Merstone Hall Limited

Merstone Hall

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?	**Inadequate**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

The inspection took place on the 19, 20 and 22 February 2018 and 12 March 2018 and was unannounced.

At the time of our inspection the service was providing care to 35 older people some of whom were living with a dementia and mental health conditions.

Merstone Hall is a nursing 'care home' in Bournemouth for up to 45 people in Bournemouth. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The manager has been registered with CQC since June 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in May 2016 the home was rated Good.

At this inspection we identified serious failings and shortfalls in the care, treatment, wellbeing and safety of people living at the home. These failing and shortfalls placed people at risk of harm. We raised multiple individual and whole service safeguarding alerts with the local authority, who are responsible for investigating any allegations of abuse. We also shared these concerns with the provider, registered manager and other statutory agencies.

The provider and registered manager did not take action in response to feedback provided by the local authority and clinical commissioning group (CCG), health and social care professionals to improve the care and treatment provided to people.

During the inspection a plan was put in place by statutory agencies to reduce the immediate risks to people. The provider and registered manager cooperated with the statutory authorities. This plan included checks on people's welfare made by health and social care professionals. Following the fourth day of our inspection health and social care professionals were visiting the service daily to monitor people's care, treatment, welfare and safety.

People did not receive the care and support they needed and this placed them at risk of harm or neglect. Their health and care needs were not always met because the care and support they needed was not delivered. People did not receive the fluids they needed to keep them hydrated, people were not repositioned to minimise the risk of pressure sores and people were not supported to use the toilet or have their continence wear changed. Risks to people were not managed or mitigated and this placed people at risk of harm and neglect.

People had poor mealtime experiences and some people were placed at risk by not receiving specialist modified diets.

Staff did not know enough about people as individuals to be able to provide personalised care. Some people were not treated with dignity and respect and staff did not respect people's privacy. Not all of the staff were caring in their approach to people. Some staff did not smile at people or reassure them when they were upset or worried.

People did not receive a personalised service that was based on their needs and preferences and there was task focused approach to care. Some people who were cared for in their bedrooms did not have anything to occupy them.

There were not enough nursing staff to meet peoples' nursing needs and to administer people's medicines as prescribed. Medicines were not managed safely. People did not receive pain relief when they needed it. Most staff did not have the knowledge, experience or communication skills to be able to understand and communicate effectively with people who were living with dementia. Some staff were not recruited safely, they did not receive any formal support sessions and they did not all have the training they needed to be able to meet people's needs.

The service was not fully meeting the requirements of the Mental Capacity Act 2005. Staff were not fully aware of the principles of the Mental Capacity Act 2005 and making best interest decisions. This meant people's rights were not protected and their consent was not sought when making decisions.

The home was not well-led and there were no clear management arrangements in place at the home. The findings throughout the inspection showed there was a failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others who may be at risk. In addition, there was a failure to assess, monitor and improve the quality and safety of the services provided. The systems in place had not identified the shortfalls we found for people or driven improvement in the quality of care or service provided.

We identified 12 breaches of the regulations and 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.

The provider gave the statutory authorities two weeks' notice that they planned to close the home and find new placements for the people living at the home. The home closed on 28 March 2018.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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

People were not kept safe at the home.

Risks to people were not managed to make sure they received the correct care and treatment they needed.

The management and administration of medicines was not consistently safe. People did not receive their medicines as prescribed.

There were not enough nursing staff to meet people's needs. Some staff were not recruited safely and some staff did not have the skills to be able to meet people's needs.

Some areas of risks in the building and environment were not safely managed.

Is the service effective?

Inadequate

People's needs were not effectively met because staff did not have the right skills and knowledge, training and support to meet people's needs.

People's rights were not effectively protected because staff did not understand the implications of the Mental Capacity Act 2005.

Some people did not receive the food and drinks they needed to make sure their nutritional needs were met.

Some people did not receive appropriate support to meet their health care needs to ensure that they were comfortable and protected from harm. Some people were referred to specialist healthcare professionals when needed.

Is the service caring?

Inadequate

The service was not always caring.

Staff did not treat people with respect or maintain their dignity and privacy Relatives told us staff were kind and caring. However, this did not reflect our findings and not all staff were caring in

their approach.

A small number of staff acted with kindness and had good relationships with people.

Is the service responsive?

Inadequate

The service was not responsive to people and their needs.

People's care plans did not reflect their current needs so staff knew what care they needed. Staff did not always provide the care to people that was included in their plans.

People did not have things to stimulate them and keep them occupied.

Complaints information was displayed but it was not clear what actions were taken in response to complaints.

Is the service well-led?

Inadequate

The home was not well-led.

There was not any effective oversight of the home and the safe delivery of care and treatment to people.

There were ineffective systems in place to monitor the quality of the service and drive forward improvements.

Notifications of safeguarding allegations, investigations or people's injuries had not been made to CQC. This meant that we were unable to monitor that appropriate actions were being taken.

Merstone Hall

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 was prompted by safeguarding concerns being raised with CQC.

The inspection was on 19, 20 and 22 February 2018 and 12 March 2018. It was unannounced on the first and fourth days. The inspection was conducted by one inspector, an assistant inspector and a specialist nursing advisor on the first day of the inspection. There were two inspectors on the second and fourth days of inspection. An inspector and an assistant inspector conducted the third day of the inspection.

During our inspection we met and spoke with all 35 people living at the home, three visiting relatives and one visiting friend. Some of the people living at Merstone Hall no longer used words to communicate, we spent time in communal areas and observed how staff supported and spoke with them. We also 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. We also spoke with one of the directors [provider], the registered manager, four nurses, seven care staff, the cook and two students.

We looked at specific elements of five people's care, health and support records and care monitoring records. In addition we looked at elements of 35 people's daily monitoring records. We looked at people's medication administration records and documents about how the service was managed. These included four staff recruitment files, five agency staff profiles and the staff training records, audits, meeting minutes, maintenance records and quality assurance records.

Before the inspection we looked at notifications we had received about the service. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. We spoke with commissioners and safeguarding professionals to get information on their experience of the service.

Following the inspection, we asked for additional information from the provider. They sent us an action plan with their immediate and short terms actions, information about how they provide end of life care, staff training matrix, information about how they had covered nursing staff shortfalls and people's preferences in relation to where they like to have their meals.

Inadequate

Is the service safe?

Our findings

On our arrival at 7am on the first day of inspection people did not have access to their call bells so they could seek assistance from staff. On the third day of inspection one person's call bell was not working and this had not been identified by staff. People were put at risk because they could not seek staff support when they needed it. People sat in the lounge did not have access to a call bell or the means of calling for staff assistance. On the third day of the inspection one person needed assistance and we found them the lounge call bell and gave it to them so they could seek assistance. On the fourth day of the inspection most people had access to their call bells. However, we needed to seek staff assistance for some people because they couldn't reach their call bell or they needed staff assistance and they were not able to independently use the call bell. This was because people were thirsty, uncomfortable or needed their incontinence wear or their position changed.

The registered manager told us when people were cared for in their bedroom, there was an hourly system of recorded checks of people. This was meant to ensure they received help when they needed it. However, people were not checked hourly and the records were not completed to show this. For example, on the first day of inspection, we checked one person from 7.30 am and throughout the morning. Their records had not been completed from 8am until 12pm. These records were then completed at 13:35 to show that fluids had been provided throughout the morning and the person had been repositioned. This was not accurate and did not reflect our observations. This placed the person at risk of dehydration and skin damage.

People had care plans that told staff how often they needed to be supported to move in order to protect their skin. The plans also detailed whether people were to be cared for on specialist air mattresses and be sat on specialist pressure cushions. People were not repositioned in line with these care plans or the records did not reflect the position people were in. For example, we observed one person who needed to be moved every four hours was not repositioned from 7.30 until 1.35pm. They remained in the same position sat up on their back but the records showed they had been turned on to their right side at 11am. This was not accurate and did not reflect our observations.

Another person who was assessed as at risk of developing pressure areas and was cared for on a specialist air mattress. On the first day of inspection, this was set at the wrong weight setting of 25 kg but the mattress check records showed the mattress was set on the correct setting of 60-75 kg. The person was then sat in the lounge in an armchair without a pressure cushion for over four hours without being repositioned or being taken to the toilet. The person was not sat on a pressure relieving cushion on all three days of inspection. This placed the person at risk of developing pressure areas. The person also had an open wound on their face but records and body maps showed that this person's skin was intact. The person had previously received treatment for this wound. However, there was not any plan in place as to how staff were to manage the wound at the start of the inspection.

A third person was sitting on a hoist sling in an armchair on two days of the inspection. The person's care plan did not specify if the sling was an in situ sling which meant it was safe for them to sit in. Staff told us the sling was an in situ sling but following the inspection we checked the type of sling and it was not safe for the

person to sit in. This placed the person at increased risk of pressure sores.

A fourth person who had a pressure sore on their heel had their feet pressing on the end of the bed base. The person told us they constantly slipped down so their feet pressed on the bed base board. We identified this to staff on the first three days of the inspection who agreed to take action to ensure this person's feet were not at risk of further pressure damage. The community nurses visited the following week and still no action had been taken and the person's pressure sore on their heel had deteriorated and they had developed pressure damage to their toes and base of their feet. On the fourth day of the inspection their feet were not pressing against the bed base, however, the person was not repositioned for over six hours and they were not sat on a specialist pressure relieving cushion. The person told us their sacrum was sore.

On the fourth day of inspection, we found thirteen people, including those people identified above, who were at risk of developing pressure sores were not repositioned, were not taken to the toilet or did not have their continence wear changed for over six hours. This placed them at increased risk of pressure damage to their skin because their position was not changed and their incontinence wear was not changed. People's care plans included they needed to be repositioned at least every four hours to reduce the risks of pressure damage to their skin.

Other risks to people's safety were not assessed or managed safely. For example, we, alongside the registered manager, observed one person trying to climb over their bed rails. This meant they were at risk of falling over the rails and that the use of bed rails was not appropriate or safe. We needed to seek additional staff to reassure the person and respond to them wanting to get out of bed. By the fourth day of the inspection no action had been taken in response to these risks identified and the person still had bed rails in place.

People's prescribed fluid thickening powder was left unattended in an upstairs corridor and on a trolley in the main lounge. This thickening powder places people at risk of choking and harm if it is ingested directly without being mixed with fluids. We told staff when the powder was left unattended so they could store it safely. However, on the fourth day of inspection two tubs of prescribed thickening powder were again left unattended on a trolley in an upstairs corridor. We told staff about this so they could store it safely.

People's medicines were not consistently safely managed. One person told us, "I don't get my tablets at the right time…I don't like it at night time. They say when they [staff] think you should have them [tablets] not when you want them. The staff get a bit cross with you when you ask".

Some nursing staff explained to some people what their medicines were and asked them if they wanted pain relief. They gave people time to take their medicines and stayed with them until they had taken them. However, nursing staff were still administering people's morning medicines at 11.30 on the first day of the inspection. Nursing staff told us it took between two and three hours to administer people's morning medicines. People did not have their medicines at the times recorded on the medicines administration records (MAR). There was not any system for recording the actual time of medicines so that sufficient gaps could be left between doses of medicines. Nursing staff told us they knew themselves what time that they had administered people's medicines so they could ensure there was sufficient gap between doses. This system was not safe because the times of administration were not recorded. The provider told us that care staff would be trained in March 2018 in the administration of medicines so they could administer medicines in addition to the nursing staff.

People did not have their creams applied as prescribed. The cream records did not identify where and how often people's creams were to be applied.

The plans for as needed (PRN) medicines did not include the circumstances of when staff should administer the medicines. This meant staff did not have clear information as to when people needed this medicine. For example, one person's PRN medicine plan for constipation did not include how many days of the person not having their bowels open before staff needed to administer the medicine.

Medicine's administration records had been completed to show people's medicines were administered. Medicines were stored securely and safely during the inspection. We checked the specialist medicines storage and register. The stock and register tallied and the nursing staff checked this daily.

We looked at the provider and registered manager's systems for assessing the skills and competencies of the nursing staff. We reviewed two of the nurses' staff files and they both last had their competency to administer medicines assessed in 2015. This meant their competency skills and knowledge in relation to medicines administration had not been assessed on an annual basis in line with NICE guidance.

Most care staff working at the home did not have English as their first language. Most people living at Merstone Hall were living with dementia and some had complex and different ways of communicating. Staff had not had appropriate support and training, reflecting their language needs, to enable them to communicate effectively. This meant staff could not understand and fully communicate with those people living with dementia. One person told us that staff did not take the time to listen and understand them. This was because the person took a long time to be able to verbalise what they wanted to say. Another person told us they did not use the call bell because "it doesn't work". We checked the call bell which did ring. However, the person went to explain, "yeah, it rings but they do not understand". The care staff who responded to the call bell tried to help but they did not understand what the person wanted because of their English language skills. A third person told us, "It would be nice if staff could speak better English. I sometime have difficulty talking with them".

Some staff told us they needed to ask some staff to translate to the other staff instructions on how to care for people. This meant that staff who needed this support would not be able to understand people particularly those people who were living with dementia and may communicate differently.

There were two overseas students working at the home on a student exchange programme. They told us they were not able to provide any person care to people but were able to assist people to eat and drink. Only one of the students was able to understand our questions but the second student relied on the other student to translate. We observed the students assisting people to eat but there was not any evidence of what training they had received in relation to supporting people to eat and drink who had modified diets and fluids.

These shortfalls in people's risk management, medicines management, and staff having the competencies, experience and skills to safely deliver people's care and treatment were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found multiple examples of records not being completed accurately in relation to the care provided, foods, fluids, repositioning, the location and position of people. We raised this serious concern about the accuracy of the records and that they did not reflect the care, fluid and food intake for people we had observed with the provider and registered manager. People's records, care provision checks were still not consistently being recorded or happening on the third day of inspection. The registered manager was present when we reviewed the records on the third day of the inspection and acknowledged the shortfalls found.

We received feedback from visiting health and social care professionals between the third and fourth days of inspection who confirmed that people's records were still not being completed accurately. On the fourth day of the inspection people's records had improved slightly but they still did not accurately reflect their current skin state or detail the care and support provided. For example, one person had significant bruising on their arms and this was not recorded on the skin integrity and body map in the care records in their bedroom. Another person had a dressing on their arm that was not recorded on their body map completed by care staff. This meant we could rely on people's records to show they had received the care and treatment they needed. This was important because most people living at Merstone Hall were living with dementia and not able to tell us, or staff, about their experiences.

These shortfalls in record keeping were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not enough nursing staff on duty to make sure that people's medicines were administered in a timely way and to ensure people's assessed nursing needs were met. The provider and registered manager told us that based on the dependency of the people living at the home they needed two nurses on duty during the day and one at night. However, since 28 January 2018 to the first day of the inspection there were 18 of the 22 days where there was only one nurse on duty.

The registered manager told us there was high turnover of staff at the home. Over 50% of the care staff working at the home were employed through a staffing agency. The staff employed and appointed by the provider either directly or through a staffing agency were not recruited safely. This was because, the provider and registered manager had not ensured they had sought all the documentation and evidence as required by the regulations to make sure that staff were safe to work with people. For example, there was evidence that some staff started work at the home before ISA first and DBS checks were received. The provider told us that these staff had only worked in the kitchen and laundry and they did not have any contact with people. However, there were not any risk management plans in place or recorded about this. However, the dates of the staff's induction records, staff rotas and staff signing in and payroll records did not correspond. In addition, no police checks had been requested from the staff's country of origin when they had recently arrived the UK. There were also gaps in staff's employment records. For some staff who were not European citizens there was not any evidence of right to work in the UK.

The registered manager confirmed that two of the staff employed via the staffing agency had lived at the home in empty bedroom. There were not any records of when and where in the home they stayed or evidence of assessments or management of any risks. There were not sufficient checks of the safety and suitability of these staff and this placed people at risk of potential harm from staff who may be unsuitable.

One nurse's PIN (registration) number had not been checked since August 2017 to see if they were still registered to practice as a nurse. The records showed the nurse's registration expired on 31 October 2017. The registered manager took immediate action and confirmed the nurse was registered. However, there was not a system in place to regularly review nurses PIN numbers.

These shortfalls in staffing and staff recruitment were a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had received safeguarding training and they knew how to report any allegations of abuse. We reviewed a safeguarding investigation completed by the registered manager following a request by the local authority. The registered manager had not included all of the information about the person's accident and the location where they were found. The registered manager told us they had not omitted this

purposely. However, this information was important because it demonstrated that the person was not being observed at the time of their fall. This should have led to the person's plans being updated and the learning from this being shared with staff.

In response to the serious concerns we identified during our first day and fourth days of the inspection we raised safeguarding alerts about named people and for the whole service. These safeguarding concerns related to the risk management and safety of people, the quality of the care they received, lack of fluids, delays in people receiving support to reposition and having their continence needs met.

The shortfalls in safeguarding people from abuse and investigating allegations was a breach of regulation 13 of the Care Quality Commission (Registration) Regulations 2009.

CQC had not been notified of any safeguarding allegations or investigations either referred by the registered manager and provider or investigated by the local authority. This meant the commission was not aware of any allegations or outcomes of any investigations. This is important as we need this information so we can have oversight or any concerns and safeguarding incidents at the home.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

People were not protected adequately from the risk of infection and the building and décor were not well maintained. One relative told us they thought the home was clean and well maintained. However, we found people were being cared for in an environment that was difficult to keep clean. Seals on floors were not intact and paintwork was missing from walls and woodwork. This increased the risk of infection as the cracks made it difficult to clean them effectively. Carpets were worn; there were malodours in the lounge and in five people's bedrooms. The floors in the shower rooms were stained and they smelt stale. The wardrobes and large items of furniture in people's bedrooms were not secured to walls. These meant they could potentially be pulled over and injure people. This risk had not been reviewed.

Some people's bedroom furniture was worn and damaged. Some people's bedding was worn, stained, threadbare and their pillows and quilts had holes in them. We raised this with the provider who told us they had purchased new bedding, pillow and quilts. However, on the fourth day of the inspection some people still had threadbare, stained bedding, quilts and pillows. The sluice on the first floor was leaking on to the corridor carpet.

Staff had access to and wore appropriate protective clothing and gloves. However, staff did not always understand when it was appropriate and dignified to wear protective clothing.

There were systems in place for fire safety at the home, this included evacuation plans for people (PEEPs), fire fighting equipment and a fire risk assessment. However, the fire alarms were not always tested weekly, the provider did not sign in and out of the building, one person's PEEPs did not reflect their changed mobility and the fire risk assessment had not been reviewed since the changes in their mobility. The provider said they had reviewed the fire risk assessment but had not recorded this and said they also knew they should sign in in case of fire but again had not.

These shortfalls were a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no evidence or any systems for reviewing and sharing learning from accidents/ incident and or safeguarding investigations. A staff member told us there was good culture for reporting incidents but were

not able to give any examples of learning from accidents/incidents or medicines errors. Any lessons learnt from safeguarding or accidents/incidents were not included in any staff memos, meeting minutes or staff supervision.

There were systems in place to ensure the safety of the premises, including regular servicing of equipment. There were up to date service certificates for premises equipment and services, which included, electric portable appliance testing, legionella, gas safety, fire alarms, fire extinguishers, call bell alarms and safety certificates for the lift and lifting equipment such as hoists.

Inadequate

Is the service effective?

Our findings

The provider sent us the staff training matrix following the inspection. Records indicated that staff had undertaken training deemed mandatory by the provider. However, this was not evident in their skills, knowledge, the care and treatment provided to people and interactions with people. For example, staff failed to identify people's needs, follow people's care plans and deliver the care they needed.

The staff employed by the provider and through a staffing agency had training certificates in their staff files issued by the provider's trainer. The provider and registered manager confirmed that staff had received training in the following subjects all on the same day: communication, health and safety, manual handling, infection control, catheter care, MCA and DoLS, safeguarding, dignity, dementia, dysphagia and thick and easy, modified diets and equality and diversity. We requested the provider send us information in relation to the content of the training programme. This was not provided so we could adequately review the content to see whether it could provide staff with the skills and knowledge they needed.

Staff told us they had received training in mental health. This was particularly important because the home was caring for some people with diagnosed complex mental health conditions. There was contradictory information in relation what staff told us they had and the training records and training certificates. For example, the staff training information we reviewed during the inspection and sent to us following the inspection did not include that any staff had received specific mental health training. Another staff member told us they had received catheterisation training within the last six months but the last date recorded on their training records was April 2016. The staff induction and training dates recorded for staff in their staff files and staff training matrix did not correspond with the payroll records and staff rotas. This meant that these records were not accurate and we are not able to make a judgement about the staff training provided.

New staff did not complete the care certificate or an equivalent induction. The care certificate is a national induction programme for people working in health and social care who do not already have relevant training. This meant staff new to care had not been provided with the training, skills and knowledge to be able to effectively meet people's needs.

Staff who had worked at the home for over a year told us they had received an annual appraisal. However, when we reviewed the records for one staff member their last recorded appraisal was in 2015. We looked at records relating to staff support and supervision for four staff. We found they had not received any formal recorded supervision sessions. However, staff told us they did receive formal supervision. In addition, there were not any arrangements in place for the supervision of the staff recruited through a staffing agency. This was of concern because these staff were working regularly at the home and some were working up to 60 hours a week at the home.

These shortfalls were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people's needs were not fully assessed before a decision was made to admit them to the home. This

had resulted in staff not being able to meet one person's complex mental health needs because they did not have the appropriate skills and knowledge. This had meant there was a deterioration in how well the person was and this was impacting on the person and the other people they lived with.

People's health needs were not effectively met. Referrals had been made to appropriate health care professionals for some people and some records were kept by staff to monitor people's nursing interventions. There was evidence of people being referred appropriately to dieticians, speech and language therapists, community mental health teams, psychiatrists and specialist consultants. However, this was not consistent for all people and the guidance from external health professionals was not always followed and planned for. For example, dressing advice given and wounds plans devised by the tissue viability nurse were not followed.

Body maps did not accurately reflect people's wounds and plans were not in place how these were to be managed. One person had an open wound on their head that was not recorded and there was not any treatment plan in place.

Another person had a wound on their arm that was not recorded. There was not any recorded explanation or body map as to how this had occurred. This person was also diagnosed with infected teeth and gingivitis. The person's dentist and GP also had prescribed gel and a mouth care plan was put in place. Throughout the inspection the person's mouth and teeth were visibly dirty and had food debris on them. The person had not had their prescribed gel and mouth care twice a day. We fed this back to the registered manager. This person was assessed by the community district nursing team one week following the inspection and the person's mouth care and prescribed gel had not been provided as detailed in their plan. On the fourth day of inspection the person's care records showed they still were not having their oral care twice a day. This put the person at risk of discomfort and further risks to their health.

A third person was not having creams applied to their eczema and dry skin as prescribed and the person was continually complaining of being itchy.

Some people did not always get pain relief appropriately and their pain was not assessed or managed in conjunction with health professionals. On the first day of the inspection, one person who was living with dementia, was calling out and saying they were in pain. We spoke with nursing staff who told us the person was able to say when they were in pain and this meant they did not need to use a pain assessment tool with the person. However, care staff had not responded to the person calling out in pain or informed the nursing staff who administered medicines. On the second day of inspection nursing staff had used a pain assessment tool with the person and this had identified they were in pain and pain relief had been administered. On the fourth day of inspection this person told staff their stomach was hurting and staff said they would tell nursing staff. However, the person was not given their pain relief until two hours later. The person told us later they were much more comfortable after they had their pain relief.

Another person told us they had pain everywhere all the time. They said, "I don't bother" when asked whether they told staff. The person was prescribed a pain relief gel and said "It helps when they rub it in, sometimes they do it sometimes they don't depends on how busy they are that's all I hear now [from staff] "we've got a lot more residents". According to the medicines records this gel was applied three times a day. However, the person was clearly saying their pain was not being managed and this had not been identified or referred back to the GP for a review.

A third person had a complex health condition and wounds that were painful. Nursing staff from the home told us and the person told visiting community nurses their pain was not managed. The person's wounds

were not being dressed with the correct dressing and nursing staff were not following the instructions of the tissue viability nurse. Community nurses identified the person may have had an infection when they visited and gave advice for nursing staff to swab the person's wound and request the GP to review the person's pain management. This was not actioned until four days later. Staff had not recognised the need to make a referral for pain management and the person's potential infection. This impacted on the person's health and wellbeing.

Staff did not support people to wear specialist equipment to relieve pain and to reduce the risk of skin injury. For example, one person had a contracted arm and hand and had palm protectors they needed to wear. The person did not have their palm protectors on for 15 hours on the second day of the inspection. We fed this back to staff. On the fourth day of the inspection, the person did not have their palm protectors on and their finger nails needed trimming and were digging into their skin.

These shortfalls were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

Staff did not have a working understanding of MCA and making best interest decisions. For example, there were best interests decisions in place for people who had the capacity to make decisions. People were routinely restricted by bed rails and these decisions did not reflect the least restrictive option and had not been made in the person's best interests. For example, one person was assessed at low risk of falls and was not able to reposition themselves but a best interest decision was recorded to use bedrails to reduce the person's risk of falls. Other least restrictive options such as lowering the bed and placing safety mats had not been considered for people. This and other decisions had been made by staff and had not included the views of representatives who were actively involved in the person's life. Some people's records indicated that they had a Lasting Power of Attorney arrangement for health and welfare and/or finance. This meant people would have appointed people to help make decisions or make decisions for them. However, copies of these were not seen to ensure those representatives had the relevant authority to act on the person's behalf. The provider and registered manager told us they knew this was an area they needed to improve and had requested additional training in relation to MCA and DoLS.

These shortfalls were 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 the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We spoke with the registered manager about their responsibilities in regard to the Deprivation of Liberty Safeguards (DoLS). They were aware of the three people who had DoLS authorised with conditions. The registered manager was able to describe what they had done in relation to meeting these conditions. However, there was not any recorded or documentary evidence as required to show how the conditions were being met and for one person this was

part of their conditions.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had poor mealtime experiences in a chaotic and noisy environment. There were two televisions and music playing simultaneously on each day of the inspection in both the lounge and dining room during meal times. People were not offered the opportunity to sit at a table before each meal. The provider told us people had been consulted about where they wanted to eat their meals. They sent us a document that showed some but not all of the people's preferences. It was not clear how some of the people made this choice as they were living with dementia and were not able to communicate their choices about other day to day matters. The document also detailed people would be asked before each meal where they wanted to eat. This did not happen. There was only table seating set for eight people on the first three days of inspection. There were not enough tables for all of the people to have the opportunity to eat their meals with others if they wanted to.

People were not offered a choice of drinks or given visual choices or descriptions of meals. By the fourth day of inspection staff were offering people visual choices of food. During all our observations no one was offered salt, pepper or any other condiments.

On the first and second days of inspection different staff supported each person throughout their meals and staff did not communicate with each other so they knew what the person had eaten and drank. Most staff did not chat with people or explain what they were eating and offered no explanation when they left them to assist another person. We fed this back to the provider and manager. On the fourth day of inspection one staff member supported each person. However, people waited for over an hour to be supported with their meals, when other people sat next to them had theirs.

One person complained they did not have breakfast and asked for second helping of dinner but staff did not understand what they said and did not provide this.

Some people did not have their dentures in so they could eat their meals. We observed people left the meat because they were not able to chew it. Staff did not offer people any support to cut up their food or notice they did not have dentures in.

Plate guards and coloured crockery were not used to make the food easier for people living with dementia or sight loss to see and scoop food from the plates without spilling it. We fed this back on first day and the provider said they had this equipment and coloured crockery so they were not sure why they were not being used. No action was taken in response to our feedback and on the second, third and fourth day of the inspection people were still eating from plain white plates without plate guards.
These shortfalls in ensuring people received appropriate support to eat and drink were a breach of Regulations 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The cook was not aware of the names of people who had specialist diets and or soft or pureed foods but just the numbers of people. They were not able to explain how they provided the tea time choices in a soft or pureed meal. The provider told us that sandwiches, sausage rolls, pork pies etc. were pureed with beans or spaghetti. This contradicted what was written on one person's food record and what they told us what they had eaten. This person had been assessed as requiring a soft diet. People's food records did not detail that the foods were soft or pureed. Staff did not consistently know who needed soft or pureed diet. The local authority contract team fed back that following our fourth day of inspection this person who needed a soft

diet had been given a plate of biscuits. This placed them at risk from eating unsuitable foods.

On the fourth day of inspection, some people did not receive enough to drink to keep them hydrated. The systems in place for monitoring peoples' fluid intake were not effective. This was because although there were records and totals of what people had drank the previous day, where people had received a low fluid intake, the staff did not make sure that peoples' fluid intake was increased the following day.

People were potentially placed at risk from staff who did not have the skills and knowledge to safely support them to eat. For example, a new staff member on their first day in the home was left unsupervised to feed one person who was in bed. This put the person at risk because there are risks associated with being supported to eat and with eating in bed.

These shortfalls in ensuring people were supported safely to eat and drink were a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the design and adaptations in the home to see whether it met the individual needs of people living with dementia. Some bedroom doors had been painted bright colours but the colours used did not reflect national good practice guidance. For the first three days of the inspection there were no names or anything on most people's bedroom doors to make it easier for each individual to recognise their bedroom. The majority of décor was in neutral colours in the upstairs corridors and for some people living with dementia they would not have been able to distinguish the differences between doors, furniture and walls. It is recommended that action be taken to make the physical environment of the home more accessible to people living with dementia and that national best practice and guidance be taken into account.

Inadequate

Is the service caring?

Our findings

Staff had a poor understanding of how to maintain peoples' privacy and treat people with respect. For example, one person was wheeled on a commode from the shower room to their bedroom with just a towel on with most of their body exposed. On the first day of the inspection, staff used privacy screens to block our view of when they were moving people. However, they did not consider that other people and visitors were still able to see the person being moved and hoisted. On the second day of inspection staff were providing personal care to one person on their bed with their bedroom door open. On the fourth day of inspection staff were still providing personal care to people with their bedroom doors open. We had fed back our concerns about this during the first three days of the inspection. Staff did not check with people whether it was ok for them to start providing personal care whilst we were in their bedrooms. Because the staff were starting to provide people's personal care we told people we would leave so they could have some privacy.

On the fourth day of the inspection some staff continued not to be respectful of people. For example, one person was asleep in their bedroom whilst we sat in their armchair looking at their care records. A staff member came in to the person's bedroom without knocking with a new member of staff who was working at the home on their first day. The staff member said the person's name and they did not respond, the staff then tapped them on their face with their fingers and the person still did not wake. The staff then spooned hot food into the person's mouth without explanation and whilst the person's eyes were still shut. The person then shouted loudly that the food was hot and was burning their mouth. The staff member then gave them a cold drink without letting them know it was coming and whilst they continued to have their eyes shut. The staff member then repeatedly said the person's name to wake them up. The person shouted at the staff to shut up and go away. The staff member did not respect the person's wishes and this meant the person became upset and agitated.

Another person who was living with dementia, had been very content throughout the day in their bed and had interacted with us whenever we spoke with them. When staff were supporting the person with personal care and hoisting them into the chair, the person was very distressed, upset and was screaming whilst staff were in the room with them. Staff did not stop what they were doing or offer any reassurance to the person. We intervened and went into the person's bedroom to reassure the person. The person continued to try and lash out at staff but the person was reassured by our presence, held our hand and relaxed. The person became very upset and agitated when the staff came back into the bedroom. The staff had not acknowledged the person's wishes to stay where they were, that they were frightened and they did not recognise that what they were doing was causing distress to the person.

Staff had stored another person's specialist chair in the bedroom of another person without asking their permission. This did not respect the person's personal space.

Some people's clothing was dirty and had food spilt on it and staff did not notice and offer to change people's clothing. Some people looked unkempt and their hair was not styled and was greasy. Staff meeting minutes from February 2018 included that staff were not to wash people's hair when they have a shower unless it was needed as this is done by the hairdresser. This did not acknowledged people's preferences or

choices about whether they wanted their hair washed when they had a shower. We raised concerns with the registered manager about people's hair being greasy, unkempt and long, they told us this was because some people's relatives would not pay for people to have their hair done or cut by the hairdresser. However, staff had not taken any other action to ensure that people's preference in relation to their appearance was met.

Some people's finger nails were dirty and others had nail varnish that was worn away. We raised this with the provider and registered manager. They told us people's nails were trimmed and cleaned by the second day of inspection. However, there remained some people by the fourth day of inspection who had still not received any nail care and no action had been taken prior to the inspection to ensure people's hands and nails were cared for.

Staff automatically placed an apron on people before their meals and referred to these aprons as 'bibs'. We acknowledge that people may wish to have an apron to cover and protect their clothing. However, people were not given a choice about this, it was not dignified to call them 'bibs' and did not respect that people were adults.

People's assessments only asked if they preferred female carers not whether they preferred male carers. This could be important for individuals and is a human rights issue for some people in relation to their faith and beliefs.

For the first three days of inspection people's names were not on their bedroom doors and staff did not always use people's preferred names. The high turnover and use of new agency staff whose first language was not English impacted on their ability to know people's names and to get to know them as individuals. For example, some staff did not know people's names when we asked them or they called people by the wrong name.

Some people's curtains and rails were hanging off the walls. Which meant the curtains could not be drawn whilst they received personal care ensuring people's privacy and dignity.

These shortfalls were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four relatives told us the staff were kind and caring and they were happy with the care their family members received. We observed some very positive and warm interactions between some people and some staff but unfortunately this was not consistent.

Inadequate

Is the service responsive?

Our findings

People who were cared for, or preferred to stay, in their bedrooms, including those people living with dementia, did not have any stimulation, anything to look at watch or anything to hold, feel or occupy them. One person told us they would like to listen to their radio but when we tried this did not work. Another person told us there television only had one working channel and another person told they loved dance music but they did not have anything to listen to music on. A third person's bed was facing a blank wall and not the window. The person did not know why this was. We fed back our concerns about the lack of stimulation for people in their bedrooms during the first three days of the inspection. No action had been taken by the fourth day of inspection and some people being cared for in their bedrooms still did not have anything to listen to, watch or occupy them.

There was an activities worker who played word, colour and counting games with individuals. However, these were not based on peoples' preferences. We observed that staff spent time with those people that it was easier to engage and communicate with. This meant those people with different communication and, or who were living with dementia, did not have the opportunity to spend time with staff, be occupied and engaged with others. These people became withdrawn into themselves during our observations. One person told us they were low in mood, bored and they were not offered the opportunity to sit and chat with other people who were able to.

The televisions and radios were all on at the same time in the communal areas. We fed this back on the first three days of the inspection. However, this was still happening on the fourth day of the inspection. People were not watching the television nor were they asked what channels or music they wanted to listen to. Call bells were loudly audible in the communal and bedroom corridors and this would have an impact on people's well-being.

People did not receive a personalised service. People's personal histories or preferences were not recorded in their care plans. People's cultural, religious, sexual identity, sexual orientation and social needs and preferences were not identified. This meant staff did not have information about people as individuals and were not able to provide care and support that was personalised to them so their wellbeing needs were met. When we asked some staff about people as individuals they did not know people's personal histories or any personal information about them. The lack of personalisation impacted on people's emotional wellbeing, we observed people being withdrawn and some people were isolated.

The registered manager told us, and we saw, people's care plans were out of date and did not reflect people's current needs. This meant that staff did not have clear directions on how to provide care, support and treatment to meet their personal care, nursing care and social wellbeing needs.

People were allocated one day a week for a shower but this was not based on any recorded personal preferences. This did not allow for people to have more than one shower a week on their specified day. One person told us if you missed your day for a shower that you were not offered another one the following day.

These shortfalls in meeting people's needs and preferences were a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place. However, the complaints information displayed did not include the contact details of the local authority.

Relatives and visitors did not raise any concerns or complaints with us. Some people who were able to tell us about their experiences raised concerns with us and their views have been reflected throughout the report. Complaints were not investigated appropriately. We reviewed the complaints records and saw one complaint that had been recorded. However, there were not any details as to what action had been taken in response or how any lessons learnt had been shared with staff. There was a complaint raised by one person's family that was recorded in a 'meetings' folder and not as a complaint or concern. There was no evidence of any action being taken in response to the concerns raised.

This was breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no-one receiving end of life care at the time of the inspection. We saw a selection of compliment and thank you cards from relatives, expressing their thanks and appreciation of the care and support they and their relatives had received at the end of their lives. Two relatives from the same family told us their family member had had an end of life care plan in place when they were very unwell the previous month. The relatives, provider and nursing staff told us anticipatory medicines had been prescribed to make sure the person would be comfortable at the end of their life if this was required. However, the person had now recovered and was now doing well. The relatives told us they were very happy with the care their family member had received at Merstone Hall and with their significant improvement in health.

Inadequate

Is the service well-led?

Our findings

The home was not well-led by the provider and registered manager. The provider organisation was made up of two directors, only one of the directors was actively involved in the oversight and management of the home. The provider and registered manager were both registered nurses. The systems for assessing, monitoring and improving the safety and quality of the service were not effective and had not identified the serious shortfalls we found during the inspection. There was no oversight, direction or management of the day to day delivery of people's care and treatment. These shortfalls had seriously impacted on people's safety, health, welfare, quality of life and wellbeing.

The registered manager acknowledged at the start of the inspection that they had not managed to keep on top of all of their managerial responsibilities. This included the auditing and monitoring people's care plans and other checks. They said this was because they had needed to support the nurses on duty and because there had not been a deputy manager in post since the end of December 2017.

There were some systems in place to audit the administration, storage and recording of medicines. However, these audits and checks were completed by the nursing staff that administered the medicines rather by the registered manager or provider who would have some independent oversight. These audits did not identify any shortfalls but this did not reflect our findings.

The provider told us they visited and monitored the home most days. However, because the provider did not sign in at the home there were not any records of when they had visited. When the provider completed any written audits such as environmental audits these were signed and dated. There was a quality assurance check completed in December 2017 and this did not identify any shortfalls. These audits and checks completed did not reflect the findings of the inspection.

The provider told us the previous deputy manager who left at the end of December 2017 had undertaken unannounced spot checks including during the night. The records of these spot checks could not be found. The provider and registered manager had not undertaken any further spot checks since December 2017 to check if people were receiving the care they needed. The registered manager undertook an unannounced weekend spot check between the third and fourth day of inspection.

The provider and registered manager had not made the improvements needed following visits made by the local authority and clinical commissioning group (CCG) contract monitoring teams in April 2017 and February 2018. The local authority contracts department had also been offering the provider and registered manager support visits, telephone calls and development opportunities. This support was implemented following their previous monitoring visits and the admission of eleven people into the home over a two day period.

During the inspection we identified shortfalls and serious concerns for the same people that the local authority and CCG identified the week prior to our first three days of the inspection. In response to the concerns we found we asked the provider to send us an action plan detailing what actions they planned to

take to address the serious concerns identified. This was received before the fourth day of the inspection. As part of the immediate actions taken the provider confirmed they would not admit any further people to the home and they would increase the monitoring of the care provided to people. The action plan also included that the provider was planning to recruit a deputy manager, another nurse and nursing assistants. The other actions and assurances put in place by the provider in relation to ensuring people received the care and treatment they needed were not effective and we identified on the fourth day of inspection that more people had been placed at further risk of harm.

We reviewed the staff meeting minutes. The meeting minutes for September 2017 showed the provider and registered manager had directed staff to wash and dress people in their day clothes and leave them in bed. This reflected our findings for people on the first day of the inspection. We also saw staff minutes that included staff were to only spend 20 minutes with each person. The provider told us this was a misinterpretation of the meetings because of the English skills of the staff recording the minutes. We raised concerns with the provider that as they were present at the meeting they had responsibility to ensure the minutes were accurate reflection of the meetings and any instructions given. The provider acknowledged this.

The communication between the provider, registered manager, nurses, care staff and ancillary staff was ineffective and this had impacted on the safety of people and the care they received. There was a handover twice a day and there was a written summary of each person's needs for care and nursing staff. However, this did not include all of the information staff needed to be able to care for people. This was important because of the high use of agency staff and staff who did not know people or could not effectively communicate with people.

The records kept about the care and treatment, food and fluids people received, the staff employed and appointed and, the management of the home were not accurate, the records included conflicting information and were not contemporaneous. The provider told us the poor culture about accurate record keeping had been raised with staff at the last staff meeting. However, there were not any references to record keeping in any of the staff meeting minutes we reviewed for the last year.

Food and fluid records did not accurately reflect what people have eaten and drank on the first three days of inspection. Records were completed showing people had eaten and drank when we observed they had not. We also received feedback from the local authority and CCG contract monitoring team that they had identified this the week prior to our inspection and fed this back to the registered manager.

The shortfalls in assessing, monitoring and improving the safety and quality of the service, record keeping and the other governance systems were a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had completed annual surveys with people, their relatives and some visiting professionals. These had been returned between July and December 2017. The surveys from relatives were all positive about the service and care provided.

The last inspection report from May 2016 was displayed in the hall way of the home. We checked the provider's website prior to inspection and there was not any rating displayed or link to the CQC website included as required by the regulations. The provider informed us they had been aware of this requirement for approximately two years and knew the website needed to be updated. This meant that people who had accessed the website were not aware of the provider's rating and latest inspection report. The website was updated following the inspection.

The failure to display the home's rating was breach of regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

CQC had not been notified of significant events, such as safeguarding allegations and serious injuries to people, as required by the regulations. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them. Following the inspection the provider submitted two notifications. However, the provider and registered did not submit notifications for all of the allegations of abuse identified prior to the inspection or a serious injury sustained by a person during the inspection period.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

The provider told us they were proud of the care they provided and how they had admitted eleven people in November 2017 over a two day period from a home that was closing. They told us they believed there had not been any impact on those peoples' wellbeing. However, this was contrary to some of the feedback we received from people, our observations and the findings at this inspection.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There were shortfalls in ensuring people's rights were protected in line with the Mental Capacity Act 2005

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The processes and systems for safeguarding people were not effective.

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