privacy and dignity was observed. However, whilst staff were able to talk about this we also observed some practice which reflected people were not consistently treated with respect.

For example, on one occasion, two members of staff supported a person from their wheelchair to an armchair using a piece of moving and handling equipment. Staff became distracted during this and did not remain focused on the person's needs. Throughout this the person facial expressions indicated they were anxious and as staff were not focused on this person they did not offer them reassurance. On a second occasion two staff supported another person from an armchair to a wheelchair using a stand aid. Whilst one care worker was moving the wheelchair to the person so they could sit down they became distracted and started to chat, laugh and joke with another person. Staff were heard talking about people in an undignified manner in front of others, in a task orientated manner. For example, "I will go and do x, you go and do y". This was while people were present.

Not all staff acknowledged the support people needed. For example, one person wished to be supported into their chair. Two staff were present in the room and were talking to each other. However, one made no attempt to provide support before leaving the room. The person received the support they needed to move when another carer entered the room. However, one of these carers talked over the person about another throughout the procedure.

Becoming distracted while supporting people, not acknowledging when people required support and talking about people in an undignified manner was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were encouraged to make choices during the day, including the clothes and jewellery they chose to wear, where they spent their time and choices in respect of food and participation in activities.

Staff showed an understanding of confidentiality and told us they would only break the confidence if the information shared put the person at risk. People's records were stored securely and confidentially.

The activity co-ordinator told us how they aimed to do resident meetings monthly. We saw topics addressed included activities, outings, meals and refreshments, small shop supplies and the impact of the planned kitchen refurbishment. Several people contributed feedback at the meeting and the activity coordinator told us of changes made as a result of people's views.

People's cultural and spiritual needs were taken into consideration and accommodated. For example one person told us that their minister visited the home regularly so they could receive communion.

Requires Improvement

Is the service responsive?

Our findings

People spoke positively about the service they received and had no complaints. One relative told us, "My relative has been here two years. When [they] arrived [they] wasn't walking but now [they] is the best I have ever known [them] for talking and mixing. They're a new person"

Staff told us how they provided person centred care. One member of staff said, "Everyone is different and we treat them as individuals". Another told us how a person had written their own care plan thus ensuring that it was person centred and just as they wanted it to be.

Pre admission assessments were carried out prior to people moving into the home. Care plans were then developed and we were told were based on people's individual needs. We saw some care plans were individualised and described the person's preferences and choices about how they wished to be supported. For example in response to the question 'What makes me better if I am anxious?' we noted 'Talking to someone about any problems'. During the inspection we noted that a member of staff had joined them in their room and spent some time talking with them about some issues. However, care plans were not consistently individualised and at times were not promptly developed to ensure all staff had the guidance they needed to support the person appropriately. For example, records showed that one person did not have care plans and risk assessments developed until a couple of months after they have moved into the home. The registered manager was unable to explain why this had happened. This person suffered with a mental health condition that staff would need individualised guidance to ensure they supported appropriately at a time when staff were getting to know the person. The lack of guidance laced the person at risk of not receiving the support they may have needed. Once the care plans were developed planning for to ensure this need was met had not taken place. There was no information about how this condition presented for the person. There was no information about any triggers and no guidance for staff about techniques they could use to support and manage the anxiety. Whilst staff we spoke with told us how they reassured this person, the lack of planning and guidance left this open to personal interpretation by staff.

Where a need was identified for a person, plans of care to meet these needs had not always been developed. For example, one person pre admission assessment identified a recurrent health issue. No plan of care had been implemented to ensure all staff had the information they needed to recognise if this condition was presenting and the action to take. We saw for another person that when this health condition presented for them, whilst care staff had recognised it, registered nurses had not acted promptly. Not having clear plans of care developed for identified needs means people may be at risk because staff may not take appropriate action promptly and when needed.
For a second person who had wounds to their skin, no plans of care had been developed to guide staff about how these wounds were to be treated. A registered nurse told us they did not know what a wound care plan was. Care had not been designed to ensure all staff had the information they needed to meet service user's needs. A lack of guidance leaves delivery of care open to individual personal interpretation by staff, meaning people may not receive the care they need.

Where care plans had been developed they lacked guidance for staff about how a need was met. For

example, one person's nutritional care plan described them as, "Assisted feeds", with no explanation about what this meant. This person had also lost a significant amount of weight that the registered manager could not explain. The lack of clear guidance about what 'assisted feed' means leaves this open to individual personal interpretation by staff meaning this person may not receive the care they need.

Care staff's understanding of people's needs was good. They were able to tell is about what time people liked to get up, how they liked to receive their personal care, what activities they enjoyed and their preferences in respect of food and drink. Most also knew about their family, friends, important life events and some of their interests.

A lack of planning and delivering care based on identified needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were kept updated with handovers and described these positively. However we identified an action for staff, which had been recorded in a person care records, had not been taken. A member of staff said this had been missed because it had not come up in handover. Handovers were not effective in ensuring people's needs were understood and met and the impact of not sharing this information meant closer monitoring of this person did not take place to reduce e any impact further weight loss may have.

The provider had a complaints policy in place and staff were aware what they should do if someone approached them with a concern or complaint. They said they had confidence that the manager would take the complaint seriously. People had a copy of the complaints policy and procedures in their room. People told us they knew how to complain. One person said, "I have never had to complain but if I wanted to I would go to the top and they would do something about it".

Records of complaints and how these had been managed were held in the locked office, confidentiality. Records showed two complaints had been received in the last year. We were not confident that complaints were always addressed promptly and effectively. For example, a senior member of staff spoke to us about one complaint received in May 2015. No records were available to demonstrate how this was addressed. The head of care told us that the complaint had been made to social services by a relative of a person and that the time when the registered manager was away from work for a period of time. An audit had identified a lack of response to the complaint and we were told the registered manager contacted the local authority to discuss this in December 2015, six months after the complaint was received. No records of these discussions were available and there was no evidence the complaint had been investigated. Whilst the complaint had been made by someone who no longer accessed the home, no evidence of any learning was found to ensure others did not have the same experience.

The lack of prompt response to the complaint and records confirming the action taken to investigate and address the issues raised in the complaint was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

People described Merry Hall as a lovely place to work and live. They consistently described the aim of the service as creating a home from home for people, with a family atmosphere where people are able to make their own choices and were well looked after.

A registered manager was in place at the time of our inspection. Staff described the registered manager positively. They said she was open, approachable and listened to them. One described her as having the, "ability to make a team cohesive". The registered manager and staff said that team meetings had been infrequent but had restarted and the registered manager planned to hold these monthly. Records of these showed staff were given updates, reminded of policies and the need to be respectful. They asked for volunteers to become champions in a specific area of care such as "dignity". Staff said that such meetings gave them the opportunity to raise suggestions for improvement to the service. One member of staff told us, "At the staff meeting in September we discussed my suggestion of bringing the staff's break time earlier in the afternoon so there was more time for them to get involved in activities with people later on. This was trialled and has been successful and people have been happy with the change".

The registered manager demonstrated a lack of understanding about what was happening in the home and the action they took to ensure the service was meeting people's needs and ensuring their safety and welfare. For example, they were unable to explain why injuries had occurred and could not demonstrate they had investigated these. They could not explain why care plans and risk assessments for one person had not been implemented for a significant period of time post the person's admission. They could not explain gaps in the recruitment records and reasons why CQC had not been notified of some serious injuries.

The registered manager was unaware of entries in daily records that indicated concerns and confirmed they did not use vital pieces of information recorded by staff to ensure plans of care and risk assessments were effective in meeting people's needs. For example, the registered manager showed us the accident trend analysis they completed monthly using the information gathered from accident sheets. We asked the registered manager if the review of the accident sheets and completion of this analysis prompted a review of peoples care plans or risk assessments and they told us they did not. The system for analysing accidents within the home was ineffective in ensure the health and safety of people.

The registered manager had undertaken audits of care plans. Whilst these audits identified some actions, they did not identify the significant concerns that they acknowledged were noted during the inspection. For example, the audit carried out on 8 and 15 January 2016 did not identify a medicines error that occurred on 1 Jan 2016. The audits did not identify the weight loss concerns and lack of planning around this person's needs. Audits completed in November did not identify the lack of care plan and risk assessments for a person who moved to the home in October 2015. The registered manager confirmed that as part of their audits they did not review any daily records completed by care staff. These records held information about people's needs and concerns identified by care staff. The failure to review these effective meant the audit system in place was ineffective in fully identifying areas that required improvement.

Audits were also carried out by the general manager, however these were not robust . For example, medicines audits carried out on 18 January and 2 February 2016 did not identify the concerns in relation to a person's prescription not being adhered to. A monthly general audit carried out by the general manager was ineffective at driving improvement. For example, the audit carried out in December 2015 identified concerns regarding the lack of safe recruitment practices and had set a timescale for completion. However this had not been addressed as significant concerns continue to be noted at this inspection.

People were asked to complete feedback surveys and following these the registered manager said they analysed them and detailed actions taken or to be taken. However the action plan did not address all of the areas of feedback to help aid service improvement. For example, when asked about 'Promptness of staff attending to your needs', 30% of people rated this as 'fairly satisfied' with 20% of people rated this as 'not very satisfied'. The registered manager was not able to explain what had been done to look at all the responses where people were "fairly satisfied" or "not" satisfied in order to drive continuous improvement. The lack of effective analysis of people's feedback meant plans had not been developed to take on board service user's feedback and make improvements.

Records were not always accurate and available. For example, one person's information about medicines was conflicting. A second person's care plan for medicines referred to the use of a medicine for a physical health condition. However it the said what staff should do in relation to anxiety attacks, if this medicine was not effect. Staff confirmed the care plan was not accurate and were aware of why this medicine was given and what they should do however the records provided inaccurate information. For a third person staff could not find records about health care professional contact and visits.

This failure to ensure accurate records and effective systems to monitor the service to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

Registered persons are required to notify the CQC of a range of matters and significant incidents, which occur within the home. The provider did not ensure they notified CQC of such events. The registered manager had a period of time away from the home but confirmed to us they had returned at the beginning of August 2015.We had not been notified of the registered manager's return from a period of absence. This was a breach of Regulation 14 of Care Quality Commission (Registration) Regulations 2009.

We found records which showed two people had sustained serious injuries in the home. We had not been notified of these. Registered persons are legally required to notify so CQC of incidents such as this so that CQC can determine if the appropriate action has been taken. The registered manager was unable to explain why we had not been notified of these matters. The failure to notify CQC of theses injuries was a breach of Regulation 18 of Care Quality Commission (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 Registration Regulations 2009 Notifications – notices of absence The registered person had not notified CQC of the registered managers return. Regulation 14(5)

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 person had not ensured they notified CQC of significant events that occurred in the home. Regulation 18(1)(2)(a)(iii)(b)(ii)

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 People were not treated with dignity and respect at all times. Regulation 10(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The registered person had not ensured appropriate consent was sought. Where required the Mental Capacity Act 2005 was applied appropriately. Regulation 11(1)(2)(3)

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 Service users were not protected because the systems to ensure safeguarding concerns were investigated and reported were not effectively operated. Regulation 13(1)(2)(3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Complaints were not acted on promptly and effectively. Regulation 16(2)

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 person did not demonstrate that staffing levels were sufficient to meet the needs of people at all times. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not ensured care and treatment was appropriate and planned to meet the individual needs of people. Regulation 9(1)(a)(b)(c)(3)(b)(i)

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake weekly audits of poeple's care plns, risk assessments and medication and to send a report to the Commission on the last day of each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Diagnostic and screening procedures Treatment of disease, disorder or injury	The registered person had not ensured medicines were managed safely. Effective assessment of risk was not undertaken and appropriate action taken to mitigate such risks. Regulation 12(1)(2)(a)(b)(c)(g)

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake weekly audits of poeple's care plns, risk assessments and medication and to send a report to the Commission on the last day of each month.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Diagnostic and screening procedures Treatment of disease, disorder or injury	Systems in place to drive improvement were not effective. Records were not accurate and always available. Feedback from others was not always used to make changes. Regulation 17(1)(2)(a)(b)(c)(e)(f)

The enforcement action we took:

We imposed a condition on the provider requiring them to undertake weekly audits of poeple's care plns, risk assessments and medication and to send a report to the Commission on the last day of each month.

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 person had not ensured recruitment procedures were operated effectively. Regulation 19(2)(3)(a).

The enforcement action we took:

We served a warning notice on the provider