Merrydale Residential Care Home Limited

# Merrydale Residential Home

## Inspection report

Merrydale
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Tel: 01983563017

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## Ratings

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|---|---|
| Overall rating for this service | Requires Improvement |

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|---|---|
| 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? | **Requires Improvement** |

# Summary of findings

## Overall summary

This inspection took place on 4 April 2017 and was unannounced. Merrydale provides accommodation and personal care for up to 16 people, who do not require nursing care. There were 14 people living at the home when we visited.

The home had 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 registered manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded. Applications to the local authority for approval of restrictions on some people's liberty had not been made where required.

Risk assessments and care plans were not up to date and lacked individual detail as to how people should be cared for. This placed them at risk of not having all their needs met in a consistent and safe way. Although staff had received training they were not always following safe procedures when they assisted people to reposition; nor did they follow care plan instructions as to how a person should be supported with drinks. We discussed these areas with the registered manager who told us they were taking immediate action to address the areas of concern.

Providers are required by law to notify CQC of significant events that occur in registered services. We identified safeguarding incidents and a fall following which a person required hospital treatment which had not been reported to us. Where incidents between people, or falls resulting in an injury, had occurred the registered manager told us they had not provided a written explanation of the event to the person or their relatives although they had spoken with them about the incident.

People received the personal care they required and were supported to access other healthcare services when needed. People received a varied diet and were supported appropriately to eat. The home's environment was homely, clean and safe for people.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to maintain friendships. People and their relatives were positive about the way staff treated them. People were treated with respect and given choice; their dignity and independence were promoted. People received mental and physical stimulation in the form of organised and ad hoc activities.

There were enough staff to meet people's needs. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work.  Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care.

There was a complaints policy in place and people knew how to raise concerns. Where issues had been raised the provider had acted to the satisfaction of the person raising the concern.

We found four breaches of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. 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?

**Requires Improvement**

The service was not always safe.

Risks to people were not always managed safely and documentation relating to risk assessment and management was not up to date.

People were supported to receive their medicines safely. All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded as required by the Mental Capacity Act. The registered person had failed to ensure people were not deprived of their liberty unlawfully.

People received the personal care they required and were supported to access other healthcare services when needed. People received a varied diet and were supported appropriately to eat.

Staff were suitably trained and supported in their work.

### Is the service caring?

**Good**

The service was caring.

People were cared for with kindness and compassion. Staff knew

people well, interacted positively and supported them to maintain friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect and choice. Their dignity and independence were promoted.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans lacked clear, specific and up to date information about people's individual needs and how these should be met however people were receiving personalised care that met their needs

People received mental and physical stimulation in the form of organised and ad hoc activities.

The provider sought and acted on feedback from people. There was a complaints policy in place and people knew how to raise concerns.

## Is the service well-led?

**Requires Improvement**

The service was not always well led.

The registered manager had not ensured that CQC was notified of all incidents which affected people who used the service.

The provider's quality assurance systems had not ensured that all aspects of the service were monitored and people were consistently receiving care in a safe planned manner.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the registered manager.

The service had an open and transparent culture. External professionals were welcomed and the registered manager consulted with them when required.

# Merrydale Residential 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 was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 April 2017 and was unannounced. The inspection was undertaken by one inspector and an expert by experience. An expert by experience is a person who has experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home and four visitors. We spoke with the main director of the company, registered manager, five care staff and ancillary staff including, the cook and housekeeping staff. We also spoke with one visiting health and social care professional. We looked at care plans and associated records for four people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care, support and activities being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

This was the first inspection for Merrydale following a change in its registration in December 2015.

Requires Improvement

# Is the service safe?

## Our findings

Not all risks to people were minimised through the use of effective risk assessments which identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Risks to people were not always formally assessed and staff did not always ensure risks were correctly managed, placing people at risk of harm. For example, one person was cared for in bed and required staff to assist them to change their position on a regular basis during the day and overnight. The person's risk assessment for repositioning did not specify the equipment required to do this safely, although we saw this was in place in their bedroom. We found that at night two staff were not always present when the person was being assisted with personal care and repositioning. This placed the person at risk as correct moving and handling procedures, as confirmed by the registered manager, required two staff. The person's care plan stated that they should be supported to receive drinks using a tea spoon. We saw the person had a desert spoon in a glass of juice on their table and asked staff about this. Staff confirmed they were using the desert spoon not a tea spoon as detailed in the care plan. Care staff also told us they used the desert spoon as they could more easily pour the drink into the person's mouth. Fluids should not be poured into a person's mouth as this increases the risk of the person inhaling them as they may not be ready to swallow. This meant the person may receive too much fluid at a time placing them at risk of inhalation or choking on the drink.

Documentation, such as individual risk assessments, were not always fully completed or updated when the person's needs and risks changed. For example, one person's risk assessment identified that they required a walking stick but may forget to use this. Other information in the care plan showed that following a fall and hospital admission in May 2016 they had required a walking frame to assist them with their mobility and no longer used a walking stick. Their falls risk assessment had not been updated following several significant falls requiring medical attention in May and June 2016. The assessment did not indicate that they had had any falls in the previous year and identified then as low risk of falls, which was inaccurate. Other risk assessments were not present, such as the risk of social isolation for people who spent all their time in their bedrooms, or where people had specific medical conditions such as diabetes which may place them at risk.

The failure to ensure risks relating to the safety and welfare of people using the service were assessed and managed was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought these concerns about the way staff were repositioning and assisting a person with their drinks in an unsafe manner to the attention of the registered manager. The registered manager took immediate action to ensure that staff always followed the correct procedures for the safety of people. We discussed our concerns about the way risks were managed and the documentation in place around risk assessment with the registered manager. They agreed improvements were required and told us action was being taken to ensure people's safety.

The registered manager reviewed all accidents and incident such as where people had fallen and considered additional measures that could be taken to protect the person. For example, they had identified that one person was stepping over an audible alarm mat which was in place to inform staff when the person

was moving about their room. As a consequence an alternative form of alert system was introduced. Records viewed showed that where necessary external medical advice was sought when people had fallen.

People were supported to maintain a level of independence by continuing to undertake some activities where there may be a risk. For example, a person asked a care staff member to see them up the stairs. The care staff member carried the person's walking aid up the stairs first then walked behind the person who climbed the stairs safely and used the walking aid again once on the landing. This enabled the person to exercise and retain the ability to use stairs whilst minimising the risks to the person.

Environmental risks were assessed and managed appropriately. The registered manager had assessed the risks associated with the environment and the running of the home; these were recorded along with actions identified to reduce those risks. They included the use of electrical equipment, fire risks and the control of substances hazardous to health COSHH. No infection control concerns were identified and people were protected as they were living in a clean environment.

Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Staff told us they received fire training which was confirmed by records. People had individualised evacuation plans in case of an emergency which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and firefighting equipment was regularly checked. An emergency contingency plan was in place to guide staff as to the actions they should take and provided essential information such as phone numbers for who staff should contact in an emergency. Arrangements had been made with a nearby care home should people need to be evacuated and require a safe, warm place to wait until they could return to the home or alternative accommodation. Staff had been trained to administer first aid.

People were supported to receive their medicines safely. Everyone we spoke with told us care staff administered their tablets. One person said "The carers give them to me. I take them as I know they are prescribed". Another person said "If you have a headache you just ask for some tablets and they'll get them for you". All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Medicine administration records (MAR) documented that people had received their medicines as prescribed. We undertook a stock check of some medicines and found that these were correct, indicating that people had received these as prescribed and recorded on the MARs. Training records showed staff were suitably trained and had been assessed as competent to administer medicines.

Some people needed 'as required' (PRN) medicines for pain or anxiety. Although staff had information about the PRN medicine, there was no individual guidance, specific to the person, as to when this medicine should be administered. Whilst most people were able to state if they required medicine for pain relief, staff told us some people may not be able to do this. A formal pain assessment tool to help staff identify when they should administer pain relief was not in use. During the inspection staff obtained a copy of a recognised assessment and told us they felt this would be useful for some people. Following the inspection the registered manager told us the pain assessment tool was now in use and helping staff determine if 'as required' medicines should be given. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

Safe systems were in place for people who had been prescribed topical creams and these contained labels with opening and expiry dates. This meant staff were aware of the expiration of the item when the cream

would no longer be safe to use. The home was storing some medicines that required to be stored at cooler temperatures. A refrigerator was available and records showed medicine refrigerator temperatures were monitored. This meant that any fault with the refrigerator would be noticed in a timely manner and the safe storage of any items stored could be assured.

There were appropriate policies in place to protect people from abuse. One person told us "I feel safe here". A visitor told us "It's such a relief that [my relative] is so well cared for and safe living here". Staff said they would have no hesitation in reporting abuse. One staff member told us, "I would speak to [name of registered manager]. If it was about them I would go to social services or CQC." Another staff member said, "If I had concerns I would contact my manager, I know they would sort it out". All staff were confident the registered manager would take the necessary action if they raised any concerns and they knew how to contact the local safeguarding team if required. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them.

There were sufficient staff available to meet people's needs. When asked if they thought there were enough staff, a person said "Yes, as far as I'm concerned". A visitor said "They [care staff] never rush her". A person told us "I ring the bell at bedtime sometimes; you don't have to wait long for them [care staff] to answer it". Another person said "It's almost instant most of the time", when asked how quickly call bells were responded to by staff. During the inspection call bells were heard ringing for only a very short time before being answered. Care staff were supported by ancillary staff, such as housekeeping and catering. This meant they were able to focus on providing care and engaging with the people they supported. The registered manager told us staffing levels were determined by the needs of the people they supported. The staffing level in the home provided an opportunity for staff to interact with the people they were supporting in a calm, relaxed and unhurried manner. Staff responded to people's needs promptly. There was a duty roster system, which detailed the planned cover for the home. This provided the opportunity for short term absences to be managed through the use of overtime and the registered manager was also available to provide extra support when required.

The provider had a recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate pre-employment 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. Staff confirmed these processes were followed before they started working at the home.

Requires Improvement

# Is the service effective?

## Our findings

People's ability to make decisions was not always formally assessed or recorded as required by the Mental Capacity Act 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Some people had a cognitive impairment and may not have been able to make certain informed decisions. These included decisions around the delivery of personal care, the use of bed rails, the use of alarms to alert staff they were moving about or leaving the home, and the administration of medicines. However, there were no records of the assessment of people's ability to make these decisions or any action taken to support the person to make decisions. The registered manager and care staff were unaware that one person had a power of attorney for health and welfare in place. When asked the registered manager told us no-one in the home had a Power of Attorney for health and welfare however we found a copy of the legal document showing this was in place within a person's care file. This is a legal procedure which gives another person, usually a close relative, the legal authority to make decisions on behalf of a person who can no longer make these decisions. People were therefore at risk that decisions which restricted their rights may not be legally made in their best interests. The registered manager and care staff had completed training in the MCA however they had not used the training to inform their practise.

There was a failure to ensure that mental capacity assessments were undertaken where appropriate in accordance with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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 was being met. The registered manager told us that there was no need for DoLS applications to be made as nobody was subject to any restrictions. However, we identified that there were audible alarms in use which would notify staff if some people were moving about the home or leaving the building. We were told that one person who had a cognitive impairment had been moved to another bedroom where they would have access to the garden so would be able to move about more freely. The registered manager informed us that the garden was completely secure with the gate locked. This meant that although the person had the freedom to enter the garden they were prevented from leaving the premises. We were also told that an audible alarm was used on the front door at certain times when staff were busy to alert staff the person was leaving the home via the front door. This meant the person was restricted and could not freely leave the home. Staff told us that in the event of the person leaving the home they would follow them and encourage them to return to the home. They said that if the person did not return they would remain with the person outside the home. Therefore a DoLS application should have been applied for in respect of this and some other people where similar restrictive practices were in use. The registered manager and care staff had completed training covering DoLS however they had not used the training to inform their practise.

The failure to ensure people were not deprived of their liberty for the purpose of receiving care or treatment without the lawful authority was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us how they offered choices and sought consent before providing care and were clear about the need to seek verbal consent before providing care or support. We heard care and other staff seeking verbal consent from people throughout our inspection. One care staff member said, "We ask them [people]. If they said no, we don't do it, we would explain why we are trying to help them and how but if they still said 'no' we would try later". One person told us "You can do what you want to do".

People received the personal care they required. One visitor told us "[Name of relative] wasn't looking after herself at home, but she's well looked after here". Care staff described how they supported people which reflected the information in people's care plans. Staff recorded the personal care they provided to people including if people had declined offered care such as a shower or bath. These records showed people were supported to meet their personal and other care needs. We saw that although people were allocated a bath 'day' each week they did not have to keep to this. If they declined, they were offered again at another time or alternative day. Where requested, people were able to bath as frequently as they wished with records showing some people received several baths each week. A person told us "There's a machine to let me down into the water. It's lovely and I can have a good old soak".

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. A person told us "I used to see a GP but now there's a doctor who comes in if he's called for". Another person told us "Someone comes in to do our feet", whilst a visitor said, "[Name of relative] had an eye test recently, they came in here to do it, and she had hearing problems which were picked up by the staff here and dealt with". People were seen regularly by doctors, opticians and chiropodists as required. The registered manager was aware of how to contact health professionals including home visiting opticians and dentists should these be required for people not be able to go out to clinics or surgeries. Should people require to be transferred to other care settings, such as hospital, the registered manager stated that a member of staff would always accompany the person if a relative was unable to do so. They explained this was to ensure essential information was provided to hospital staff and support the person in the unfamiliar environment. We spoke with a visiting healthcare professional who was complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's health care needs were met.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. A visitor said "[Name of relative] takes an age to eat but the carers don't rush her". Another visitor said "You just watch them [staff] with one or two [people] who are not managing to eat much, they are so patient with them". Another person told us "I don't eat meat and they give me fish or a vegetarian meal". People received the appropriate amount of support and encouragement to eat and drink. Where people required support this was done in a kind, unhurried way. Staff were attentive to people and noted when people required support. Staff noted when people had not eaten well and recorded this within care records and passed this information over during handover meetings to the next set of care staff.

People were supported to have a meal of their choice. People told us the food provided at Merrydale was very good. One person said "The food is lovely here, all freshly cooked". Another person said "We are very well fed here I think". The cook was aware of people's preferences and dietary needs. They told us that where people had dietary needs linked to medical conditions, such as diabetes, they were aware and able to provide a suitable meal. Drinks, snacks and fresh fruit were also offered to people throughout the day, Staff told us they could provide people with food at any time this was requested or required.

Staff were also aware of people's dietary needs and preferences. One person had a different dessert to other people sitting with them. They told us "I'm diabetic so can't have the other pudding". Staff told us they had all the information they needed and were aware of people's individual needs although people's needs and preferences were not always clearly recorded in their care plans. Meals were appropriately spaced and flexible to meet people's needs. People were able to choose where they ate their meals. Some were happy to eat in the dining area, others in their bedrooms. Mealtimes were a social event and staff engaged with people in a supportive, patient and friendly manner.

People were supported by staff who had received an effective induction into their role, which enabled them to meet the needs of the people they were supporting. Each member of staff had undertaken an induction programme, including a period of shadowing a more experienced member of staff who assessed their suitability to work on their own. Staff who were new to care, received an induction and 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. New staff confirmed they had received an appropriate induction and were doing the Care Certificate.

Staff were supported to undertake vocational qualifications and had access to other training focused on the specific needs of people using the service, such as, dementia awareness and end of life care. When asked if they felt staff were suitable trained, one person told us "Yes, they have to be. There is a woman who comes in for training and tests them sometimes". Care staff were positive about the training they received. Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, we saw staff supporting a person appropriately to stand from their chair and walk with their walking frame.

Staff had regular supervisions with a senior member of staff. Supervisions provide an opportunity for management to meet with staff, feedback on their performance, identify any concerns, offer support, assurances and identify learning opportunities to help them develop. Staff also received an annual appraisal, with the registered manager, to assess their performance and identify development objectives. Staff said they felt supported by the management team and senior staff. There was an open door policy and they could raise any concerns straight away.

Merrydale provided a homely environment with all bedrooms for single occupancy and some with ensuite facilities. Communal areas were spacious and provided a variety of sitting areas where people could choose to sit in quieter areas if preferred. We saw the conservatory was used to provide a more private area where people could receive visitors away from other people. Most bedrooms were provided on the ground floor with stair lift equipment available for people to access bedrooms on the first floor of the home. Outside there was an enclosed garden with access suitable for people with mobility needs or using a wheelchair. The registered manager said they had started using signs to help people living with dementia orientate themselves around the home such as to identify people's bedrooms, toilets and bathrooms.

Good

# Is the service caring?

## Our findings

People were cared for with kindness and compassion. People spoke warmly about all the staff at Merrydale including care, management, housekeeping and catering staff. One person said of the staff, "The girls [care staff] are so kind you wouldn't believe it – all of them". Another person told us "The carers are very good and helpful". A third person said "They're very helpful here. I had a lot of problems at first and they helped me". A visitor said, "My overwhelming comment is that the staff are kind, caring and friendly here". Another visitor said, "The staff are lovely; it is so important". These comments were echoed by other people and visitors we spoke with, including a visiting health professional who told us, "They [care staff] seem caring and compassionate".

Interactions between people and staff were positive and friendly. A person told us "I've just had a good bath and a good laugh". We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff did not rush people when supporting them. We heard good-natured, friendly conversation between people and staff showing they knew people well. People were clearly relaxed and comfortable in the company of staff. Staff spoke warmly about people and knew how to relate to them in a positive way. A visitor told us "She loves the staff, some more than others. They saw that she was taken by a soft Christmas decoration animal figure. They gave it to her and she carries it everywhere".

Staff treated people with dignity and respect and described the practical steps they took to preserve people's dignity when providing personal care. Before entering people's rooms, staff knocked, waited for a response and sought permission from the person before going in. A sign was available on bedroom doors to alert staff or visitors if personal care was being undertaken and that they should not enter. Care staff explained how they always closed curtains, kept people covered as much as possible and told people what they were about to do. This would help ensure people's privacy and dignity during personal care. All bedrooms were for single occupancy and many had ensuite facilities. This meant personal care could be provided in private. Confidential care records were kept securely and only accessed by staff authorised to view them.

People were offered choices and their decisions were respected. One visitor said "It's not institutional here, it's friendly and homely". A person told us, "I like to eat in my room. I have a tray and my own cutlery on it", whilst another person said, "We can have what we want for breakfast. I don't want fried food, just cereals or an egg". We heard staff asking people what they would like for their evening meal. One person requested an alternative not on the menu and we saw this was provided. This showed people felt comfortable telling staff what they wanted. Another person told us how they were involved in decorating their bedroom. They told us "I was encouraged to make my room just the way I wanted. I chose cream and green colours, just like my lounge at home. I love my room, at night I can see the lights twinkling from the ships going by in the Solent". Some people living at Merrydale had a diagnosis of dementia. This can affect their ability to make choices. Care staff described how they supported people by showing them clothing options from their wardrobe. The registered manager told us they did not have picture cards to help people make choices about which meal they would prefer. They said "That's something we were going to start doing, I think we took some pictures

but have not really got organised on that yet". They were aware this would help improve people's ability to make choices.

People's independence was promoted. At lunch time staff encouraged a person to eat without taking over. Plates with slightly higher sides, but which still looked like standard dinner plates were provided where necessary. These supported people to eat independently without appearing to be using specialist equipment. A range of drinking cups was available to suit the various needs and preferences of people. Care staff were seen encouraging people to rise from their armchairs safely by pushing themselves up using the arms of the chair rather than relying on staff or equipment to stand up. People were also encouraged to undertake valued tasks. For example, we saw a person asking if they could help the care staff by drying up the coffee cups. They were supported to do this and also to help lay the tables for lunch. By enabling people to undertake day to day tasks people would continue to be active but also feel they were a valued member of the home, thereby promoting their self-esteem and well-being.

Care files contained information about people's lives, preferences and what was important to them. Staff were able to tell us about people's preferred drinks and foods. For example, they were able to explain why one person's fluid recording sheet showed they were not being offered hot drinks. A care staff member said "We noted that [name of person] didn't really drink much if it was tea or coffee but would if it was juice". The same staff member was also able to tell us the person's favourite food and confirmed this was provided if the person did not eat other offered food. Staff were able to tell us about people's life histories, such as their previous occupations. Merrydale supported people to maintain family relationships. Visitors told us they were made welcome and felt able to visit at any time. People living at Merrydale told us they liked animals. One person said "Some of the carers have dogs and they bring them in sometimes to see us". There was a resident cat who people told us was friendly and they loved to see. They were also pleased to see a small dog who came into the home daily with the provider. We saw one person asking the dog to jump onto their lap so they could stroke him.

Where people had spiritual needs these were known and met. Care plans detailed any spiritual beliefs or needs a person may have and how they liked these to be met. A person told us "Once a month we have a service here with a local vicar". We saw there were hymn sheets within a bookcase and a person told us "That's my cross in that vase; the vicar gave them out last year". The registered manager was aware of how to access religious leaders of various faiths if required.

Merrydale had a system of keyworkers. A keyworker is a designated member of care staff with additional responsibility for a person such as ensuring they have everything they need and have someone they can ask about things. People were aware of their key workers. One person told us "We've all got a carer whose name is in my room. I can ask her to get things for me from shops outside".

Requires Improvement

# Is the service responsive?

## Our findings

Care plans did not support staff to deliver consistent care and support to people. Care plans lacked clear, specific and up to date information about people's individual needs and how these should be met by staff. For example, one person was diagnosed with diabetes and was receiving daily insulin injections from the district nurses. Care staff were monitoring the person's blood glucose levels but there was no specific guidance for care staff within the care plan as to the action they should take depending on the results of the blood glucose tests. The care plan stated the person should have a diabetic diet but there was no information about when or what this should be or about snacks the person required to help ensure their blood sugar levels remained stable at all times.

Other people's care plans also lacked information as to how known medical conditions should be managed or the individual support people required who were living with dementia. Where people had individual preferences about food and drinks, but were unable to say, this was also not detailed within their care plans. Care plans did not state what people's preferred activities were. For example, one person was cared for in bed but their care plan did not specify that they liked the radio on or the type of music they enjoyed. Care staff were aware of this information but it had not been recorded. Information was not included in care plans about people's preferences for how they liked personal care to be provided, or specific routines they liked to follow. The lack of up to date individual detail in care plans meant people may not receive the care and support they required in a consistent way should their regular care staff not be available.

Care staff told us they reviewed care plans on a monthly basis. However, this was a review of the previous month, and events which had occurred, rather than a review of the care plan to determine if it was still relevant to the person or needed updating. When we asked people about their care plans they were unsure about these. There was no information within care plans as to how people or relatives had been involved in the assessment of need, planning of how needs would be met or to confirm their agreement with the care plan.

The failure to ensure an up to date care plan for each person was in place detailing how decisions in relation to the care provided were taken was a breach of regulation 17 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

However, people experienced care that was personalised and staff were aware of the care people required. People told us that the care staff knew their preferences and respected their wishes. People and relatives were happy with the way their personal and other care needs were met. One person said "I've got a problem that needs treatment up at [name local NHS Hospital]. They [care staff] make sure I'm ready on time before I go every time".

Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift, including, information about the personal care people had received and if they had eaten and drunk well. A visiting health care

professional told us staff noted changes in people's needs and contacted them appropriately. There were systems in place to respond to changes in people's prescribed medicines. The registered manager told us that they were able to obtain medicines promptly by collecting these from out of hours pharmacies meaning there would not be a delay in the person commencing treatment.

People received mental and physical stimulation in the form or organised and ad hoc activities. Staff had time to spend with people providing individual and group activities. Each morning and afternoon a designated staff member was responsible for organising an activity. There was a general plan in place but we saw this could be changed to suit the needs and wishes of people on the day. One person told us "We have quizzes; a man comes to do it with a big screen". Another person said "We play cards, musical bingo and things like that". A third person said "You get plenty of entertainment; we even had someone come down from Carisbrooke Castle. They brought things from the castle museum to show us, it was very good". People also told us about a visiting musician and a visiting activities provider for arts and crafts. During the inspection we saw people involved in a competitive game of jumbo skittles which they were clearly enjoying. This provided both physical and mental stimulation. People were happy with the level and type of activities provided at Merrydale.

Meetings were held several times each year with people to discuss their views about the service and see if there were any changes they would like. We viewed the minutes of these meetings which covered areas such as activities and menus as well as providing information for people about any changes which may affect the home.

People and visitors said they would make any complaints to the registered manager, who they knew by name. Everyone we spoke with said they would feel able to raise a complaint but none had any complaints or told us they had ever needed to complain. For example, one person said, when asked if they had any complaints "No, I can't think of any". The registered manager told us people and relatives were informed about the complaints procedure when they undertook a pre-admission assessment and written guidance was also provided to people or relatives. The complaints log was reviewed and showed that no formal complaints had been received; however, there were systems in place to deal with complaints if these occurred. The registered manager said they spoke with people and visitors every day and were therefore able to resolve any issues before they became formal complaints. For example, they told us people had commented they were cold and therefore a new boiler and more efficient radiators had been installed.

Requires Improvement

# Is the service well-led?

## Our findings

People were positive about their experience of living at Merrydale. One person said "It couldn't be better here. Never a day goes by when I don't say to myself how lucky I am to live here". Another person said they had settled into Merrydale very well. They added "I had a bad dream recently. I dreamt that the home was closing, I was so upset. I told the owner the next day and he reassured me it wasn't closing". A visitor said "Once [name of relative] was here she improved and enjoys the company, It's the staff who make all the difference, the staff are wonderful here".

Although people and visitors were happy with the care provided and felt the home was well run we identified areas where improvements were required. The registered manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded. Applications to the local authority for approval of restrictions on some people's liberty had not been made. Risk assessments and care plans were not up to date and lacked individual detail as to how people should be cared for, placing them at risk of not having all their needs met in a consistent and safe way. Although staff had received training they were not always following safe procedures when they assisted people to reposition or following care plan instructions as to how people should be supported with drinks. This was also placing people at risk. We discussed these areas with the registered manager who told us they were taking immediate action to address the areas of concern we identified.

Providers are required by law to notify CQC of significant events that occur in registered services. This allows CQC to monitor occurrences and prioritise our regulatory work. We identified safeguarding incidents and a fall following which a person required hospital treatment which had not been reported to us. Discussions with the registered manager showed they had not realised that these incidents required to be reported to us.

The failure to notify CQC of incidents of a serious injury and allegations of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person, the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. Where incidents between people, or falls resulting in an injury, had occurred the registered manager told us they had not provided a written explanation of the event to the person or their relatives although they had spoken with them about the incident. The registered manager wrote to us following the inspection and informed us that the policy in respect of duty of candour was now being followed.

Prior to the inspection we requested the registered manager to complete provider information Return (PIR). We did not receive this. We contacted the provider who told us they had not received the request for the PIR which was sent via email. Other information requested by CQC such as contact lists were submitted promptly when requested.

There was a clear management structure, which consisted of the registered manager, deputy manager and senior team leaders. Staff were confident in their role and understood the part each other played in delivering the overall service for people. The registered manager encouraged staff and people to raise issues of concern with them, which they acted upon. A new care staff member said "I feel very supported by all the staff", they added how much they enjoyed working at Merrydale. Another care staff member told us that the home was a "good place to work". Most staff had worked at the home for several years. We observed staff worked well together, which created a relaxed atmosphere and was reflected in people's care.

Although a limited company, Merrydale is essentially family owned and the provider was actively involved in the day to day running of the home. They told us they visited the home daily and we observed them interacting with people in a way that showed they knew everyone living at the home. One person said "I know the owner, he comes in everyday, I take my hat off to him". Another person said "The owner? Oh, yes it's that man who is here today with the little dog". Visitors were aware of who the provider and registered manager were. Staff were also aware of the provider and interactions observed showed they felt at ease with him. Care staff said they would feel able to raise any areas of concern with the registered manager or the provider.

The registered manager had an open door policy for people, families and staff to enable and encourage open communication. Staff told us there were staff meetings. One staff member told us, "Staff meetings are held quite regularly and we always get asked at the end for any ideas or if we have any concerns". We saw the minutes of the most recent staff meeting were available for staff to read. This meant any staff unable to attend would be aware of what had been discussed. The registered manager told us how they had changed the dates of some weekly checks following suggestions from a staff member. This had resulted in the weekly checks being spread out over the week and not all being completed on one day, making it easier for staff to do these and undertake their routine duties.

The registered manager described their goal for the home as being to provide "A happy place where people could live and enjoy their lives". Staff were aware of the provider's vision and values and how they related to their work. One member of care staff said "It's their [people who lived at Merrydale] home, we are here to help them enjoy their lives and have their needs met as they want them to be". People all told us they were happy with the service provided. All staff members said they would be happy for a member of their own family to receive care at Merrydale.

The registered manager told us they ensured the quality of the service provided by talking to people, relatives and staff. More formal quality assurance systems were also in place, including seeking the views of people about the service they received. Surveys had been sent to people, visitors and external professionals in August 2016. The surveys could be completed anonymously and those which had been returned showed everyone was happy with the service provided at Merrydale. Auditing of all aspects of the service, including care planning, medicines, infection control and accidents was conducted regularly. We saw that audits of medicines had identified staff were not always signing the Medicines Administration Records. Action was taken to address this with staff and a subsequent audit noted that there had been an improvement in staff signing these records. However, the audits and management quality assurance procedures had failed to identify the breaches of regulations we identified during the inspection and were therefore not fully effective.

The registered person's failure to establish systems and processes to ensure compliance with regulations whilst caring out the regulated activity was a breach of regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they kept up to date with current best practice and was keen to develop the service for the benefit of people. For example, they had taken pictures of staff to be used on a notice board to inform people which staff were on duty each day. The registered manager had introduced 'care kits' within each bedroom. These included all equipment staff would need should a personal care need be required; the kits included disposable gloves, aprons and bags to transport any soiled linen or waste to the laundry or for disposal. An unused bathroom had been converted into a sluice room as the registered manager had identified a need for this. When we identified areas which could be improved the registered manager was receptive to these and where necessary took immediate action. This showed they were willing to listen to others opinions and views about the service.

There was an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the office and were told policies were reviewed yearly or when changes were required. This ensured that staff had access to appropriate and up to date information about how the service should be run.

Merrydale aimed to be involved with the local community as far as possible. People had been supported to attend performances at a local school and when able were assisted to visit local shops or banks. The home supported its staff to develop their careers and had provided a placement for an apprentice. This had been successful and the apprentice had gained a permanent job at Merrydale.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The registered person did not notify CQC of relevant incidents involving the people who used the service. Regulation 18 (1) and 18 (2) (a)(e) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 11 HSCA RA Regulations 2014 Need for consent<br><br>The registered person had failed to ensure that where people lacked the capacity to give informed consent action was taken to comply with the Mental Capacity Act when providing care and treatment. Regulation 11 (1)(3)(4) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>The registered person had failed to ensure risks relating to the health and safety of people using the service were assessed and action taken to mitigate identified risks to ensure the safety of people. Regulation 12 (1)(2)(a) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered person had failed to ensure people were not deprived of their liberty |

unlawfully. Regulation 13(5)(7)(b).

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered person had failed to ensure an up to date care plan for each person was in place detailing how decisions in relation to the care provided were taken and to establish systems and processes to ensure compliance with regulations whilst carrying out the regulated activity. Regulation 17 (1)(2)(a)(b)(c) |