Merstone Hall Limited

Merstone Hall

Inspection report

20-22 Florence Road
Boscombe
Dorset
BH5 1HF
Tel: 01202 309813
Website: www.merstonehall.org

Date of inspection visit: 20 January, 21 January, 23 January 2015
Date of publication: 06/05/2015

Ratings

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

Overall summary

This was an unannounced comprehensive inspection carried out on 20, 21 and 23 January 2015. Merstone Hall provides both residential and nursing care for up to 45 people, some of who may be living with dementia. There were 43 people living in the home during our inspection.

At the time of this inspection the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The provider had recently appointed a new manager who told us that they were in the process of registering with the Care Quality Commission.

Although people's needs were being assessed, care was not always delivered to meet people's needs. Some care plans lacked detail about the support some people

Summary of findings

should receive. The information in people's care records was not always up to date and some people's plans did not reflect their current needs. This meant people were at risk of receiving unsafe care.

People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines safely.

Records showed that not all staff had received safeguarding training, which meant there was a risk that staff may not fully understand their responsibilities in relation to protecting people from abuse.

Feedback received from the manager and staff was that the home was understaffed. Staffing levels had not been calculated based on people's needs. People were not always cared for, or supported by, enough skilled and experienced staff to meet their needs. On the second day of our inspection, staffing shortfalls were not covered until the afternoon of our inspection.

Staff had not all received appropriate training or support.

The provider could not be assured that they were complying with the Deprivation of Liberty Safeguards as they were unable to locate the relevant records. Some mental capacity assessments had been undertaken resulting in best interest decisions being recorded. However for one person with a diagnosis of dementia, who may have lacked capacity to make decisions about their care and treatment, it was not evident in their care plan that the Mental Capacity Act 2005 had been appropriately followed.

Complaints had been responded to appropriately and any lessons learnt were implemented.

Infection prevention and control procedures required improvement as they put people at risk of harm.

People received a choice of suitable healthy food and drink ensuring their nutritional needs were met. At meal times appropriate assistance was provided.

People's physical health was monitored and appropriate referrals to health professionals were made. The provider worked effectively with health professionals and made sure people received good support when they moved between different services.

Most staff were aware and knew how to respect people's privacy and dignity.

Activities were provided both in the home; however we identified shortfalls in activities for people who were cared for in their bedrooms. Staff told us people were encouraged to maintain contact with friends and family.

Robust systems were not in place to assess and monitor the quality of the service provided. The provider was not ensuring that people were protected against the risks of inappropriate or unsafe care and treatment as effective analysis of accidents and incidents and audits had not been carried out.

We found multiple breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back 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?

Requires Improvement

Improvements were required to ensure the service was safe.

There were not enough staff employed by the service to meet people's needs.

Systems for the management of medicines required improvement as they did not fully protect people using the service.

People and others were not protected against the risks of unsafe premises.

Infection control procedures were not robust.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Is the service effective?

Requires Improvement

Improvements were required to ensure the service was effective

Not all staff had the right skills and knowledge, training and support to care for people safely and using best practice methods

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

Staff were aware of people's dietary needs and preferences. People were supported to eat and drink enough to meet their needs.

Is the service caring?

Good

The service was caring

People told us they liked the staff who had got to know them and understood their needs. They said staff respected their privacy and dignity. Most staff interacted with people in a polite and friendly way.

Visitors told us that they were always made to feel welcome when they visited their relative in the home.

Is the service responsive?

Inadequate

Care plans did not always include sufficient information about people's care and support needs. This meant staff did not have up to date information to tell them about people's individual needs and how to provide personalised care.

Appropriate systems were not in place to reduce the risk of pressure sores.

People's need to be kept occupied and stimulated was not consistently met

People and their relatives knew how to complain or raise a concern at the home.

Summary of findings

Is the service well-led?

Systems for checking and monitoring the service were poor. This meant shortcomings in the home and the service people received were not always identified and responded to promptly.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

Staff told us that they felt the culture in the home was improving since the new management joining the home. The atmosphere was open and inclusive.

Requires Improvement

Merstone Hall

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider was 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 20, 21 and 23 January 2015 and was unannounced. There was one inspector in the inspection team. We spoke with and met eight people living in the home and two relatives. Because some people were living with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spoke with the manager, registered provider, and for care staff and three ancillary staff.

We looked at six people's care and support records, an additional two people's care monitoring records, two people's medicine administration records and documents about how the service was managed. These included eight staff training files, four staff recruitment files, audits, meeting minutes, training records, maintenance records and quality assurance records.

Before our inspection, we reviewed the information we held about the service. This included information about incidents the provider had notified us of. We also contacted two commissioners to obtain their views.

We asked the provider to complete a Provider Information Return before our inspection. This is a form that asks the provider to give us some key information about the service, what the service does well and the improvements they planned to make. They did not complete the Provider Information Return and we took this into account when we made the judgements in this report.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us they felt safe living at the home. One person told us, “The staff are lovely, I feel perfectly safe here.”

However we found that suitable arrangements were not in place to ensure the communal outside space was safe. The garden area was cluttered and unsafe for people to use. There was rotten, broken trellis at neck height on the entrance to the garden. There were stacks of loose bricks, stacks of tables and chairs, a broken stand aid and microwave and an unravelled hose pipe. There were rotten wooden beams on the floor covering the basement with large holes in them which posed a risk to people and others.

Two ramps had been constructed. One was located outside the manager’s office; the other was located outside to the rear of the property. Neither of these ramps had handrails. There was no risk assessment in place for either of the ramps. The manager acknowledged that the ramps may pose a risk to staff. Following the inspection we liaised with the environmental health officer who told us that they would provide support and guidance to the home.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have robust systems to prevent the potential spread of infections. During the first day of our inspection we took a tour of the premises. We found a linen basket containing bags of used disposable gloves. The storage of used disposable gloves in a linen basket was an infection control risk. The paintwork in the communal areas and many of the doors and skirting had worn down. This meant that it was difficult to clean effectively and was an infection control risk. Two mop heads had been left on the carpet in one of the corridors of the home which presented an infection control risk. We saw two slings stored on top of each other on the ground floor landing. On closer inspection we found these were heavily soiled and did not contain the name of the person they belonged to, which presented an infection control risk. The manager told us staff mainly used disposable slings, which could not be washed. However, there was no system in place to ensure that disposable slings were regularly checked, assigned to one person only and disposed of in accordance with infection control guidelines.

A member of domestic staff told us that they had not received infection control training; staff training records corroborated this. We raised this with the manager who told us that they were in the process of booking all staff onto infection control training.

There were no records in place that showed communal furniture, wheelchairs and hoists were regularly cleaned. We noted that many unlabelled wheelchairs in the home were stored under the staircase in the home and were soiled. A member of domestic staff told us that the night staff were responsible for cleaning such items.

The provider was not always following relevant infection control guidance, such as the code of practice for health and adult social care on the prevention and control of infections and related guidance. The provider was not completing infection control audits, which meant that it was not identifying shortfalls, such as the ones we identified during our inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People’s bedrooms were visibly clean and tidy. Some bedrooms had been painted and new hard flooring and carpets installed. The kitchen was clean and well organised. We looked at the kitchen cleaning rota and found it was complete and up to date. The kitchen had been awarded a five star hygiene rating by Bournemouth Borough Council in 2014. The laundry room was tidy and uncluttered. The room was separated into a "clean" and "dirty" area to reduce the potential spread of infection. There were sufficient supplies of protective equipment for staff to wear, such as gloves and aprons. These were worn by staff at appropriate times.

Equipment had been checked regularly. The lift had been serviced in January 2015. Portable Appliance Testing had been completed in June 2014. Emergency lighting, fire door and gas safety were all periodically tested.

Requires Improvement

Is the service safe?

Legionella testing had been taken place on 28 April 2014. Legionella are water-borne bacteria that can cause serious illness. Health and safety regulations require persons responsible for premises to identify, assess, manage and prevent and control risks, and to keep the correct records.

People living in the home had personal evacuation plans so that staff and emergency services knew how to safely support them in an emergency. However the last fire drill was undertaken on 24 December 2014. Records showed that this should have been performed weekly. We also saw records which stated that the last fire training had taken place in July 2013.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received positive views from people and visitors about whether there were enough staff available to help them when they needed assistance. One person told us, “When I use my call bell staff come quickly, I never have to wait long.” Three people told us that staff assisted them promptly. Two visitors told us that they felt that most of the time there were enough staff on duty to meet their relative’s needs. However, we spoke with three members of staff who told us that they did not think there were always enough staff to help people when they needed it. They said that this was partly due to an increase in the level of support people needed and because there had been a number of new admissions to the home. They told us this meant they were increasingly task focused to ensure that people’s care needs were consistently met.

Our observations confirmed that there were not always enough staff available to help people when they needed it. We saw occasions where one person became increasingly restless and did not receive prompt support from staff to ensure their safety and welfare. During the second day of the inspection the home was one member of staff short. One person got up from their chair in a communal area of the home and fell, injuring themselves. This person required support from staff to assist them to mobilise. Whilst the fall was not directly attributable to the lack of staff, this may have been a contributory factor. We discussed this with the manager, who told us that the home needed to employ more staff and they were in the process of recruiting. They also told us that they were looking to utilize volunteers and apprentices. The provider had not assessed the required staffing levels based on people’s individual needs. Therefore, there was a risk that people’s care needs might not be met as they did not have an accurate picture of how much support each person required.

Members of domestic staff told us that generally there were enough cleaning staff, but suitable arrangements were not in place to cover staff absence and holidays. They said this meant there were times when the domestic staff struggled to keep the home clean.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The relevant safety checks had been completed before staff commenced work. Staff recruitment files contained evidence of enhanced checks with the Disclosure and Barring Service. References were obtained and the provider also conducted checks to ensure that staff were eligible to work in the United Kingdom. For two members of staff recruited, there were only partial employment histories. Paragraph 6 of Schedule 3 to the Health and Social Care Act 2008 (Regulated Activities) regulations 2010 states the requirement as: "A full employment history, together with satisfactory written explanation of any gaps in employment.”

This was a breach of Regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicine administration records (MAR) contained an up-to-date photograph and details of any known allergies. All medicines had been signed for when given. However, we found two instances where medicines had been carried over from the previous month yet the number of tablets that remained in the boxes had not been recorded. This meant the staff could not be sure how many tablets were in the boxes and therefore whether there was enough stock or whether any had gone missing. We also found other discrepancies where medicines stock did not match the amount signed for on the MAR.

Requires Improvement

Is the service safe?

These shortfalls in the management of medicines were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

General medicines were stored appropriately in secure lockable cupboards. Some medicines required storage at a low temperature. The provider had a fridge to keep these medicines at the correct temperature. Staff were conducting regular temperature checks to ensure the medicines were kept at the correct temperature. There were appropriate systems in place for the management of controlled drugs.

Staff who managed medicines had been competency assessed to ensure the safe management of medicines. This meant that people living at the home and the provider could be assured that staff had the necessary skills and knowledge to administer medicines safely.

The provider had safeguarding policies and procedures in place to guide practice. However we noted that safeguarding notices were not on display in the home to enable people, staff and visitors to contact the appropriate safeguarding authority should they need to.

The three members of staff we spoke with had a good understanding of safeguarding and knew when to report concerns. They were readily able to describe various types of abuse and gave us examples of what they would do if they felt that a person was being abused. They were also aware of the provider's whistle blowing procedure.

Requires Improvement

Is the service effective?

Our findings

The provider had not ensured that all staff received adequate supervision, appraisal and training to enable them to fulfil their roles effectively.

Five out of eight staff files contained no record of any safeguarding training being completed. This meant that there was a risk that staff may not be aware of the correct procedures to take to safeguard people living in the home. For three members of staff there was no record of any infection control training. Two members of staff had not received Mental Capacity Act and Deprivation of Liberty Safeguards training. A member of staff confirmed this. Another member of staff had no record of any fire training. There was no training plan in place to ensure that staff received adequate training. The manager acknowledged the shortfalls and confirmed that they were in the processes of arranging additional training for all staff.

The manager was unable to locate records of staff supervisions and did not know if staff had received supervision. Supervisions are meetings between a supervisor and staff which can involve reflecting on and learning from practice, personal support, professional development. There was no supervision plan in place to ensure that staff had received supervision. On the second day of our inspection we found unsorted, loose copies of staff supervisions in the office. They showed that most staff supervisions were carried out by the registered nurses. There was no record on the supervision forms of progress since the previous supervision, so it was unclear if any training/development needs identified at the previous supervision had been met. A member of staff had raised concerns during their supervision in November 2014 that they lacked confidence and training with some people living in the home who displayed behaviours that challenge others. Their training file showed that no additional training or support had been provided following this supervision. Another member of staff's supervision stated "would like to receive training" but their supervision file contained no further information on what type of training they required. A nurse who was involved with carrying out staff supervisions told us they had not received any training in how to supervise staff effectively.

This was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty these are assessed by professionals who are trained to assess whether the restriction is needed. The manager understood when an application should be made and how to submit one and was aware of a recent Supreme Court Judgement that widened and clarified the definition of a deprivation of liberty. However, as they were newly in post, they were not sure if any applications had been made to the local DoLS office and could provide no record of these applications.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had a mixed understanding of the Mental Capacity Act 2005, including DoLS. Some staff had a good understanding and had received training in the Mental Capacity Act 2005 and DoLS. However one member of staff had not received training and did not understand the principles and how these were applied in practice.

One person was cared for in bed and had bedrails in place to prevent them falling out of bed. Their care records did not contain an assessment of their capacity to consent to this decision and a best interest assessment had not been completed to show the restriction was required to meet their needs. We were concerned that the person may have been deprived of their liberty. Following our inspection we contacted the local DoLS office who confirmed that they would prioritise an assessment for this person.

The shortfalls in the implementation of best interest decisions, for this person was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Other people's records showed the provider had acted in accordance with the Mental Capacity Act 2005. For example, one person had capacity assessments and best interest decisions in place for aspects of their care including personal care and medicines.

People told us they were happy with the food. One person said, "The food is very good and I have a large appetite". Another person said, "The food is marvellous, it's really, really good. We get a choice too." People chose their meals each morning. People told us that if they didn't like the two choices the cook would make them something different. We discussed people's food choices with the cook, who told us that for people who may find it difficult to express their choices, staff could offer them a choice food in pictorial format.

Kitchen staff understood people's individual dietary needs. The cook explained how they were informed of people's dietary requirements on admission to the home. They were knowledgeable about people's food likes, dislikes, cultural and dietary requirements. For example, they were able to describe to us that some people required their food to be puréed, food allergies that people had and that one person would not eat pork. They showed us records that detailed people's dietary requirements and any allergies.

Some people who were at risk of dehydration required their fluid intake to be monitored. People's care plans and fluid charts contained no target fluid input which meant that staff may not know what the person's ideal fluid intake was. We asked a member of staff how much one person should drink; they told us that they did not know. Fluid charts were also not regularly totalled and reviewed so that prompt action could be taken if people were not drinking enough to ensure their welfare. This was an area for improvement.

Care plans for some people stated that they had specific dietary and nutritional needs. Staff had worked with health professionals such as dieticians and speech and language therapists to meet these needs. Some people required their food pureed. There was information in these people's care plans to support why this decision was made and their care records contained safe swallow plans. People had a safe swallow plans in their care plans.

Nutritional risk assessments had been undertaken and reviewed monthly. People were weighed each month and appropriate action was taken if they gained or lost weight to an extent that threatened their health and wellbeing. For example, one person who had lost weight had been referred to a dietician. We saw that the person was then prescribed food supplements. The person's medicine administration record showed they were receiving the supplement as prescribed. They were regularly weighed and their weight had stabilised following professional input. This demonstrated that people were protected from the risks of inadequate nutrition.

We observed the lunch service in the main lounge/dining area. There were enough staff available to help people and they were assisted and encouraged in a supportive and dignified manner. Two people required staff support to eat their meal. Staff waited until the person had finished what was in their mouth before offering more food. Staff were able to spend time with those that needed it and offer encouragement to eat more to those people whose attention had drifted from the meal. For example, one member of staff noticed that one person had not eaten much of their meal, and asked the person whether they would like an alternative. We also observed a nurse offering people who were at risk of malnutrition additional desserts. This meant people were supported to eat and drink sufficient amounts to meet their needs.

Care records showed that local health care professionals, such as the GP and district nurse, were involved with people when they needed it.

Good

Is the service caring?

Our findings

People who used the service and their families told us they were happy with the care and support they received. One person said, "It's very good here because they [staff] look after me properly. The staff are nice and kind, all of them." Another person told us, "The staff are very nice, not met a bad one, they are all very helpful." Two visitors told us that they were very satisfied with the care their relative received. They told us that they visited the service regularly and found that staff welcomed them. One relative told us, "I think the staff are very caring. They are also welcoming to me; I am always offered a coffee or refreshments. I feel involved in [my relative's] care. The staff keep me informed."

Staff interacted in a positive manner with people and were sensitive to people's needs. People responded well to staff and were comfortable with them. People who were unable to verbally express their views appeared very comfortable with the staff who supported them. We saw people smiling and touching staff when they were approached.

Staff had a good understanding of people's needs, some of their personal preferences and the way they liked to be cared for. For example, staff knew one person enjoyed spending time in their room and another person enjoyed reading the paper and completing crosswords. People's life histories and personal preferences were recorded. However, some staff told us they did not have time to read people's care plans. This meant they may not have been aware of people's preferences so would not be able to respect these and ensure people received personalised care.

Staff generally respected people's privacy and dignity. However, we observed one occasion where people's personal care needs were discussed amongst staff loudly in a communal area. On another occasion we saw a continence product left in the communal hallway. This was an area for improvement.

Staff knocked on people's doors before entering and that doors were closed when people were assisted with personal care. Staff understood how to treat people with dignity and respect, such as ensuring curtains were drawn and the doors were shut when providing personal care.

Lunchtime in the main dining room was a pleasant and positive experience for people. People appeared relaxed and chatted with each other. Staff provided support and assistance to people in a sensitive manner in order to ensure that people received sufficient nutrition. For example, a person was struggling to eat their meal and staff asked if they wanted help and offered to cut their food up for them. Some people had specialist equipment to help them eat, such as plate guards and bowls in order to promote their independence.

One person was distressed and staff reassured them and stayed with them until they were settled. When staff supported people to move they did so at their own pace and provided encouragement and support. Staff explained what they were going to do and also what the person needed to do to assist them.

Most of the rooms at the home were for single occupancy. This meant that people were able to spend time in private if they wished to. Bedrooms had been personalised with people's belongings, to assist people to feel at home.

Care files and other confidential information about people were kept in the main office. This ensured that people such as visitors and other people who used the service could not gain access to people's private information without staff being present.

Inadequate

Is the service responsive?

Our findings

People who used the service told us that staff understood their needs well. One person told us, "I get really good care here, it's much better than the last care home I lived in."

People had an assessment of their needs completed prior to moving into the home, from which a plan of care was developed. However, people did not always receive support as described within their care plans. Some care plans were not fully updated as people's needs changed or were not in sufficient detail for staff to be able to follow them. Staff told us they had not read people's care plans but were told about people's needs in handover and discussions with other members of staff. This placed people at risk of not receiving the care and treatment they needed. We discussed this with the manager, who told us they were in the process of creating summary sheets detailing people's needs that staff could also refer to when supporting people.

People had risk assessments and management plans in place for falls, moving and handling, pressure areas and nutrition. However, risk assessments and management plans were not in place for some areas of risk. One person had epilepsy and was prescribed medicine to help manage this. There was no plan in place to instruct staff how this person's epilepsy was managed, what to do if the person experienced a seizure and when they should call paramedics. Care staff were not able to tell us how the person may present when they had an epileptic seizure and what action they needed to take in response to this person having a seizure. This meant that the person may be at risk of not receiving the support they require should they have a seizure.

Another person had diabetes; whilst they had a diabetic care plan it lacked detail and did not give staff information about the condition. For example, there was no information about hypo/hyper glycaemia, how staff would recognise this and what steps they should take in an emergency. We spoke with staff during our inspection who were not able to tell us how a person with diabetes may present in an emergency. This meant that person was at risk of unsafe care or treatment.

There were not appropriate plans in place to reduce the risk of people developing pressure sores. Some people were cared for in bed on an air mattress. Care plans did not state the setting of the air mattress. We looked at the person's air mattress and saw that it was set to '50'; however when we looked at the person's care records we saw they weighed 35kg. We asked care staff what the air mattress should be set to. They were unaware and did not know whose responsibility it was to check. There were no checks being undertaken to ensure that air mattresses were correctly set. This meant air mattresses may not have been fully effective, as there was no assessment or plan in place to ensure they were programmed to the correct setting to meet people's needs.

The care plan for a person who was cared for in bed stated they required a pressure mat next to their bedroom door to ensure their safety and welfare, as there was a risk of people wandering into their room. On the first day of our inspection the pressure mat was not in place. This meant that the person was at risk of harm. We raised this with the manager, who arranged for the pressure mat to be put in place.

Some people living in the home had been prescribed as required (PRN) medicines. However we found that care plans that set out what the medicine was for, when it was to be offered and the dosage were not always in place. There were no pain assessment tools in place to enable staff to assess and provide pain relief for people who were unable to communicate that they were experiencing pain. The provider's pain management policy stated, "Pain intensity should be measured with the appropriate measurement tool."

Some people did not receive adequate support to meet their social needs. During the day we observed a member of activities staff providing different activities including arts and crafts, hand manicures and ball games in the main lounge area. An activities plan and a poster in the home advertised a 'Burns night'. People told us they enjoyed the activities provided. The member of staff told us that they were short staffed, which meant that people who were cared for in bed were only provided with activities once per week. This meant people cared for in their rooms were at risk of social isolation. We looked at the provider's activities diary for one person who was cared for in bed and saw that staff had spent time with them providing activities on 31 December 2014, 5 January 2015 and the 9 January 2015. This person's socialisation care plan stated, "stimulation in

Inadequate

Is the service responsive?

room as [person] unable to take part in activities in the lounge". We asked a member of staff why this person did not take part in activities in the lounge. We were told that they were "too disruptive to the other residents."

One person was recorded as displaying behaviours that challenged others. The person's care plan contained no information regarding management of these behaviours and there had been no referral to relevant health professionals to help staff support this person. This placed staff and others at risk and meant the person was at risk of being provided with inappropriate or unsafe care.

These shortfalls were a breach in Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and visitors told us they felt able to raise any concerns about the service they received among their comments were: "If I had any concerns I would go to a member of staff". A visitor told us: "I can comfortably feedback any issues. I have just raised a small issue about [person's] missing clothes."

Some arrangements were in place for people to inform the manager of their concerns. There were copies of comments/suggestion forms in the main entrance of the home. However there was no complaints information/ procedure on display. The manager told us this may have been temporarily removed due to redecoration works and they would ensure it was replaced. They told us that they were in the process of actively engaging with people and visitors to gain their input, as they were new to the home.

Concerns and complaints were considered and action taken. Records showed one recent complaint had been received by the provider. The complaint had been investigated in a timely way and the outcome of the investigation reported to the person who complained.

People's needs were recognised and shared when they moved between services. The manager told us that when a person was admitted to hospital staff, provided information explaining why they required hospital support, a copy of their medicine administration record (MAR) and records of their care needs.

Requires Improvement

Is the service well-led?

Our findings

At the time of this inspection the home did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The home has not had a registered manager since 2011. The previous manager left the employment of the home in December 2014. A new manager had been appointed in January 2015.

The provider had not completed or returned a provider information return that was sent to them by the commission in September 2014. This is a document that provides relevant and up to date information about the home that is provided by the manager or owner of the home to the Care Quality Commission. We discussed this with the provider, who told us the provider information return was forwarded to the previous manager and was unaware that it had not been completed.

The manager explained that they had identified a number of areas for improvement. This included staff training, infection control and staff supervision. They explained since recently commencing in the role as manager they had conducted a staff meeting. We saw hand written minutes of this meeting. Topics discussed included training, teamwork, staffing levels, mealtimes, confidentiality, safeguarding, infection control and mobile phones.

The provider had not completed regular audits in order to monitor the quality of service. For example, there was no audit of the premises, recruitment, infection control, accidents and incidents and care planning.

The provider had copies of returned questionnaires that had been sent to people and their relatives throughout 2014. We looked at a sample of these questionnaires and saw that people had responded with both positive and negative feedback. For example, one relative wrote, 'I know my parents are extremely well looked after here'. Another relative wrote, 'A little more stimulating activity required.' None of the questionnaires had been reviewed and there was no action plan in place to address lower scoring areas. Some people also commented about the food in the home, detailing food that they would like more of and food they disliked. The cook was unaware of the questionnaires, which showed the systems for obtaining and acting on people's and relatives' views were ineffective.

There were records of accidents and incidents, but no system to look for any patterns and trends. Accident forms recorded that one person had fallen over five times from 29 September 2014 to 9 November 2014. There was no record of any actions taken to identify the potential causes of the falls and to prevent reoccurrence. People were not protected from further harm as the provider was not conducting an effective accident and incident analysis.

These shortfalls were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager explained that the provider had recently purchased new policies and procedures. They explained that these required review to ensure that they reflected the service being provided at Merstone Hall.

Staff told us that since the new management joining the home the atmosphere was open and inclusive. One member of staff told us, "The new manager is better than the previous manager. I feel like I can talk to this manager, I couldn't do this before". Another member of staff told us that they felt far more valued by the current management and their suggestions were listened to. All of the people and relatives we spoke with told us they received a good quality service. They said they were able to speak to the manager and staff. Comments included: "I think the home is well organised" and "It's quite a friendly and homely place." Throughout our inspection the home was calm and staff spoke with all of the people in the home in a kind and friendly way. Staff thought the culture in the home was improving. However two relatives did comment that no regular resident/relatives meetings were held, which meant they were not always able to feedback any comments or suggestions about the running of the home.

Many of the records we asked to view were unavailable to us during the inspection. The office was cluttered and disorganised. Care plans had not been reviewed effectively, which led to errors and inconsistencies. For example, one person's care plan referred to their bedrails being in use in

Requires Improvement

Is the service well-led?

parts of the care plan, but not in use in other parts. Another person was documented as having a catheter in parts of the care plan, but was recorded as having been removed in other sections.

This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: The provider had not taken proper steps to ensure each service user received care that was appropriate and safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or inappropriate care because the registered person did not have effective systems in place to monitor the quality of the service delivery.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: People were not protected from the risk of infection because appropriate guidance had not been followed and appropriate standards of cleanliness and hygiene were not maintained.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met:

This section is primarily information for the provider

Action we have told the provider to take

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: People who use the service, staff and visitors were not protected against the risks of unsafe or unsuitable premises.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: People who use services and others were not protected against the risks associated unsafe or inappropriate care because records did not contain up to date and appropriate information.

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed How the regulation was not being met: Appropriate checks were not always undertaken before staff began work.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There were not enough qualified, skilled and experienced staff to meet people's needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or inappropriate care because staff had not received adequate training or supervision.

This section is primarily information for the provider

Enforcement actions

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