Willerfoss Homes Limited

Merrywick Hall

Inspection report

41 New Road
Hedon
East Yorkshire
HU12 8EW
Tel: 01482 899477
Website:

Date of inspection visit: 21 April 2015
Date of publication: 01/07/2015

Ratings

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

Overall summary

This inspection took place on 21 April 2015 and was unannounced. We previously visited the service on 11 December 2013; at that time the home was registered under the provider Willerfoss Homes and it is now registered under the provider Willerfoss Homes Limited. When we visited Merrywick Hall on 11 December 2013 we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and accommodation for up to 28 people with a learning disability. The home is located in Hedon, a market town close to Hull, in the East Riding of Yorkshire. It is close to local amenities and on good transport routes. The home consists of a main house and a bungalow that is located within the same grounds. The bungalow accommodates five people who are more independent than the people who live in the main house. Most people have a single bedroom and some bedrooms have en-suite facilities.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who

Summary of findings

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.

People told us that they felt safe living at the home. Staff had completed training on safeguarding adults from abuse and were able to describe to us the action they would take if they had concerns about someone's safety. They said that they were confident all staff would recognise and report any incidents or allegations of abuse and that concerns would be dealt with effectively by managers.

We observed good interactions between people who lived at the home and staff on the day of the inspection. People told us that staff were caring and compassionate and this was supported by the relatives and health / social care professionals who we spoke with.

People who used the service, relatives and social care professionals told us that staff were effective and skilled. Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them.

People were supported to make their own decisions and when they were not able to do so, meetings were held to ensure that decisions were made in the person's best interests. If it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

Medicines were administered safely by staff and the arrangements for ordering, storage and recording were robust.

We saw that there were sufficient numbers of staff on duty to meet the needs of people who lived at the home and to enable them to spend one to one time with people. New staff had been employed following the home's recruitment and selection policies to ensure that only people considered suitable to work with vulnerable people had been employed.

People's nutritional needs had been assessed and people told us that they were satisfied with the meals provided by the home. People were supported appropriately by staff to eat and drink safely and their special diets were catered for.

There were systems in place to seek feedback from people who lived at the home, relatives, health and social care professionals and staff. People's comments and complaints were responded to appropriately.

People who lived at the home, relatives and staff told us that the home was well managed. The quality audits undertaken by the registered manager were designed to identify any areas of concern or areas that were unsafe, and there were systems in place to ensure that managers and staff reflected on practice and made any necessary improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe.

Good

The arrangements in place for the management of medicines were robust and staff had received the appropriate training.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they observed an incident of abuse or became aware of an abusive situation.

We found that there were sufficient numbers of staff employed to ensure that the needs of the people who lived at the home could be met. Recruitment practices were robust and ensured only those people considered suitable to work with people who lived at the home were employed.

The premises were being maintained in a way that ensured the safety of people who lived, worked or visited the home.

Is the service effective?
The service is effective.

Good

People were supported to make decisions about their care and best interest meetings were arranged when people needed support with decision making. We found the location to be meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

Staff told us that they completed induction and on-going training that equipped them with the skills they needed to carry out their role and this was supported by the records we saw.

People's nutritional needs were assessed and met, and people's special diets were catered for. We saw that staff provided appropriate support for people who needed help to eat and drink.

People had access to health care professionals when require. Advice given by health care professionals was incorporated into care plans to ensure that people's health care needs were fully met.

Is the service caring?
The service is caring.

Good

People who lived at the home and their relatives told us that staff were caring and we observed positive interactions between people who lived at the home and staff on the day of the inspection.

It was clear that people's individual needs were understood by staff.

We saw that people's privacy and dignity was respected by staff and that people were encouraged to be as independent as possible.

Is the service responsive?
The service is responsive to people's needs.

Good

Summary of findings

People's care plans recorded information about their previous lifestyle and the people who were important to them. Their preferences and wishes for care were recorded and these were known by staff.

People told us they were able to take part in their chosen activities and people who were able were supported to go to work, attend day centres or make visits to relatives.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Is the service well-led?

Good

The home is well led.

There was a competent registered manager in post on the day of the inspection.

The registered manager carried out a variety of quality audits to promote the safety and well-being of people who lived and worked at the home.

There were sufficient opportunities for people who lived at the home, relatives, staff and care professionals to express their views about the quality of the service provided.

Merrywick 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 took place on 21 April 2015 and was unannounced. The inspection team consisted of an Adult Social Care (ASC) inspector and 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 care service. The expert-by-experience who assisted with this inspection had experience of supporting people with severe learning disabilities.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider, information we had received from the local authority who commissioned a service from the home and information from health and social care professionals. The registered provider submitted a provider information return (PIR) prior to the inspection; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who live at the home.

Prior to the inspection we contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they have had with the home. On the day of the inspection we spoke with four people who lived at the home, two members of staff, five relatives, the registered manager, the registered manager of the 'sister' service and the registered provider. We also received feedback from a social care professional.

We observed the serving of lunch and looked around communal areas of the home. We also spent time looking at records, which included the care records for three people who lived at the home, staff records and records relating to the management of the home.

Good

Is the service safe?

Our findings

We spoke with four people who lived at the home and chatted to others. We asked them if they felt safe and they all told us that they did. One person said, "I like living here and I feel safe." One visitor told us that they felt their relative was safe living at the home, because the home employed good staff and the premises were secure. Another relative told us, "I am confident (my relative) is safe here – it gives me peace of mind."

Staff told us that they kept people safe by following the home's policies and procedures, by providing a safe environment including the identification and reduction of any hazards, and by undertaking training on topics such as moving and handling.

We saw that care plans included management plans for any behaviour that might cause the person or other people harm. These plans gave staff clear instructions about how to manage the person's behaviour to achieve the most positive outcomes, and an explanation for staff about what specific behaviours may mean. There were also risk assessments in place for any identified risks. These included details of the risk, the severity of the risk and the proposed action to reduce the risk, and had been signed and dated. We saw that there were risk assessments in place for topics such as social interaction, increasing dementia, use of a shower chair, the risk of choking and the risk of being close to traffic. Some risk assessments had been completed for everyone who lived at the home, and some were more specific to the person concerned. Risk assessments were reviewed by staff each month which meant that staff had up to date information to follow.

During most times of the day there was a senior care worker and two care workers on duty, plus another care worker in the bungalow. There were two care staff on duty overnight in the main building, and one member of staff in the bungalow. The deputy manager was on duty from Monday to Friday in addition to these staffing levels. Ancillary staff were also employed; there was a cook on duty every day and a domestic assistant on duty for five days a week. On the day of the inspection we saw that there were sufficient numbers of staff on duty, although a relative told us, "I think sometimes they are short staffed – there have been a lot of changes recently."

Staff told us that they were getting used to their new shift patterns; they had previously worked twelve hour shifts and these had been reduced. They told us that there were always enough staff on duty and that they had enough time to socialise with people and ensure they receive personalised care. We checked staff rotas and saw that staffing levels had been consistently maintained.

We saw that care plans included a section called "Exercising my human rights." One person's care plan recorded, "I understand my rights and exercise them well. I am encouraged to make choices and decisions but my motivation is low. I enjoy a quiet calm atmosphere and like my own privacy. My carers accept this and respect my wishes."

There were safeguarding policies and procedures in place and the registered manager submitted alerts to the local authority as required. We spoke with the local authority safeguarding adult's team and they told us they currently had no concerns about the home. The registered manager also submitted notifications to the Care Quality Commission about any incidents or allegations of abuse. We saw that all safeguarding information was stored in a specific folder and this included copies of any safeguarding alerts submitted to the local authority.

CQC had received information of concern prior to the inspection and had submitted safeguarding alerts to the local authority. The registered manager was aware of these alerts and investigations were on-going at the time of this inspection. We saw that appropriate action was being taken by managers to ensure that all staff understood the principles of safeguarding people from harm. Some additional training had been organised but this had been cancelled by the training provider. As an alternative measure, group supervision had been arranged so that the topic of safeguarding could be discussed in depth. This included information about whistle blowing and Deprivation of Liberty Safeguards (DoLS).

Staff who we spoke with were aware of the whistle blowing policies in place at the home. They told us that they were confident that any confidential information shared with managers or a senior staff member would be treated sensitively.

Training records evidenced that staff had undertaken training on safeguarding adults from abuse and staff who we spoke with confirmed they had undertaken this training.

Good

Is the service safe?

They were able to describe different types of abuse, and were able to tell us what action they would take if they observed an incident of abuse or became aware of an allegation. Staff told us they felt all of their colleagues would recognise inappropriate practice and report it to a senior member of staff. One member of staff told us that they would escalate any concerns to the local authority or Care Quality Commission (CQC) if they felt issues were not being properly addressed at the home.

We checked the recruitment records for two new members of staff and saw that the application form recorded the names of two employment referees, a declaration that they did not have a criminal conviction and the person's employment history. We noted that there was a small amount of space on the form to record previous employment and suggested that the application form be expanded so that people could record more detail. Prior to the person commencing work at the home, checks had been undertaken to ensure that they were suitable to work as a care worker, such as references, a Disclosure and Barring Service (DBS) first check and a DBS check. DBS checks identify whether people have committed offences that would prevent them from working in a caring role. We saw that a thorough interview had taken place that including recording verbal questions and responses. The deputy manager told us that they viewed people's existing training certificates so that they could measure their training achievements and needs, but people were still expected to undertake the home's three day induction programme.

We saw that there were policies and procedures in place on the administration of medication, plus good practice guidance on covert administration and a homely remedy protocol.

We noted that the pharmacy that supplied the home with medication had carried out an advice visit in September 2014. There were some recommendations in their report; these included that room temperatures needed to be taken and the fridge thermostat needed to be adjusted. We saw that action had been taken; room temperatures and fridge temperatures were being checked and recorded and were seen to be within recommended guidelines. These checks ensured that medication was stored at the correct temperature.

The medication trolley was fastened to the wall and stored in an enclosed area of the dining room.

Creams were stored in a separate cupboard and we saw that the pharmacy provided a body chart to advise staff where on the person's body the cream should be applied. We saw that there were some gaps in the recording of creams. The registered manager told us that they had identified this as a concern and had asked the pharmacy to supply 'topical' charts for each person's bedroom.

Medication was supplied in blister packs that recorded the person's name and the name of the tablet. The blister packs were colour coded to identify the times that the medication needed to be administered. The medication administration record (MAR) charts were also colour coded to coincide with the blister packs; this reduced the risk of errors occurring. We noted that the senior care worker gave one person their medication at 11.15 am; they told us that this person needed their antibiotic medication one hour before lunch. This showed that individual administration regimes were being adhered to.

All staff that administered medication at the home had undertaken appropriate training and care workers confirmed that only senior care workers administered medication. We observed the administration of medication and saw that this was carried out safely; the senior care worker did not sign MAR charts until they had seen people take their medication. People were provided with a drink of water so that they could swallow their medication, and the medication trolley was locked when not in use.

Although none of the people who lived at the home had been prescribed controlled drugs, there was a controlled drug (CD) cabinet and record book in place should this change.

We checked MAR charts and saw that each person had an additional sheet in place that recorded their date of birth, any known allergies, the name of the medication prescribed, the reason the medication had been prescribed, any possible side effects and a photograph. Two staff had signed hand written entries. We noted that the records for some 'as and when required' (PRN) medication had not been signed. The registered manager told us that MAR charts were only signed when PRN medication was administered and that codes were not used when it was not required. We discussed that the protocol for PRN medication could be recorded on the rear of the MAR chart so everyone was clear about how and when it should be administered.

Good

Is the service safe?

We noted that some of the holes punched in MAR charts had torn and the sheets were loose. There was a risk that they could be lost from the folder. The registered manager told us that this would be addressed.

There was an effective stock control system in place and this included a stock balance sheet for each person who lived at the home. We saw the date was recorded on liquid medication to record the date it was opened and the date it expired to ensure the medication was not used for longer than stated on the packaging; this had been another recommendation from the home's pharmacist that had been actioned. We checked the records for medicines returned to the pharmacy and saw that these were satisfactory; a specific returns book was being used that recorded the reason for disposal, for example, that the date had expired.

We saw that a variety of medication audits were carried out. The audits recorded any discrepancies and how / when these had been rectified. Audits also included details of regular competency checks with staff who administered medication to monitor that their practice remained safe.

We observed that the premises were suitable for the needs of people who lived there. There was a current gas safety certificate in place and portable appliances and bath seats and hoists had been serviced. The fire alarm system, fire extinguishers, emergency lighting and the nurse call system had also been serviced. These checks ensured that the premises were maintained in a safe condition to protect the well-being and safety of people who lived and worked at the home.

There was a contingency plan in place that was in the process of being reviewed. The details of each person who lived at the home, information about people's nearest relative and staff telephone numbers were included. We saw a list that managers had prepared recording additional information that needed to be included. We saw that personal emergency evacuation plans (PEEPs) had been developed for each person who lived at the home and a copy of these was included with the contingency plan; a copy of each person's patient passport was also included. This meant that this information was readily available to staff in the event of an emergency.

Good

Is the service effective?

Our findings

The Care Quality Commission monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA) legislation which is designed to ensure that the human rights of people who may lack capacity to make decisions are protected.

Discussion with the registered manager evidenced that there was a clear understanding of the principles of the MCA and DoLS, and staff who we spoke with told us that they had undertaken training on these topics. We saw that care plans included application forms to submit to the local authority to request a DoLS authorisation should it be needed. One application had been submitted and the registered manager was waiting for a decision from the local authority.

Assessments had been completed to record a person's capacity to make decisions. When people lacked the capacity to make decisions, we saw that best interest meetings had been held to assist them. For example, a best interest meeting had been held to enable a decision to be made about a person who needed surgery. Best interest meetings are held when people do not have capacity to make important decisions for themselves; health and social care professionals and other people who are involved in the person's care meet to make a decision on the person's behalf. Relatives told us that they were involved appropriately in any major decisions that needed to be made.

Care plans recorded people's ability to make decisions and to consent to aspects of their care. On the day of the inspection we saw that people were encouraged to make decisions and that choices were explained to them clearly. Staff told us that they supported people to make decisions. For example, they may advise them to wear something that would keep them cool on warm days.

One person's care plan recorded that they had been diagnosed with dementia. Their care plan recorded, "When I am having a good day and I am willing to participate in daily living, I will need a carer to support me and ask me if I want to tidy my room or dust. This can help with my dementia if it is part of a daily routine."

One relative who we spoke with told us that staff, once established, were well trained. Another relative said, "(The home) has always employed good staff.

The organisation had recently introduced a three day induction programme for new staff. This was provided by the training company used by the organisation and staff were required to complete this training before they started to work unsupervised on the staff rota. Topics covered included health and safety, food hygiene and infection control. The staff who we spoke with confirmed that they had undertaken induction training and shadowed experienced staff as part of the process. A new member of staff told us that they had completed training on safeguarding vulnerable adults, moving and handling, fire safety, food hygiene, behaviours that challenge and the CQC Key Lines of Enquiry (KLOE) since they started to work at the home.

Most staff had completed training on epilepsy, fire safety, moving and handling and first aid. Some staff had attended training on food hygiene, health and safety, dementia awareness, diabetes and infection control. We saw a notice on the staff notice board recording that eight staff were due to be enrolled on a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3. The notice also recorded that the organisation expected all staff to be trained to this level as recommended in the newly introduced Care Certificate. Another notice listed training planned for May and June 2015; eleven staff were enrolled on health and safety training, three staff on fire safety and food hygiene training, six staff on safeguarding adults from abuse training and eight staff on first aid training.

The registered manager acknowledged that staff had not attended supervision meetings during 2015; the most recent meetings had been in November and December 2014. This was because a new manager had been appointed who had then left the service. We saw that supervision meetings had been arranged for senior staff on the day following this inspection. It was planned that the registered manager would supervise senior staff, and senior staff would then supervise a designated group of staff.

We saw the systems in place to ensure that staff were aware of people's up to date care needs were robust. A communication book and handover sheet were being used to record information for each day; this included information about any activities planned for that day, any appointments for people who lived at the home and the

names of the first aiders on duty. The information shared at handover meetings ensured that all staff were clear about people's up to date needs and who would be doing what during the shift.

There was a record of any contact people had with health care professionals, for example, GP's and district nurses. This included the date, the reason for the visit / contact and the outcome. We saw advice received from health care professionals had been incorporated into care plans. This included advice from speech and language therapists (SALT), the Community Team for Learning Disability (CTLD) and care coordinators from Social Services. Details of hospital appointments and the outcome of tests / examinations were also retained with people's care records. This meant that staff had easy access to information about people's health care needs.

People told us that they could see their GP whenever they needed to and that the optician visited the home regularly. A dentist visited the home to see people who were unable to go to the dental surgery. Relatives told us that they were kept informed of their relatives health and well-being. One person told us, "I am always kept informed – 100%." A social care professional told us that they had always had a good working relationship with staff at Merrywick Hall and they were informed about changes in people's needs. They said that staff always sought advice from appropriate professionals such as GPs and the CTLD. They added that keyworkers had a good knowledge of people's needs and said, "Any changes made have been for the benefit of people who live at the home."

People had patient passports in place; these are documents that people can take to hospital appointments and admissions with them when they are unable to verbally communicate their needs to hospital staff. They include details of the person's physical and emotional health care needs. This meant that hospital staff would have access to information about the person's individual needs. We saw that there was also a pre-admission form and body map to be completed when someone was due to be admitted to hospital and a post discharge form and body map to be completed when someone was discharged from hospital. This helped staff to monitor people's condition prior to and following hospital stays or appointments.

We observed the lunchtime experience and saw that one person who lived at the home set the tables prior to lunch. We noted that the food served looked nutritious, appetising and plentiful, and included fresh vegetables. There was a menu on display in the dining room and people told us they had a choice of meals at lunch time and tea time. It was clear that staff were aware of people's different likes and dislikes and special dietary needs.

We saw staff assisted people to eat their meals and noted that this was unhurried and carried out with a caring approach. We saw that one person was distressed during lunch and that staff were patient and kind, and encouraged them to eat.

We saw care plans included a nutritional assessment and recorded the person's special dietary needs. A new dietary information form had been introduced. This recorded any special dietary needs, how the person's meal should be served, any special crockery needed, likes and dislikes and any allergies. One person who we spoke with told us that staff at the home "Coped well" with their relative's special dietary needs and made sure they received the correct diet.

There were risk assessments in place to record any difficulties with eating or drinking. Some people had mealtime prescriptions in place that had been produced by the Speech and Language Therapy service (SALT) and these recorded specific details about how food and drink should be served. Staff were able to describe people's diabetic, blended, gluten free and coeliac diets to us and told us that they were aware of any allergies that people had.

People were weighed as part of nutritional screening and charts were used to record people's food and fluid intake when this was an area of concern. During recent months only one person had needed their food and fluid intake to be monitored; this was to check if they were having an allergic reaction to any food or drink items.

The home had achieved a rating of 5 following a food hygiene inspection; this is the highest score available.

Good

Is the service caring?

Our findings

We observed staff working with people in a kind and caring manner and saw that they engaged in positive relationships with people. They took time to listen to people and to help them in any way they could. We heard one member of staff offering to go shopping for someone on their day off work. We asked people who lived at the home if they felt staff really cared about them and they responded positively. Comments included, "Staff look after you here", "I talk to (staff member) a lot" and "They look after me OK." Relatives also spoke positively about staff. One person said, "(My relative) couldn't live anywhere better – genuine staff who really care", another said, "The staff are very kind and caring" and a third person told us, "They are like a big extended family."

Staff told us that they really cared about people and were like a 'large family'. They were feeling emotional on the day of the inspection as a long-term resident had to move elsewhere. However, it was acknowledged that this person needed more specialised care than they could provide.

We observed people who lived at the home looked appropriately dressed and wore clothes and hairstyles that they had chosen. People told us about the relationships they had with their family and friends and it was evident that staff helped people to maintain these relationships. One person wanted to write a letter and a member of staff went away and brought back paper and envelope, helping them to write it.

We saw that care plans included information about each person's specific support needs, and information about a person's life history and family relationships. This helped staff to understand the person and provide more individualised care. The deputy manager told us that they were in the process of introducing a new style of care plan that they thought would provide more effective records of the person's care needs and the actual care or support provided. We saw the new documentation and noted it included a document called, "About Me" that would record individualised information about the person's care and support needs.

When there had been a change in a person's care needs, we saw that the appropriate people had been informed. This included their family and friends, and any health or social care professionals involved in the person's care. This ensured that all of the relevant people were kept up to date about the person's general health and well-being.

We saw that people's privacy and dignity was maintained. Staff explained to us how they promoted people's privacy by knocking on doors before entering and by closing curtains when they were assisting them with personal care. They told us that they asked people what they required assistance with and what they could manage themselves, to promote their independence. Most people had a single bedroom and staff told us that those people who shared a room had chosen to share a room. People who we spoke with told us that, if they wanted privacy, they went to their own rooms. They said that staff respected this and did not disturb them.

A social care professional said that they had observed that care workers treated people with dignity and respect. They said, "People who live at the home are always happy to discuss their lives at Merrywick Hall and in the local community with me, either alone or with a member of staff present." We asked a relative if they thought people's privacy and dignity was respected and they said, "Definitely."

The home had previously used the services of an advocate who would assist people with decision making but the person had retired. The managers acknowledged that they needed to locate alternative advocacy services so they could inform people about the support that was available.

People who lived at the home told us that they had meetings that involved them in the running of the home. We saw the minutes of 'residents' meetings that had been held in January, February and April 2015. At one of these meetings people had been asked about menu choices and the time breakfast was served, and at the following meeting they were asked if they were happy with the new timings. People were asked if they had any complaints, "What had been good" since the last meeting and were told when satisfaction surveys would be sent out. People were informed about on-going decorating and that sinks in bedrooms were going to be replaced. We saw that the minutes of meetings were in both written and symbol format to aid people's understanding, and that the minutes of the previous meetings were read out at the next meetings.

Good

Is the service responsive?

Our findings

We saw a variety of activities taking place on the day of the inspection and that these were tailored to the person's individual interests and skills. There was an activities programme on display but staff told us that this was not always adhered to; activities were discussed at each handover meeting and the programme was amended depending on the needs and wishes of people who lived at the home. We also saw that staff had time to sit and chat to people who did not want to take part in activities.

We observed that some people were able to make decisions about how they spent the day and were able to go out independently, including going out to work, shopping and to day centres. People told us about trips to the pub and about going out for coffee with friends. They told us about holidays they had already taken and holidays that they would be taking later in the year, and it was evident that planning for holidays was a big part of life at the home. One person who lived at the home told us they did not like to go out but said, "I keep busy watching football and films. I also make models." One person said that they regularly went out on the bus or on the train but that they home's mini-bus was mainly used for appointments rather than outings.

One person told us that their relative used to go out alone but this was no longer safe due to their epilepsy, so were now accompanied by staff. Relatives told us that they were able to visit the home at any time and could "Just turn up." One person told us that they and other family members were always made welcome. Staff told us how they supported people to keep in touch with family and friends and that some people regularly went home to visit family.

We saw in care plans that people's needs had been assessed when they were first admitted to the home, that care plans had been developed to record people's individual needs and that care plans were regularly reviewed and updated accordingly. Key workers completed a sheet to record the monthly reviews of care plans; this recorded checks on the care plan, risk assessments, health monitoring form, management plans, activities and weight records. We saw that there was a list in the office to record the timetable of care plan reviews. There had been 14 reviews in 2015; nine were in-house and five had been undertaken by the local authority who commissioned the placement. This meant that people's care needs were continually reviewed to ensure they received appropriate care.

One relative said that they had been asked a lot of questions about their relative when they first moved into the home and that this information was used to help develop their care plan. One relative also said that they had attended care plan reviews.

We noted that care plans included information about a person's previous lifestyle, their hobbies and interests and people who were important to them. One person's care plan recorded, "I like music and looking at photos." We overheard conversations between people who lived at the home and staff and it was clear that staff knew people well, including their likes and dislikes and their individual preferences for care. We saw that people's bedrooms were personalised with their own items, for example, family photographs, memorabilia and furniture.

We saw that care plans also included information about people's individual ways of communicating and how staff would be able to understand the person's needs when they were not able to verbalise these. On the day of the inspection we observed that staff were skilled in understanding people's individual needs, including their body language, their facial expressions and their gestures.

We saw that the complaints procedure was displayed in various areas of the home. We checked the complaints procedure and saw that this included the contact details for CQC (should someone wish to take their concerns further) and a review sheet that recorded the details of any complaints made. No formal complaints had been made to the home during the previous twelve months.

People who lived at the home were asked at every 'resident' meeting if they had any concerns or complaints. Staff told us that the registered manager dealt with any complaints or concerns professionally and that they had "Every confidence" that she would deal with any complaints made or issues raised. Only one relative who we spoke with said that they had previously had a reason to complain about a minor concern but they told us, "It was dealt with quickly by the registered manager." All relatives said that they were happy to approach the registered

Good

Is the service responsive?

manager with any concerns and were confident that their concerns would be taken seriously and acted on. Everyone who we spoke with told us they would not hesitate to speak with a manager or senior member of staff.

Good

Is the service well-led?

Our findings

The homes statement of purpose recorded, "Our prime objectives are to provide the highest standard of care available to our client group, and to maintain and improve upon existing quality levels. We achieve this by ensuring each individual receives a holistic programme specifically tailored to their needs." A relative described Merrywick Hall as "Home from Home."

We observed appropriate conversations between people who lived at the home and staff and the atmosphere was relaxed and friendly. Everyone who we spoke with supported this view. Although staff were observed to be busy throughout the day, they did not present as being stressed in any way.

Staff described the registered manager as "A strong manager" and said that she listened and they felt any issues could be discussed with her. They said that the registered manager would keep information confidential when this was appropriate.

The registered manager was due to retire and there were plans in place for the manager of another service operated by the registered provider to manage both Merrywick Hall and the other care home, with assistance from a deputy manager in each.

A social care professional told us that they were pleased the manager of the 'sister' home was also going to be the manager of Merrywick Hall. They felt that she was a strong and knowledgeable leader and that this would enhance people's quality of life. They also said that they were confident the new manager would "Ensure capacity, best interest and DoLS were paramount considerations."

The registered manager carried out a variety of audits to monitor that systems in place at the home were being adhered to by staff. This included audits on care plans, health and safety, accidents, infection control, safeguarding, medication and housekeeping. The registered manager told us that, as part of the infection control audit, they asked two staff specific questions about infection control and to give examples of how they prevented the spread of infection. A new medication audit was being used that checked cleanliness of the medication trolley, gaps in recording, that correct codes had been used on MAR charts, medicine returns, CD's and that medication had been 'booked in' correctly.

Any accidents or incidents had been recorded correctly and we noted that the accidents we saw recorded in care plans had been notified to the Care Quality Commission as required. The accident report form recorded the date, the time of the accident, detailed information about the accident, any action taken and a staff signature. There was also a review and analysis record form that recorded more detail of the accident or incident and whether a safeguarding alert had been submitted to the local authority or a notification had been submitted to CQC. In addition to this, a falls assessment form had been introduced and this recorded whether any falls were witnessed, the location, whether first aid required and whether there was an injury or any pain. This evidenced that accidents were audited continually to identify any recurring problems or any areas that required further action.

The local authority had identified some concerns about care planning at the home. The registered manager told us that they had introduced a new care planning format and that they were gradually working through care plans to update them. The registered manager had audited all care plans and had made a list of missing information. We did not identify any concerns in the care plans we checked and the local authority told us that they were satisfied with the progress being made.

The registered manager had recently introduced a "Reflective account diary" and we saw that there were some entries about learning from incidents that had occurred. For example, the recommendations made by CQC at the inspection of their 'sister' home were recorded, the outcome of a spot-check that had been undertaken by a manager during the night had been recorded and recommendations made following a review carried out by Social Services staff were included. One of the changes recommended was that body maps should be completed before people went into hospital and again on discharge; we saw that this had been implemented. This showed that the manager understood reflective practice and how positive changes could be made to the service as a result of learning from incidents at the home.

There was also a "Time to Reflect" notice board for staff. This included information about making meal times

Good

Is the service well-led?

special and focussing on what people could do, and included a quote "Silent care is bad care." The manager told us that this information was intended to challenge staff to think about their approach and practice.

We saw that a survey had been distributed to people who lived at the home in July 2014. Fifteen surveys had been given out and all had been returned. The responses had been collated and we saw that the responses to all questions had been positive. A survey had also been completed by a health care professional. They had recorded, "A very welcoming home to visit. Residents seem very happy. Staff were very polite."

The registered manager told us that surveys were due to be sent out in April 2015 to staff, people who lived at the home, health and social care professionals and relatives. These would be collated, analysed and an action plan would be produced if needed. Feedback would be shared with people by displaying the information on the home's notice boards and in 'resident' and staff meetings. Two relatives told us that they had previously completed a satisfaction survey and one relative said, "The manager's door is always open to anyone."

Staff told us that they attended meetings and that they could raise issues and ask questions. One member of staff told us that they liked to attend meetings and added, "If I didn't, I wouldn't be able to speak up." We saw the minutes of a staff meeting held in January 2015. These recorded that the provider had thanked everyone for keeping the home running smoothly in the absence of a registered manager. Other topics discussed included that disciplinary action would be taken if staff did not attend required training, staff supervision, the importance of care planning and accurate record keeping, and the pension scheme.

The registered manager told us that there were plans in place to introduce "Employee of the quarter"; staff would be asked to nominate a colleague who had worked especially well during the previous three months. The 'sister' home had recently had an inspection and the registered provider and manager were happy with the outcome; all staff had received chocolates and wine as a 'thank you'. It was intended that the same incentive would be introduced at Merrywick Hall.

We asked the registered manager if they had considered introducing 'champions' amongst the staff group and they told us they planned to have 'champions' for nutrition, dignity and moving and handling. This would create a system within the home where one member of staff had responsibility for collating information about a specific topic and sharing good practice with their colleagues.

We saw that there was a wide variety of information displayed on staff notice boards. This included details of the safeguarding thresholds introduced by the local authority, a social media policy, the new mealtimes introduced at the home and information about the appointed first aiders. Another notice board was designed to display information from Skills for Care including information about the Care Act and the new Care Certificate.