Avery Homes (Nelson) Limited

Merlin Court

Inspection report

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Ratings

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

Overall summary

Merlin Court provides accommodation which includes nursing and personal care for up to 62 older people. At the time of our visit, 50 people were using the service. The bedrooms are arranged over two floors. The ground floor provides care and support to those people who are living with dementia and/or require personal care. The first floor provides support for those people who require nursing care. There are communal lounges and a dining area on each floor with a central kitchen and laundry. The home is part of Avery healthcare who took on the running of the service in November 2014.

The inspection took place on 22 and 23 July 2015. This was an unannounced inspection. We carried out this inspection as we had received a number of concerns relating to the care being provided to people living in the home and about how records were being kept. During our last inspection in May 2014 we found the provider satisfied the legal requirements in the areas that we looked at.

A registered manager was employed by the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

Some people's care plans did not always identify how care and support should be provided. This meant that people were at risk of not receiving the care and support they needed.

Whilst most people and their relatives spoke positively about the care and support they received it was evident throughout the inspection there was a significant divide between the safety and quality of services provided on the first floor and the ground floor. We found that whilst care on the ground floor was centred on the person we did not always experience this on the first floor. Staff on the first floor did not always inform people of what they were doing when providing care and support. Staff did not always respond to people's requests. There was a lack of consistency with how staff supported and cared for people.

There were not enough staff available on the first floor to fully respond to people's care and support needs. People on the first floor went for long periods of time without any social interaction. In contrast there were enough staff on the ground floor to meet people's care and support needs.

Whilst there were systems in place to reduce the risk and spread of infection. Staff working in the service did not consistently apply infection control practices. Most staff we spoke with were clear about their responsibility in regard to infection control.

Staff knew how to identify if people were at risk of abuse and what actions they needed to take should they suspect abuse was taking place. The registered manager dealt with and responded to all safeguarding concerns.

People were supported to eat a balanced diet. There were arrangements for people to access specialist diets where required. There were snacks and drinks available throughout the day during our inspection.

Staff managed medicines safely and ensured people received their medicines as prescribed.

The registered manager had systems in place to monitor the quality of services people received. People using the service and their relatives were regularly asked their views about the services people received.

We found six 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 the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

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

There was not always enough staff available on the first floor of the building to ensure that people received appropriate support.

Whilst there were systems in place to reduce the risk and spread of infection. Staff working in the service did not consistently comply with infection control practices.

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse.

Requires improvement

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

People using the service on the first floor did not always receive effective care from staff who had the knowledge and skills they needed to carry out their roles.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed

People had food and drink available to them throughout the day.

Requires improvement

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

People on the first floor where not always treated with dignity and respect. They were not always involved in their care and support.

We observed that staff on the ground floor were attentive and respectful towards people they were supporting.

Requires improvement

Is the service responsive?
This service was not always responsive.

We looked at four care plans and found that some guidance did not always identify how care and support should be provided. This meant that people were at risk of not receiving the care and support they needed.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. Most people were confident their concerns would be listened to and appropriate action taken.

Requires improvement

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

Requires improvement

Summary of findings

It was evident throughout the inspection there was a significant divide between the safety and quality of services provided on the first floor and the ground floor and this was due to a lack of leadership on the first floor.

The registered manager had systems in place to monitor the quality of service.

People and their family were regularly involved with the service and their feedback was sought by the provider and the registered manager.

Merlin Court

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 July 2015 and was unannounced. Two inspectors carried out this inspection with support from an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service. During our last inspection in September 2013 we found the provider satisfied the legal requirements in the areas that we looked at.

Before we visited we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

We used a number of different methods to help us understand the experiences of people who use the service. This included talking with eleven people and seven relatives about their views on the quality of the care and support being provided. We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records which included four care and support plans, staff training records, staff duty rosters, staff personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices throughout the day.

During our inspection we observed how staff supported and interacted with people who use the service. We spoke with the registered manager, the residential care manager, four registered nurses, eight care workers (which included agency staff), the activities co-ordinator, housekeeping staff and the head of catering. We arrived early on the second day of our inspection to speak with night staff.

Requires improvement

Is the service safe?

Our findings

We found that on the first floor there was not always enough staff available to meet the needs of people living in the home. Staff did not always have time to spend with people. Staff said "We work as a team, it's busy but we pull together" and "It would be good if we had time to really talk to people when providing care, but it can be a bit rushed." One member of staff said "It would be really good if someone was free to be with people in the lounge." One relative told us "I can never find a member of staff and have actually gone and knocked on other people's doors to find someone." We observed another relative knocking on people's bedroom doors trying to locate a member of staff during our visit.

At 12.05 pm on day two of our inspection, people on the first floor were still waiting to be assisted with their personal care and to be able to get up out of bed. A relative told us "I visited at 11.30 am one day and (family member) was still in bed."

We observed that people living on the first floor often went for long periods of time without any interactions with staff. For example, after lunch we saw that most people were sat in the lounge area. One person was constantly shouting out to other people to "Shut up" which other people found upsetting, however no member of staff came into the lounge to offer people any support for the two hours we were sat at the nurse's station. We also observed that some people on the first floor were left for long periods of time in their room with no interaction from staff. People sitting in communal areas were not given call bells and had no way of alerting staff if they needed assistance. As staff were not able to sit in the lounge with people there was a risk that people were not having their needs met.

The service was not proactive in respecting people's diversity and preventing potential conflicts between people living in the home. There was a risk of one person using the service causing harm or distress to other people living or working at Merlin Court. During the inspection we witnessed a member of staff being hit by this person. Although all members of staff on duty were aware of the risk, they did not demonstrate a consistent approach in reducing the risk of harm for others. This person was left sitting in-between people who were not able to move away from this person should they choose to hit out. Staff were not present in the communal area for long periods of time and appeared unaware of the risk posed by this seating arrangement. One relative told us "My young grandson won't visit anymore because he gets scared when visiting if one of the residents is shouting and swearing."

The registered manager informed us that staffing levels were reviewed against people's needs. Whilst we looked at the staff roster which indicated there was a consistent level of staff each day, on the first floor there was a high level of agency staff being used. Through conversation with agency staff and observation, not all agency staff were familiar with the needs of people and told us they had not read care plans. For example, many of the people using the service were unable to mobilise independently and needed to be moved using a hoist. Details of which hoist and which size sling to be used were clearly documented in care plans. We observed staff moving people using the hoist. Permanent staff knew which size sling was required to move people safely, but not all the agency staff knew this information as they had not read people's care plans. There was a risk that due to the high number of agency staff being used that the wrong size sling could be used if a permanent member of staff was not available to assist with the procedure. This could cause harm to people being hoisted and to the staff hoisting them.

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

Whilst there were systems in place to reduce the risk and spread of infection. Staff working in the service did not consistently comply with infection control practices. Although the hoists were visibly clean, slings were shared between people. This contradicts the guidance issued by The Department of Health on the Prevention and control of infection in care homes (2013) which states that "slings should be laundered in the hottest wash cycle allowable according to the manufacturer's instructions and not shared between residents". Slings were hung from hooks in the lounge area and there was no information available for staff to indicate if slings had been cleaned or which person they should be used for. Only one person using the service had a sling dedicated to their personal use. This meant people were at risk of cross contamination because the slings were shared and there was no cleaning schedule in place.

There were aprons and gloves available for staff to use. We observed staff wearing personal protective equipment and

Is the service safe?

during discussions, staff were knowledgeable about their role in the prevention and control of infection. However, during observation we saw staff did not wash their hands or use hand rub before or after transferring people using the hoist. This was not in accordance with the provider's procedure which stated staff should perform hand hygiene before and after direct resident contact.

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

Assessments were undertaken to identify risks to people who used the service. When risks were identified appropriate guidance was in place to minimise potential risks. For example the provider had carried out risk assessments in relation to falls prevention, malnutrition and the moving and handling of people. However the registered manager had not identified the risks posed by people sharing the same slings and the lack of infection control. They had also not identified strategies to reduce the risk from one person using the service causing harm or distress to other people living or working at Merlin Court.

On the ground floor people and staff told us there was enough staff to meet people's needs. One person told us "I am safe and comfortable. I have no worries about being safe. I know and trust my carers." A relative said "I feel my relative is safe here because staff know what they are doing. I have no worries when I leave."

Staff had received training on how to protect people from abuse and were knowledgeable in recognising signs of potential abuse. They felt confident with reporting any concerns they may have and that appropriate action would be taken by the management team. Any concerns about the safety or welfare of a person were reported to the manager or residential care manager who investigated the concerns and reported them to the local authority safeguarding team as required.

Medicines were managed safely and in accordance with the provider's guidance. People were assisted with their medicines when needed and were not rushed. Medicine Administration Records (MAR charts) had been signed and were completed. Some people were receiving their medicines covertly. This is when medicines are concealed in food or drink. Where this was happening people had been fully assessed and a best interests decision had been taken in conjunction with the GP. Nobody was self-administering their medicines. Protocols for 'as necessary' medicines had been completed for people in line with the provider's procedure.

Medicines were stored safely and disposed of in accordance with the provider's procedure. Medicines requiring refrigeration had been stored in the fridge and the temperature log was completed and up to date. Bottles of medicines had all been dated and signed when opened. This meant staff were aware of when medicines would expire. However, there were not always photographs of people on the front of their MAR charts. This meant there was a risk of medicines being incorrectly administered because staff who were unfamiliar with the people using the service, such as agency nurses, may not know who people were. We discussed this with the agency nurses administering the medicines. Both said they relied on the permanent care staff informing them who the person was if they did not know. This was not safe practise. Some people using the service had a "preferred name"; this meant the name they responded to was different to the name on the MAR chart which could increase the risk of a medication error. Although a medication audit had identified the missing photographs during February, this had not been completed. We discussed this with the registered manager during our inspection and when we returned on day two, it had been addressed.

There were safe recruitment and selection processes in place to protect people receiving a service. All staff were subject to a formal interview in line with the provider's recruitment policy. Records we looked at confirmed this. We looked at six staff files to ensure the appropriate checks had been carried out before staff worked with people. This included seeking references from previous employers relating to the person's past work performance. Staff were subject to a Disclosure and Barring Service (DBS) check before new staff started working. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Requires improvement

Is the service effective?

Our findings

People on the first floor did not always receive effective care from staff who had the knowledge and skills they needed to carry out their roles. For example, one person was in bed and making coughing and choking noises. The person was receiving a PEG feed, (Percutaneous Endoscopic Gastrostomy) which is used when people are unable to swallow or to eat enough, and needed to be in an upright position in order to prevent choking. When we observed them coughing, they were not in an upright position as directed in their care plan. Agency staff walked past the room and did not go in to see if the person was alright nor seek assistance from the registered nurse who eventually went in to attend to the person.

When people displayed behaviour that might cause distress to others, this was not dealt with consistently by staff. We observed staff responding to people in different ways. For example, one person who was calling out was offered reassurance by one member of staff but had been ignored previously by another member of agency staff. Some permanent staff said they had been trained on how to deal with behaviour that may appear challenging and they were familiar with people's care plans whilst other staff said they were not. Some staff on the first floor gave positive examples of how they dealt with situations for example, one member of staff said "If (person's name) becomes agitated, I sing to them which calms them down." When we looked at the provider's training matrix there was no record of staff having undertaken training in how to manage behaviour that may be challenging or dementia awareness.

There was no clear leadership for staff on the first floor because of the high use of agency staff. The registered manager explained that they had been without a deputy manager on this floor for several months. A permanent member of staff said "I don't mind working with agency care staff; most of them work here a lot so I've got to know them" and "It can be a bit difficult when we (care staff) know more about people than the nurse in charge."

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

People using the service on the ground floor received effective care from staff who had the knowledge and skills they needed to carry out their roles. All permanent staff , on the ground floor, we spoke with and observed demonstrated they had the necessary knowledge and skills to meet the needs of the people using the service. They were able to describe people as individuals. Staff knew about people's likes, dislikes and preferences. People on the ground floor felt they received a good quality of care and support as they had developed good relationships with staff. One person said "I'd rather be here than on my own." Another person said "I've worked hard all my life. I quite enjoy being here."

Staff were aware of their roles and responsibilities. Newly appointed care staff went through an induction period which included shadowing an experienced member of staff. Staff told us they received the core training required by the provider, such as safeguarding, infection control, manual handling and health and safety. Training records confirmed this. Regular meetings were held between staff and their line manager. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meeting would also be an opportunity to discuss any difficulties or concerns staff had. Staff said they felt supported by both the registered manager and the residential care manager. They said they could approach them at any time to seek guidance and support.

People's healthcare needs were regularly monitored. There was evidence of regular consultations with health care professionals where needed, such as dentists, doctors and specialists. Concerns about people's health had been followed up and there was evidence of this in people's care plans.

People had access to food and drink throughout the day and staff supported them when required. People told us they enjoyed the food provided by the home. Comments included, "The food here is very good. It tastes and looks nice" and "There is always plenty to eat and if you don't like what is on offer then chef will make you what you want."

People who were having their food and drink intake monitored had up to date and completed charts in place. People's weights were monitored and staff had documented if advice regarding supplements had been sought. Where people had specific food preferences these had sometimes been met. For example, one person's plan stated they only wanted to eat a few things and they were

happy to have a limited diet. The person had been assessed as having capacity to make this decision. The chef continued to visit the person to check if their personal preferences had not changed. However, another person's care plan stated they liked tomato sauce at mealtimes. On both days of our inspection the person was not asked if they wanted tomato sauce with their meal, even though a labelled bottle was available for them in the kitchenette area of the dining room.

The head of catering manager told us they received information from staff about people's dietary requirements. They would also go and chat with people and their relatives about their menu preferences. People had access to specialist diets such as pureed and soft food where required.

CQC is required by law to monitor the application of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

The Mental Capacity Act 2005 sets out what must be done to make sure that the rights of people who may lack mental capacity to make decisions are protected, including when balancing autonomy and protection in relation to consent or refusal of care or treatment. This includes decisions about depriving people of their liberty so that they get the care and treatment they need where there is no less restrictive way of achieving this. DoLS require providers to submit applications to a 'Supervisory Body', the appropriate local authority, for authority to do so.

During the inspection, the registered manager told us they were in the process of making applications for DoLS authorisations. Applications had been submitted by the provider to the local authority and they were awaiting a response. Appropriate assessments of people's capacity to make decisions had been undertaken and best interests decision had been taken in conjunction with the other health and social care professionals.

Requires improvement

Is the service caring?

Our findings

It was evident throughout the inspection there was a significant divide between the safety and quality of services provided on the first floor and the ground floor.

Staff said they knew how to maintain people's dignity, but we did not observe this consistently. On the first floor we saw some positive interactions between staff and people using the service. Most people were treated with kindness. For example, we observed one member of staff showing compassion and concern for someone who was distressed and they walked and talked with them in order to relieve the anxiety. Staff were gentle with people, crouched down to their level when talking to them and knew people by name. However, not all interactions we observed were positive. We also observed staff ignoring people who were calling out. Staff did not always knock before entering people's rooms or explain why they were entering the room. For example we observed one member of staff enter a person's room in order to put some gloves in their bathroom. They did this without knocking or speaking with the person. This showed a lack of respect that this was the person's room and staff should ask permission or make the person aware before entering.

We observed lunchtime on both days of our visit. The lunchtime experience for people was not always positive. Although the meals looked and smelt appetising and people said the food was "Very nice", the experience for people who could manage to eat their meal independently was very different to those who needed assistance with their food. On both days of our inspection we observed members of staff support two people to eat at the same time. This showed a lack of respect for people and did not maintain their dignity, although staff did interact with the people they were assisting asking "Is it warm enough?" and "Would you like some more?" One member of staff said "It's normal for us to feed two people at the same time. I know it's not ideal though, it's undignified."

On another occasion a member of agency staff was encouraging a person to eat their lunch. The person was adamant they did not want lunch; they said they felt unwell and wanted to go back to their room. Even though the person became upset the staff member continued to ask them to eat more of their lunch. The person's choice not to eat their lunch was not respected. A permanent member of staff eventually stepped in and provided reassurance and took the person back to their room as they had requested.

Staff on the first floor appeared task led rather than person led. After lunch people were all taken to the communal lounge area. People were not asked if this was what they wanted to do. People were lined up to wait to be hoisted from their wheelchairs in to an armchair. We observed that staff did not offer reassurance to people during this task. For instance people were told they were "Going up" but staff did not check they were alright and tell them what was going to happen next. People were not asked where they wanted to sit. When we asked a member of staff why people were taken to the lounge area they said "We always take people into the lounge after lunch, I don't know why, we just do."

People were not asked if they wanted the television or music on. Music playing had been put on several hours earlier and was just playing continually. People did not have any social activity or interaction for the rest of the afternoon. We observed staff focussing on tasks such as putting the laundry or cutlery away and not spending time with people.

A relative told us "Some of the carers are lovely, but there are others who are only here for the money. I don't feel confident that the agency staff really know (relative's name)" and "Sometimes the staff don't seem to think. They put the CD player on in the lounge and the TV is still on too, so you can't hear either properly". We saw this happen during our inspection until a member of staff switched one off.

Staff were able to explain their understanding of how to gain consent to care and treatment. However, consent to care was not always sought before staff assisted people on the first floor. For example staff did not ask if one person was happy to be hoisted from their wheelchair to an armchair. Instead they just said "We're going up". After lunch people were not asked if they would like to sit in the communal lounge and were just taken there by staff.

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

On the ground floor we saw staff were patient and polite when supporting people. We sat in the communal lounge

Requires improvement

Is the service caring?

on the morning of the first day we visited. When staff entered the room they greeted people by saying "Hello" and asking how they were. We observed an agency worker supporting a person who was reading the paper. They sat with the person talking about the news on each page of the paper. The person looked relaxed in their company smiling and touching the person's arm during their conversation.

Staff were respectful and caring in their approach to supporting people. Where people needed assistance staff sought their permission before assisting them, explained what they were doing and offered reassurance throughout the task. We observed lunchtime on one day of our visit. Staff checked people had enough to eat and asked people if they wanted any more when they had finished. Staff took time to reassure people when they were anxious. One person was anxious about where to eat their lunch. Staff asked if they would like to sit at another table and organised for their lunch to be set up where they chose to eat. The person then sat down and enjoyed their lunch. Staff came back every so often to check the person was alright and they were eating their lunch.

People on the ground floor spoke positively about the care and support they received. One person told us "The girls are very kind and the care is really good." Another person said "All the staff are very kind and caring."

People were asked if they preferred a male of female staff member providing their personal care. People on the ground floor told us they could express a preference for a male or female staff member. Not all people on the first floor were able to tell us there preferences but it was noted on care plans we reviewed.

One member of staff said "I really care about the people here and I know I do a good job" and another said "I really like working here, I feel very passionate about my job."

Requires improvement

Is the service responsive?

Our findings

During our inspection we looked at seven people's care and support plans and identified that some information on how people should be supported was missing. For example we looked at the diabetes care plan for one person. It informed staff to "Observe for signs of hypoglycaemia and hyperglycaemia." It did not explain what the terms meant and did not list the signs staff should observe for. This meant the person's health could be at risk because staff would not know the signs of ill health.

One person who could become anxious and verbally abusive to both staff and people using the service did not have any guidance in their care plan on how staff should support them during these times. We observed that staff treated the person differently when the person was being verbally abusive. Some staff just ignored the person, other staff tried talking to the person but responded differently. We saw that in records the person at times had been taken to their room when they had been verbally abusive. There was no guidance in place to state what staff should try before doing this. This person was also sat with their back to everyone during lunchtime. We observed that they kept trying to turn around whilst in their wheelchair to engage with other people. When we asked staff why they seated this person this way they explained it was because they thought the person might like to look out of the window. Health professionals had been involved in observing this person to assist the service in developing guidance on how best to support this person. However there was no guidance to support this in the person's care plan. This meant the person was at risk of receiving inconsistent care from staff to help them manage their behaviour.

In another person's care plan it stated they had a history of 'verbal and physical aggression'. Again there was no detail of how the person should be supported during these times. A health professional had written in the person's notes that 'Staff should pick their battles' with this person'. The registered manager had not sought clarity as to what this statement meant and produced guidance on how best staff could support this person. There was also a statement written by a staff member which said 'if they kick off and hurt anybody we can call the police'. There was no clarity as to what 'kick off meant' and how staff could support the person in this situation.

Daily support plans for people were kept in their bedrooms. These contained a one page summary of the person's background and interests and personal care needs. Agency staff said they read these to gain an overview of how people needed to be cared for. Permanent staff also said they read these rather than read the care plans in full because "There isn't enough time." Care staff said they were not involved in writing care plans despite providing care for people although one nurse said they felt that care staff should be involved in the process as it would help them to feel more empowered and would be a good training opportunity.

Daily records to monitor people's well-being were not always completed. Position change charts had been fully completed and were designed so that staff could clearly identify when a person's position needed to be changed. However, although peoples position had been changed regularly and in line with the care plan, it was not documented on the charts what the frequency of position changes should be.

We looked at the ABC (behaviour) chart for one person which had been implemented to identify triggers for a person's behaviour. Staff had documented when the person had been shouting and asking staff to leave them alone, but had not written what they had done to alleviate the situation or what the outcome had been. There was no detail written in the progress notes of the person's plan either which meant planning person centred care would be difficult because of the lack of detail.

Where required people had their daily intake of food and fluid recorded for monitoring purposes. We saw in one person's care plan they had a urinary tract infection (UTI). The person was to be encouraged to drink frequently to alleviate the symptoms of this. On the two days before the inspection we saw this person's daily records noted they had gone for up to five to six hours with no fluid intake recorded. There was no record to state if this person had been offered fluids during those time periods and if they had refused.

Some plans did not demonstrate person centred care because the exact same wording had been replicated in other plans we looked at.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires improvement

Is the service responsive?

The care plan system was being transferred to the new provider's paperwork. The new paperwork was person centred and easy to use. When it had been completed in full it provided clear guidance to staff on how to provide person centred care.

The home had one activity co-ordinator who organised group activities throughout the week. They also offered people activities on an individual basis when they could. The registered manager explained that they were currently in the process of recruiting another activity co-ordinator to be able to offer more opportunities for people to get involved. Activities included golf, coffee mornings, bingo and day trips out. They also invited outside entertainment to come in to the home to perform. The activities co-ordinator told us it was people's choice if they wished to join in. On the first day on our visit a small group of people went out for lunch. We found that in the absence of an activity co-ordinator staff on the first floor did not provide any activities for people on that day.

There was a procedure in place which outlined how the provider would respond to complaints. People and their relatives told us they knew what to do to make a complaint if they were unhappy with any aspects of care they were receiving. Most said they said they felt comfortable speaking with the manager or a member of staff. One relative told us that when they had needed to make a complaint it had been dealt with swiftly and effectively by the registered manager. Some people however felt management could be rather dismissive when concerns were raised. We looked at the complaints file and saw complaints had been dealt with in line with the provider's procedure.

Requires improvement

Is the service well-led?

Our findings

Evidence during our visit demonstrated staff working within the service meant well and cared about people. However, it was evident throughout the inspection there was a significant divide between the safety and quality of services provided on the first floor and the ground floor and this was due to a lack of leadership on the first floor. Staff were not effectively deployed to ensure that people received the care and support required. The registered manager explained that they had been without a deputy on the first floor for several months. They explained that they had started to base themselves on this floor to ensure that people had their care and support needs met. However, in their absence systems were not in place to ensure that people continued to receive the required care and support.

The provider had systems in place to monitor the quality of the service. This included audits carried out periodically throughout the year by the registered manager, residential care manager and senior management. The audits covered areas such as infection control, care plans, the safe management of medicines and health and safety. We saw records of recently completed infection control and managers monthly audits. Where actions had been identified a plan to resolve these was in place and signed by the manager when completed. There was evidence that learning from incidents / investigations took place and appropriate changes were implemented. However, whilst the provider's home visit reports had identified a number of areas for improvement, the quality assurance systems in place had not picked up on all the issues found during the course of our inspection.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

There was a registered manager in post who was supported by a residential care manager who managed the ground floor. Permanent members of staff said they felt there was an open and transparent culture at Merlin Court. Staff said they felt confident any comments or concerns would be listened to and taken seriously by the registered manager. Comments included "The manager is kind and supportive" and "The manager is very approachable." Staff meetings had been held at the service. The meetings provided an opportunity for staff to feedback on the quality of the service. The home is part of Avery healthcare who took on the running of the service in November 2014. Staff we spoke with were not aware of the new provider's values.

All staff understood the provider's whistleblowing policy and procedure and would feel confident speaking with management about poor practice. Whistleblowing is a term used when staff alert the service or outside agencies when they are concerned about other staff's care practice.

People and their family were regularly involved with the service and their feedback was sought by the provider and the registered manager. Relative and resident meetings were held periodically throughout the year. During these meetings updates were provided and people were invited to make suggestions about how the service could be improved. People and their relatives told us they felt involved with their care. One relative said "I come to meetings with all people involved with my relatives care. There is always a good exchange of ideas."

Staff members' training was monitored by the registered manager to make sure their knowledge and skills were up to date. There was a training record of when staff had received training and when they should receive refresher training. Staff told us they received the correct training to assist them to carry out their roles. They said that if they felt they required additional training then they could request this from the registered manager. Some staff we spoke with had completed their health and social care qualification.

The service had appropriate arrangements in place for managing emergencies. There was a contingency plan which contained information about what to do should an unexpected event occur, for example a fire. There were personal evacuation plans in place in people's care plans. This meant staff had guidance on how to support people from the building safely in the event of a fire. There were arrangements in place for staff to contact management out of hours should they require support.

Regular maintenance was undertaken to ensure the property remained fit for purpose. Environmental risk assessments such as fire risk assessments were completed. We did note that chair covers on some chairs on the ground floor were ripped. We were informed that the provider was planning an extensive programme of refurbishment at Merlin Court although the start date had not yet been confirmed. Some of the proposed changes involved

Requires improvement

Is the service well-led?

communal areas and the registered manager explained the aim was to make these spaces more user friendly. One relative said they had been informed by the provider of the decoration plans, but said they had not been told when it would happen.

We recommend that the service seek to ensure that appropriate systems are in place to ensure that people continue to receive care and support in the absence of management.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing On the first floor there was not always enough staff suitably deployed to meet the needs of people living in the home. 18 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered manager had not assessed the risk of preventing and controlling the spread of infections in line with the homes policy. 12 (2)(H)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing People on the first floor did not always receive effective care from staff who had the knowledge and skills they needed to carry out their roles. 18 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect People using the service were not always treated with dignity and respect 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

We found that the registered person had not designed care and treatment to reflect people's preferences and ensured that support plans reflected people's care and support needs because accurate and appropriate records were not maintained. (3) (b) (d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered manager had not assessed and identified the risks to relating to the health, safety and welfare of people using the service and put plans in place to ensure consistency of care was provided to people on the first floor in the absence of a deputy manager. 17 (B)

This section is primarily information for the provider

Enforcement actions

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