

Buckland Care Limited

# Merry Hall Nursing & Residential Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Requires Improvement** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Inadequate** 

# Summary of findings

## Overall summary

This inspection took place on 4 and 5 September 2017 and was unannounced. Prior to the inspection the Commission had received information of concern regarding staffing levels, moving and handling practices and treating people with dignity and respect. We looked at these concerns throughout our inspection.

Merry Hall Nursing & Residential Care Home is a registered care home and provides accommodation, support and nursing care for up to 32 people, some of whom live with dementia. Support is provided in a large home that is across two floors. Communal areas include two lounges and a dining room. At the time of our inspection there were 19 people living at the home.

The service has a history of breaching legal requirements. Following an inspection in February 2016, the Commission served one warning notice for failing to ensure effective and safe recruitment processes. Due to concerns about the safe care and treatment of people, person centred care and governance, the Commission also imposed a condition on the provider's registration that required them to audit all people's care plans, risk assessments and medicines on a weekly basis and produce a monthly report for the Commission regarding this. In addition, requirement notices were issued for failing to ensure people were safeguarded against the risk of abuse or harm; failing to ensure appropriate numbers of skilled and trained staff were available; failing to ensure appropriate consent was sought; failing to ensure complaints were responded to and failing to ensure people were treated with dignity and respect. At this inspection the service was rated overall inadequate and placed into special measures.

We carried out a further inspection in October 2016. Whilst some improvements had been made and the service was rated as overall requires improvement, the key question well led remained inadequate. The improvements made were insufficient to take the service out of special measures. The provider remained in breach of the regulations regarding the safe management of medicines, recruitment, staffing levels and support, gaining consent and governance of the service. Requirement notices for breaches of Regulations 11, 18 and 19 were issued. The provider was required to submit an action plan to the Commission telling us how they would meet the requirements of these three regulations; however they did not submit this in the time specified. The Commission considered the previously imposed condition remained appropriate for breaches of Regulation 12 and 17.

Following information of concern received in March 2017 a further inspection was carried out. We found serious concerns about the safety of people living at the home. The home were failing to keep people safe because risks were not adequately assessed and staff did not have the training, skills and knowledge to support them safely. In addition they continued to provide insufficient numbers of staff, they had failed to ensure staff treated people with dignity and respect at all times and their governance system remained ineffective. The overall rating for this service had returned to inadequate and we did not remove the service from special measures. The Commission took enforcement action and cancelled the registered manager's registration.

A registered manager was not in place at this inspection. However, the provider had recruited a person to undertake this role and they had started work in the service five weeks prior to our inspection. This person told us they intended to submit an application to become the registered manager for the service. Throughout this report we refer to this person as the 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.

Improvements have been found at this inspection and some previously breached regulations had been met and the home was no longer in breach of these regulations. However, the provider's history demonstrates that they have been unable to fully embed and sustain improvements in the past at this service. The overall rating for this service is 'Requires improvement'. However, we are keeping the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive comprehensive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Whilst changes had been made to the systems used to monitor and assess the safety and quality of the service, these still required some review to ensure they were fully effective and truly embedded in to practice. We found some concerns about these systems and their ability to fully analyse the service and ensure information for staff was clear so as not to pose any potential risks to people.

Improvements had been made to the assessment of risks to people, to planning the delivery of care to reduce these risks and to ensuring staff had a good understanding of this. However, some areas still required improvement including identifying risks associated with some medicines and the monitoring of some health conditions and pressure relieving equipment.

Staffing levels were sufficient to meet the needs of people living in the home at the time of the inspection; although the system used to identify this was not understood by the management team. Staff had received supervision and additional training since the last inspection which enabled them to understand the needs of people living in the home. The management team were aware of the gaps in the training staff had received and were addressing this. Recruitment process ensured that staff who commenced work in the home were safe and appropriate to work with adults at risk. Staff had a good understanding of safeguarding people and were confident to raise any concerns they had with the manager or externally if they felt this was needed.

People were involved in their care plans however, work was needed to ensure there was always a personalised approach to care planning. They were supported by staff that understood the importance of gaining their consent before delivering care. Staff understood the principles of the Mental Capacity Act 2005 and applied this to their practice. Although staff lacked an understanding of where deprivation of liberty safeguards had been authorised, they consistently described approaches that were least restrictive for people.

People consistently told us how staff were kind, caring and supported their independence. Interactions observed confirmed this. Although people said the food could be repetitive, they all said they enjoyed it. Plans were in place to change the menus and staff monitored people's nutrition. People had timely access to other professionals when they needed this to ensure their health care needs were met. Records and discussions showed that the service responded to people's change in needs and requests.

People knew how to complain but all said they had not needed to. There had been no complaints since the

last inspection but a system was in place to ensure these were recorded and acted upon.

Everyone we spoke with described the manager in a positive way. They felt the manager was open, approachable and were confident in their ability. They had a clear focus of what they needed to do, although they did not have a formalised plan in place to identify how and when each issue would be addressed.

We found two on-going breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The Commission are considering the appropriate regulatory response to the shortfalls identified during this and previous inspections. Where providers are not meeting the fundamental standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take. You can see what action we told the provider to take at the back of the full version of this report.

## 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 was not always safe.

Improvements had been made to the assessment and management of risks for people, but further improvements were required.

Medicines were managed safely but improvements were needed to the monitoring of medicines storage.

Staffing levels had improved and these were sufficient to meet the needs of people living in the home at the time of the inspection.

Recruitment process ensured that staff who commenced work in the home were safe and appropriate to work with adults at risk.

Staff had a good understanding of safeguarding people and were confident to raise any concerns they had with the manager or externally if they felt this was needed.

**Requires Improvement** 

### Is the service effective?

The service was not always effective.

Improvements had been made and staff had received supervision and additional training since the last inspection which enabled them to understand the needs of people living in the home. However, there remained some gaps in training.

People were supported by staff that understood the importance of gaining their consent before delivering care. Staff understood the principle of the Mental Capacity Act 2005 and applied this to practice. Staff lacked an understanding of where deprivation of liberty safeguards had been authorised.

Although people said the food could be repetitive, they all said they enjoyed it. Plans were in place to change the menus and staff monitored people's nutrition. People had timely access to other professionals when they needed this to ensure their health care needs were met.

**Requires Improvement** 

### Is the service caring?

Good 

The service was caring.

People were supported by staff who were kind, caring and supported their independence.

People's privacy and dignity was respected and maintained.

### Is the service responsive?

Requires Improvement 

The service was not always responsive.

People were involved in their care plans however, work was needed to ensure there was always a personalised approach to care planning.

People knew how to complain but all said they had not needed to. There had been no complaints since the last inspection but a system was in place to ensure these were recorded and acted upon.

### Is the service well-led?

Inadequate 

The service was not well led.

Some improvements had been made to the systems used to monitor and assess the quality and safety of the service, however these were not always effective in identifying concerns. Records had improved but some still required improvement which the management team had not yet identified.

Although a new management team was in place and had a clear focus of what needed to be done to make improvements, they needed time to embed themselves and the changes that had been made.

Everyone spoke positively about the new manager who was described as open, approachable and supportive.

# Merry Hall Nursing & Residential Care Home

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider had made improvements and 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 4 and 5 September 2017 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience who had experiences of caring for persons with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In addition a specialist advisor supported the inspection. This person was a nurse who had experience of older persons nursing care.

Before the inspection we reviewed information we had about the service, including previous inspection reports and notifications the provider had sent to us. A notification is information about important events which the provider is required to tell us about by law. We also spoke to the local authority.

During the inspection we spoke with six people who lived at the home and 3 relatives. We observed the care and support people received in the shared areas of the home. We spoke with the manager, quality manager and nominated individual for the provider. We spoke to 12 staff, including nurses, care staff and ancillary staff. We also spoke with two visiting health professionals.

We looked at the care plans and associated records of 11 people. We looked at medicines records for six people who lived at the home, staff duty rotas, and eight new staff files, which included recruitment checks, supervisions and training records. We also looked at a variety of quality assurance records including; complaints, accidents and incidents, meeting minutes, policies and procedures, safeguarding and audits.

# Is the service safe?

## Our findings

Everyone we spoke with said they felt safe living at the home. One said, "I like it here". Another said "It is lovely here." The family members all said that they felt their loved ones were safe. A visiting professional told us, "I think people are safe; from the experience I have coming in, I can't think of anything. If anything they are over cautious."

At the last inspection in March 2017 we found that people were not always protected from harm because risks had not been assessed and plans of care had not been developed to reduce the risks to people. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

At this inspection improvements were seen but further work was needed to ensure people's safety. Since our last inspection a new care planning and risk assessment system had been introduced. This had only recently been introduced and was not fully embedded.

At the last inspection care records identified health conditions and behaviours that posed a risk to them and at times others, risk assessments and care plans were not in place and the registered manager at the time was not always able to tell us about these conditions. During this inspection we found staff's knowledge of people's needs and the risks associated with these had improved, further improvements were required and the provider had not met this regulation.

For example, for one person living with diabetes, a plan was in place which stated, "Check blood glucose levels weekly usually on a Sunday. According to the [British National Formulary], normal limits are between 4-9. If abnormal readings or not within normal limits, re check [person's] normal pattern. Dip urine [Cather Specimen of Urine] to check for ketones. If still no improvement within 7 days, inform GP and send a copy of [person's] readings." Although the care plan told staff about the signs of a hypo or hyperglycaemic episode (conditions occurring as a result of either low or high blood sugars) and how to manage this, the lack of information about the person's normal blood sugar level meant it would be difficult to establish an appropriate management plan and identify an appropriate timeframe before calling a GP. This could therefore put the person at risk of receiving care or treatment that was inappropriate and potentially unsafe.

Blood sugar records were held for people however these were inconsistently recorded. In addition, where a person's blood sugar required checking twice a day this did not always take place. For example, for two people, records showed these were not checked all day on two occasions in a month and on a further three occasions they recorded these only once a day.

At the last inspection we found that effective plans to reduce the risks of skin breakdown for those where this was identified as a risk had not been done. In addition the management of pressure relieving equipment to aid the reduction of this risk was not effective.

During this inspection, care plans for people had improved and provided information about the support



they needed which included how often they should be supported to move position, the type of pressure relieving mattress they were using and the setting this should be on. When people required the use of pressure relieving cushions this was provided. Daily records showed that repositioning took place or was offered and encouraged however, this was inconsistently recorded. However, the checking of pressure relieving mattresses remained inconsistent. For example, for the week commencing 21 August 2017 one person's record showed their mattress setting was not checked for three consecutive days. When this was checked it was correctly set; however a lack of checking could place this person at risk. On the second day of our visit it was unclear whether one mattress was working correctly. This mattress was removed and replaced with an alternative when we pointed this out to staff.

Two nurses told us four people were on an anti-coagulant medicine. This is a medicine which thins the blood to prevent it from clotting. They confirmed that no risk assessments were in place regarding the use of this medicine and the increased risk of bruising and bleeding had not been incorporated into care plans. Whilst registered nurses were aware of this and knew what to look for they told us care staff would be unlikely to know what medicines people were on and what risk this may pose, as this was not information that was provided to them. They agreed that risk assessments needed to be implemented.

Whilst no one had suffered any harm as a result of the above, the lack of clear action taken to reduce risks associated with people's medicines, skin integrity and health conditions placed people at risk. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Significant improvements had been made with the management of the risk of choking for people. At the last inspection we found the risks associated with choking had not been fully and effectively assessed, appropriate plans had not been implemented to reduce the risks and staff lacked the skills and knowledge to manage this risk. Each person assessed as at risk of choking had been reviewed by a speech and language therapist and the information provided had been incorporated into detailed care plans. These care plans identified the risks; the action to mitigate the risks and what to do should the person show signs of choking. The handover sheet provided clear information to staff about the action they should take to minimise the risk. The kitchen staff were aware of those people who needed a texture modified diet, such as fork mashable or pureed and the provider had bought in a meal provider to ensure these meals were appropriately modified. All staff we spoke with during the inspection were aware of who was at risk and what they should do to prevent people from the risk of choking. Staff were observed to be following the guidance in people's care plans.

Care records also contained detailed records for the management of people's mobility needs. Where people were at risk of falls this was clear and staff were aware. Where people had fallen we saw clear action taken, for example one person became agitated by the use of an alarm mat which caused them to fall when trying to move this. This had been removed immediately and staff ensured they checked this person regularly.

Staff had been trained in fire safety training and fire drills were carried out on a regular basis. Fire safety equipment was maintained and tested regularly and staff were able to tell us the action they would take should there be a fire alarm. There was an emergency 'grab bag' in the foyer, which contained a summary of people's emergency evacuation plans which detailed people's ability to respond in case of a fire and the support they would need if they had to be evacuated in an emergency.

During inspections in February 2017, October 2016 and March 2017 we found that the appropriate number of staff were not available to meet people's needs at all times. We found this to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This had improved and was no longer a breach of regulation.

There were sufficient numbers of staff to meet the needs of people living in the home at the time of our inspection. When asked if they had to wait for staff to respond to them pressing their call button, one person said, "They know that when I press my buzzer, they know that I need help and they come quickly." Two people told us they sometimes had to wait for staff to respond, however our observations during the inspection reflected that there were sufficient numbers of care staff. Staff responded to people's needs promptly and they did not wait for extended periods of time before they received support. Staff were not hurried or rushed throughout the inspection and we observed them spending time chatting with people. One person said, "The staff are so patient, they never rush me." Staff told us there were sufficient care staff when no one was off sick. The manager and compliance manager told us they were aware of difficulties in covering last minute absence and said that whilst the rota reflected the staffing levels on occasion were lower than their current minimum staffing of 4 care staff throughout the day, they were working on resolving this by recruiting additional staff and a bank of staff that could be available for this emergency situations. Both the manager and quality manager told us that on the occasions where last minute sickness had occurred, they had both provided direct support to ensure people's needs were met. Staff confirmed that both of these managers did this and we observed this throughout our inspection visit.

We did observe that on both days the morning medicines round carried out by the registered nurse on duty took a very long time to complete. On the first day the nurse did not finish giving people their morning medicines until 11:40am and on the second day this did not finish until 12:05. We observed this was because they responded to the needs of people in the home. The manager told us they would review the number of nursing staffing during these times.

At our last inspection a new electronic medicines system was being introduced into the home. The system would enable the reduction of medicine errors and would alert the manager to near medicine misses should they occur. Staff had been trained and were competent in the use of this system. We were told no administration errors had occurred since our last inspection, although there had been two occasions when the stock appeared incorrect for controlled medicines; however this was due to an administration error and had been resolved. In order to ensure the safe management of controlled medicines paper records were maintained. However, for one person their records showed they had been given a higher dose of insulin than they were prescribed, on two occasions. The manager was not aware of this until we pointed it out but assured us they would investigate this. Following the inspection the manager confirmed this was a recording error.

Medicines were stored in locked trolleys, rooms and fridges. We were told the temperature of the storage should be checked daily however records reflected that this did not consistently happen and we were told by nursing staff that this was due to a high level of agency nurses being used. This did mean that whilst the storage was secure, we could not be confident the medicines were always stored at a temperature that would not have an impact on their effectiveness.

People were supported by trained and competent staff to take their medicines in a way that suited their needs. Medicines were administered on an individual basis, in line with best practice guidance. The member of staff waited and checked people had swallowed their medicine. Where people required the fluids to be thickened to enable them to swallow their medicines this was done. For two people we saw their medicines were being crushed to enable them to swallow this. The manager had documented discussion and instructions from a pharmacist to ensure this was suitable and records showed the GP had agreed to this. Although we could not see that people's formal consent had been sought, each person was aware that their medicines were being crushed,

Where medicines were prescribed on an 'as required' basis (PRN) protocols were in place which provided

guidance to staff about the purpose of the medicines and when to consider administering this. For a person who expressed distress, good practice was seen in the PRN protocol encouraging alternative activities being attempted to distract and calm the person (including activities meaningful to the individual). The sedation was recommended to be given only as a last resort.

Disposal of medicines was clearly recorded and undertaken promptly.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. The manager involved people living at the home in the interview process and decisions about recruiting new staff. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. However, gaps in people employment records were not always identified. We raised this with the Quality Manager, who had already identified the concern and had put in place a new recruit management system to ensure employment gaps were fully explored. They also had an action plan to review all recruitment files prior to the introduction of the system to ensure compliance.

People experienced care in a safe environment because staff had the knowledge necessary to enable them to respond appropriately to concerns about people's safety. No referrals had been made to the local authority or the Commission about safeguarding concerns. Although we found one record which identified a potential safeguarding concern, which had not been reported to the local authority, the quality manager told us how this had been investigated and addressed. The manager and all except three members of staff had received appropriate training in safeguarding. All of the staff we spoke with were able to explain the actions they would take if they had a concern about people's safety. They were aware of the provider's policy and the other organisations they could report concerns to, such as the local authority and the Commission.

## Is the service effective?

### Our findings

Everyone we spoke with said that staff had the skills to support them. One person said, "The staff know what they are doing and the way I like things done."

At our last inspection in March 2017 we found staff had not received the training required to support them to deliver effective care. This was a breach of Regulation 18 of the Health and Social Care Act 20014 (Regulated Activities). During this inspection we found the provider had met this regulation. Improvements were seen, however the manager and quality manager were aware that there were some gaps in training for some staff and had been working on resolving this. A training matrix had been implemented to support the manager and quality manager to quickly see what training was needed and when this was due.

Staff were offered training in a variety of formats to meet their individual learning styles and subject matter. These included practical face to face workshops and individualised on line training or workbook based learning.

In March 2017 we found that not all staff had received training to enable them to understand the need to support people with dignity and respect and our observations reflected that people were not treated respectfully. During this inspection we found 19 of 27 staff providing direct care had received training in either equality and diversity or dignity and respect. Whilst there remained staff who needed to complete these training courses, the manager and quality manager were aware of those staff and our observations showed people were cared for by staff who were respectful.

During the inspection in March 2017 there were no records of any staff having completed risk assessment or care planning training. Registered nurses and seniors were required to complete and review care plans and risk assessments which we found were not accurate and reflective of people's needs. At this inspection, the manager, deputy manager, five of 19 carers and two of five nurses had completed risk assessment training. One senior carer and one nurse had completed care planning training while the other senior carer had been instructed to complete this. Whilst we saw improvements in some of these, further work was required to ensure consistent, effective risk assessment and care planning.

At the last inspection we were concerned about the lack of staff training around the management of the risk of choking for people. All the staff we spoke with were aware of who was at risk, the support needed, what they should look out for and the action to take should someone choke. Since our last inspection 15 of 22 care staff had received training in Dysphagia (the medical term used for swallowing difficulties), three of five nurses had completed this. A further nurse had completed training in the management of the risk of choking, and three had completed a first aid and basic life support course.

Staff told us how they had received more training and that this had been useful for them. One member of staff said, "Training is good I've done lots of training consent, choking, records, fire. Do [name of training provider] workbooks and on line [training]. I like the on line; you can see it visually. I keep the [name of training provider] workbooks so I can look back, like the skin integrity one. I have done safeguarding training

and just completed my NVQ 3." A second said, "We have had so much training I have certificates coming out of my ears. We had lots of training it has been quite intense. I prefer on line to the work books. I have done fire, manual handling, mattress checking, first aid and CPR and choking."

People were supported by staff who had received an effective induction into their role. Each member of staff had undertaken an induction programme before being allowed to work on their own. If they were new to care they completed additional training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. The quality manager told us that all new staff were allocated a mentor, who was part of the supervision process and be their buddy to support them with the care certificate. One member of staff told us, "Induction did give me the skills but I was nervous to start with but found the best way was to ask questions if not sure. Someone will always tell you."

Staff told us they felt supported by the management team and senior staff. They received regular observational assessments and supervisions. Supervisions provide an opportunity for management team to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. One said, "I have had two supervisions since I came here [in April 2017]. Just recently I had a direct observation on manual handling." There was an open door policy and staff could raise any concerns straight away.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Consent forms showed staff sought consent regarding issues such as sharing information and the use of photographs. However, these had not always been reviewed for a significant period of time.

Staff understood the need for consent and understood people had the right to make their own decisions. We observed staff seeking consent when supporting people. They asked consent to support people before moving in close. They asked people if they would like to go to the dining room for lunch. They were discreet in asking if people wished to be supported to go to the toilet. They were aware that if a person lacked capacity to make a particular decision any actions on their behalf must be in the person best interests.

Staff described how most people were able to make their own decisions and how this was supported. We observed one person asking to go for a cigarette even though they no longer smoked. Staff provided information about the need to smoke outside and the weather conditions. At the persons request they supported them to go outside where the person then changed their mind as it was too cold.

Where it was felt a person lacked capacity we saw that best interest decision making took place involving a variety of people, including family, advocates, social and health professionals.

Whilst there was a good understanding of DoLS and what this meant, staff and the manager lacked an awareness of those people who had an approved DoLS in place and if there were any conditions attached to these. Whilst we saw copies of approved DoLS in care plan folders they had not been incorporated into care plans. Staff consistently described the use of least restrictive approaches to support including such as, using medication to support a person to calm as a last resort and making sure they were aware that distress maybe caused by something else so to explore those first.

We recommend the provider seek advice and guidance from a reputable source on developing a systematic approach to monitoring DoLS and ensuring staff understanding.

Three people said that the food was good, whereas two other people's comments were not as positive. One person said, "The menu is ok but a little repetitive." One said, "no comment." Another said, "I don't always enjoy the food but it will never be as good as my own."

Staff who prepared people's food were aware of their likes and dislikes, allergies and preferences. People were offered a choice of two main meals and alternatives if they did not want what was on the menu. During the inspection one person had changed their mind at lunchtime and did not want the meal they had chosen. They were offered alternative options and chose a cheese omelette, which was prepared for them. The chef told us for those people who were diabetic they prepared the same food as others were eating but used a sugar substitute.

Snacks and drinks were readily available throughout the day with squash and juice available for people to help themselves if they wanted to. Staff were seen to be continually asking if people would like a drink and encouraging people to have one.

The kitchen staff were aware of people's needs in relation to their diets and the food was fortified to ensure sufficient calorie intake was provided. Since our last inspection the meal times had been staggered to ensure that those who needed a higher level of support and supervision while eating could safely receive this. Observations reflected that people received the support they required over meals times and the support was provided in a dignified way. People appeared to enjoy their meals with one person saying, "This is very nice."

People's weight was monitored regularly and where it was identified they had lost weight, this was addressed with referrals to GP's and dieticians, using food supplements and ensuring high calorie meals were provided alongside support and encouragement to eat.

People had timely access to healthcare professionals including the GP, physiotherapist, opticians, dentist, dietician, and speech and language therapists. Evidence of GP's and specialist's involvement in supporting people with a wide range of conditions to maintain their health and wellbeing had been recorded. One visiting professional said, "They may call us too often but that's better than not calling us. They have complex residents but do a good job. When I have been coming over the last few months there is always a nurse who comes with me and knows why I am here and the issues."

## Is the service caring?

### Our findings

At the last inspection in March 2017 we found that people were not always treated with dignity and respect. Staff used degrading language when talking about people, there was a lack of acknowledgement to calls for help and a failure to maintain privacy. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014. During this inspection we found that improvements had been made in this area and the provider had met this regulation.

People were happy with the care and support they received. They told us they were well looked after and said all the staff were kind and caring. One person said, "The staff are caring and lovely." Another said, "The staff are great." Another said, "The staff are very good." Another person said "If I cannot be in my own home, I could not think of anywhere better to be." One person said if the staff did not treat me with respect, I would have to say something but they are very respectful."

We observed positive and caring interactions with good communication between members of staff and people. Staff recognised when people needed reassurance and provided this in a positive manner. For example, one person was clearly anxious when being transferred using moving and handling equipment. Staff supporting them provided ongoing reassurance throughout, checked by asking the person if they were ok and took their time to explain what would be happening. Where needed staff provided comfort and reassurance by holding people's hands and stroking their arms.

Staff spoke to people in a kind and respectful manner and people responded well to this interaction. Staff didn't talk down or over people. There was a light friendly atmosphere and there was banter and laughing between staff and people.

Staff did not rush people; they took time to engage with people in a meaningful way. Staff had time to have friendly chats with people and we heard people given praise and encouragement from staff. For example, we observed one member of staff sitting with a person having a mid-morning drink and general chat. During the inspection we saw that staff took the time to listen and interact with people and their relatives. People were relaxed in the company of the staff.

Although some care records for people were conflicting at times, staff were knowledgeable of people's life histories and preferences. They understood people's needs and the support that should be provided. For example, one person's care plans referred to them liking to watch the TV, despite a monthly evaluation saying that this was not accurate and they liked listening to the radio. Each time we saw this person in their room they had their radio on and within their reach.

People were supported to maintain their independence as much as they could. One person said, "I do as much as I can for myself." Another said, "I can do most everything for myself, I only need help first thing in the morning and that is because of the medication I take." Staff were available when people needed them, however, they supported people from a distance when appropriate. For example, some people who had been assessed as at risk of choking but wished to remain independent with their meals were observed



discreetly from a distance.

People's privacy and dignity was supported and maintained by staff. Staff understood the importance of this and took action to protect people's dignity. For example, for one person who required the use of a hoist (a piece of equipment which enables staff to help a person move) chose to wear a skirt. When using the equipment staff ensured they had a blanket across their legs to protect their dignity. We saw that people's bedroom doors remained open and it was unclear whether this was always their choice. However, when personal care was taking place, signs on doors advised they were not to be disturbed.

At the last inspection we recommended the provider and the previous registered manager review and take action to improve the process of involving people in making decisions about the service and their care.

At this inspection people were involved in decisions around their care and support. People told us they, and where appropriate their relatives had been involved in their care plans and for some people we saw evidence that they had signed confirming their agreement with these. People said there were regular residents' meetings and they could attend if they wished. Although it appeared that there were only a small number of people who did attend and it was unclear how those who remained in their rooms or had limited communication abilities were engaged. The activities coordinator told us how they visited these people every day and any feedback they provided was shared with the management team. The manager told us how they intended to change the way in which these meetings had been held. They planned to structure the frequency of them to a minimum of quarterly and invite relatives to attend to enable those who may not be able to communicate to have support to express their views and opinions.



## Is the service responsive?

### Our findings

People told us they were looked after well. They had no concerns about the support they received and felt staff understood their needs and the support they wanted. A visiting professional told us, "There does seem to be a culture of change to how they approach the residents and care given; They do now do the things I ask, if I need them to."

Since our last inspection, no one had been admitted to the home. However, the manager and quality manager planned to introduce a new pre admission assessment document and process. They had started to use this documentation for people currently living in the home as a means to undertake a complete reassessment of their needs. This had only recently been introduced and had therefore not been completed.

Care plans in place were at times person centred but the manager and quality manager told us this remained work in progress. For example, one person's care plan contained no information about the support they wanted and needed with their personal hygiene. Others lacked information about people's 'normal' habits. For example, one person was prescribed medicines for constipation and whilst a protocol was in place to aid staff with when to administer this there was nothing recorded about what the usual pattern for this person would be. Diabetes care plans were in place where needed but they lacked information about the persons usual blood sugar range, which would ensure they were fully person centred. Staff had a good knowledge of the people they cared for. They knew what people liked and disliked and gave us examples of how they supported people differently dependent upon their individual needs.

Other care plans were more person centred. For example, one person's care plan described how they could get "very anxious and frightened" while receiving the support they needed to be able to move and therefore needed reassurance. We saw this happening.

Records and discussion showed that the service responded to people's change in needs and requests. For example, one person had moved bedrooms as they had wanted one closer to the front of the house. When this room became available staff supported them to move. For another, the manager told us how in an attempt to be more independent a person had fallen. Staff responded appropriately and the person received the correct immediate support. However, following this the manager and staff had talked to the person about the support they needed and a risk assessment had been developed. Following an incident of behaviours that deemed to challenge for one person; the GP had been involved and prescribed some calming medicines. However the manager had reviewed their support and developed a plan which reflected how this should always be used as a last resort and staff should consider the past history of health conditions to ensure they check for these and resolve any underlying cause. Staff were aware of this and how it could impact on the persons behaviour and what they would do.

The manager and quality manager told us about discussions that had taken place with staff to ensure person centred approaches. For example, they had made some changes to the daily recording of some personal care tasks and supported staff to understand that care must be based on an assessed need. For

example, undertaking specific checks on people throughout the night. We mostly observed care being given in a personalised way. For example, one person had requested that they did not wish to get out of bed until the afternoon and this was respected. This person wore no socks, shoes or slippers but told us that staff knew they did not like to wear these as they get too hot. However another person who had severe sight issues was given their meal on a plate with no plate guard, (this prevents food from being pushed off the plate) despite this being documented as needed. Once staff became aware this was rectified for the person.

Everyone said they could get involved in activities if they wished to. One person said, "I love the activities, they keep my brain going." Another said, "The activity coordinator is great."

People's care plan folders contained information about their life history and biography, hobbies and pastimes. However, it was not apparent how this was used to create meaningful activities for people. The activities co-ordinator produced a monthly plan of the activities that would take place. For example, one person said, "There are only so many puzzles I can do. I used to teach woodwork and metal work. I love making things." However, no provision was in place to enable them to continue to enjoy this. The activity co-ordinator spent time with everyone living in the home, either on an individual or group basis. For example, we saw they chatted with one person while painting their nails, they spent time reading a paper with another and in the afternoon on the first day of our visit a game of scrabble took place with some people, while an external entertainer was booked for the second day of our visit. The activity co-ordinator knew everyone well and was able to describe the activities everyone liked to participate in. They told us how they had recently spoken to people about changing the time of they worked to enable them to hold a "pub quiz" night. However, people had told them they did not want this change as they liked to go back to their rooms after their afternoon activity. During the visit both the activity coordinator and staff engaged meaningfully with people and supported them with activities that they enjoyed.

A complaints procedure was in place in a written format and on display by the main entrance. People and their families knew how to raise a concern or complaint. They said that they had not had reason to do so. A complaints folder was in place which held and logged any supporting documentation about the nature of any complaints, how these were investigated and the outcome of these. There had been no complaints since our last inspection.

Resident meetings were in place to support people to share feedback about the service in order that the staff could respond to people's requests. At the last inspection action plans had not been developed following these meetings and there was no clear evidence that peoples requests had been acted upon. During this inspection one person said, "I attend the meetings and I have made suggestions and they have been acted on." The last meeting had been held in April 2017 and an action plan had been developed. Timescales had been set but it was not clear that these had been followed up and no further meeting had taken place. For example one action recorded that once the menu had been produced a follow up meeting would be held to ensure people were happy with this. The completion date was set for "2 weeks" but there was no record this has been completed. People gave mixed view about the food with one person saying, "The menu is ok but a little repetitive." The manager told us there were plans to change the menu's.

## Is the service well-led?

### Our findings

Since the introduction of the changes to the way in which CQC inspect locations, Merry Hall Nursing and Residential Home has not achieved an overall rating of good or a rating of good in the well led question. February 2016, October 2016 and March 2017 rated the well led domain as inadequate, with the February 2016 and March 2017 inspection rated as overall inadequate.

During each of these inspections we found multiple and repeated breaches of the regulations. The provider has been in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014 since February 2016. This regulation relates to the providers monitoring and assessing of the quality and safety of the service. At this inspection we found the provider continued to breach this regulation.

Since our inspection in March 2017 the provider had recruited a new management team. This included a deputy general manager, a quality manager who commenced their role in June 2017 and a new manager who started working at the home five weeks prior to our inspection. There was no registered manager in post but the manager had commenced the process to apply to become the registered manager. The previous registered manager was no longer in post and was due to leave the home the week of our inspection.

The Commission had previously imposed a condition of the provider's registration requiring them to carry out weekly audits of all people's care records and medicines. On a monthly basis they were required to submit a report to the Commission informing us of their findings and actions. We had received the report required for the month before our visit however, the care plan audits were not available in the home for us to see and to check their accuracy. The report we received told us the last audits were carried out on 27 August 2017. However, medicine audits were not available at the time of the inspection and the last care plan audits we found for people were dated 2 August 2017. We were told this had been the responsibility of the previous manager who had since left and the records could not be found. We were concerned that the manager said they had not been made aware of this condition of registration until after our inspection visit. They advised the nominated individual for the provider sent this information to them a week after our inspection.

We saw examples where the weekly care plan audit dated 2 August 2017 had been successful in driving changes. For example, one person identified no activities had been recorded, we found at our inspection; activities had been recorded in the form of a code. Some care plan audits identified the need to use a Waterlow assessment and this had been implemented. A Waterlow assessment is used to assess a person risk of skin breakdown. However, the audit had not been effective in identifying all improvements needed. For example, one person's care plan audit did not identify that information about a food allergy they had was not in place. Another person's care plan audit did not identify conflicting information between their different care plans and the handover about the frequency the person should be repositioned. Where blood sugar records were inconsistently completed and mattress checks were recorded inaccurately we were unable to see if audits had been effective in identifying these as the weekly audits were not available to us. Audits had not been effective in identifying recording errors in the administration of medicines and a lack of

temperature checks on medicines storage. Effective audits would identify these issues and ensure that action was taken to provide staff and agency workers with accurate information about people's needs.

The quality assurance manager told us that they were not confident in the accuracy of the care plan audits that had been completed and said they had intended to complete a thorough audit of all people's care records the week of our inspection; however this had been delayed in order that they could support the inspection visit. They intended to complete this following our inspection.

Since the last inspection the provider had purchased a new electronic management and quality system. The manager and the quality manager were in the process of introducing this at the time of the inspection visit and it had not been fully embedded by the time of the inspection. The first audits had been completed on a variety of area's including; housekeeping; laundry; health and safety; maintenance; quality assurance and care. These audits then produced action plans however we noted that the reports did not include the date the audit was completed. The action plans were not always specific, timescales were not set and the person responsible was not allocated. For example, the care audit asked if risk assessments were completed within correct timescales. The action plan recorded 'no' as the response and the action required stated, "If no, review risk assessments and any consequent care documentation carry out review, supervision and retrain responsible staff member. Delegate, train and resource someone to review the system to ensure that the QCS policies are being followed and the problem will not occur again." No timescales had been set for this. The quality assurance manager told us this audit was about the level of compliance with the management system and not individual people's risk assessments. They told us the system aimed to provide an enhanced monitoring framework across all aspects of the management of the service.

The provider had told us a new tool had been implemented to aid in the assessment of people's needs to ensure that appropriate numbers of staff were provided. However there were no records to show an assessment had taken place since June 2017 and the staffing levels had reduced since this time. The manager, compliance manager and nominated individual were unable to explain how this assessment worked. The nominated individual told us there were no instructions to support its use and we could not establish how this related to people living in the home.

Since the last inspection the provider had developed an action plan to address the concerns found. The nominated individual told us this had been theirs and the deputy general manager's responsibility to monitor and update. This had been successful in planning some improvements and ensuring they were completed. For example, at the last inspection we found the handover had been ineffective in ensuring staff and agency workers had the information they needed to safely support all people living in the home. At this inspection the handover documentation was more comprehensive and gave an overview of the most significant needs for people. We observed three handovers and found that information was clearly provided to staff on shift about people's needs and how they had been. However the action plan had not been reviewed since 10 July 2017. Although actions had been signed off as completed, this process had not ensured systems and process were fully embedded. For example, this had recorded the dependency analysis system as completed but had not identified a change in staffing levels had taken place without a review of this. The lack of review had not identified that timescales had not been completed for some actions. For example, this recorded that all staff were to complete risk assessment training by 31 July 2017. However, the training matrix showed one senior carer and three nurses had not done this.

Although systems had been implemented to monitor and assess the quality and safety of the service these were not embedded. We continued to find some concerns about the management of risks for people and the accuracy of care records. The systems implemented and ongoing weekly audits had not always identified the concerns we had. This was an ongoing breach of Regulation 17 of the Health and Social Care

Staff understood their roles and responsibilities in the home although this needed improving in areas. For example, two nurses told us that there had been problems with people running low, or running out of their medication. They said this was due to no one nurse taking responsibility for monitoring and ordering stock. However, we observed that the system used an alert to inform nurses when stock was running low and they could reorder this directly using the system. The manager told us they had asked the clinical lead to undertake weekly stock checks which would aim to reduce these occurrences however, one nurse told us these had not taken place yet. The manager told us they were arranging further training for the nurses on the use of this system. The manager had also identified the need to ensure nurses were supported and clinical governance was improved. They had agreed with the provider to recruit the support of a consultant to assist with the clinical governance and clinical supervision of nurses. The first meeting with this person took place during our inspection and a further meeting had been planned for the week following our inspection.

The manager and quality manager had a good understanding of the service and where improvements were required. They had identified individual staff member's strengths and areas for development. They were aware of the need to make improvements to records and to the involvement of people and their relatives in making decisions about the service. Whilst they had a clear focus of what they needed to do, they were not able to show us a plan which prioritised and addressed each issue. The manager and quality manager told us they intended to produce a clear plan of all actions needed, with timescales which would support them to track these effectively.

People and family members told us that the new manager was very approachable and open to suggestions. One person said, "The manager is lovely." Another said, "I like the manager." Another said, "The manager is very good, compassionate." A visiting health professional told us, "I think they are a lot better. There were some issues last year but things have got better over the last 12 months; I deal mostly with the nurses or [named person] but I do feel the home is well led now; I honestly think they have made some significant changes; acting appropriately; very caring; It is a lot more calmer; the atmosphere; they have got a handle on it now."

Staff told us how they felt things at the home had improved and that they felt supported and listened to by an open and approachable management team. One member of staff said, "I feel it is a lot better now that [the manager and quality manager] are here. It was very difficult before as you weren't certain what was happening. I feel supported by them [the manager and quality manager]. I feel there is someone above me who is sorting it out." A second member of staff said, "I think it is just different, different managers have different ideas. There is more support [now], more openness from management. I am not afraid to ask or raise anything. I find the carers really good. The back up now is good. If they need to ask something they can. Yes I feel supported [by the management team]. All we need to do is be open so we can speak with them; I feel I would be listened to and something would be done".

Registered persons are required to display the rating given to them by the Commission following an inspection. The rating given following our inspection in March 2017 had been displayed on the provider's website and was on display in the entrance hall.