Care Quality Commission

Buckland Care Limited

Merry Hall Nursing and Residential Care Home

Inspection report

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Date of inspection visit:
22 March 2017
23 March 2017

Date of publication:
18 January 2018

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

This inspection took place on 22 and 23 March 2017. The inspection was unannounced and was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. The information shared with CQC about the incident indicated potential concerns about the assessment and management of the risk of choking for people. This inspection examined those risks as well as other areas.

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 27 people living at the home.

The service has a history of breaching legal requirements. Following an inspection in February 2016 CQC 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 CQC also imposed a condition in June 2016 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 CQC regarding this. In addition requirement notices were issued for failures to ensure safeguarding of people, appropriate numbers of skilled and trained staff, ensuring appropriate consent was sought, ensuring complaints were responded to and for a failure to ensure people were treated with dignity and respect. At the inspection in February 2016 the service was placed into special measures.

At the last inspection in October 2016 CQC found that whilst some improvements had been made these were insufficient to take the service out of special measures. The provider remained in breach of the regulations regarding safe management of medicines, recruitment, staffing levels and support, gaining consent and governance. Whilst we continued to find concerns with the provider's compliance the condition CQC had imposed required them to take weekly action to make the improvements needed and ensure these regulations were met. CQC considered this condition remained appropriate for breaches of Regulation 12 and 17 of the Health and Social Care Act 2008. Requirement notices for breaches of Regulations 11, 18 and 19 were issued. The provider was required to submit an action plan by 3 January 2017 to CQC telling us how they would meet the requirements of these three regulations; however they did not submit this prior to this inspection.

A registered manager was in place at this inspection. 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.

At this inspection the overall rating for this service is inadequate and we did not find sufficient

improvements to remove the service from special measures. CQC are now considering the right regulatory response to address the concerns.

People were not safe because risks associated with their care needs had not been consistently and appropriately assessed and plans developed to mitigate these risks. Where there were plans in place these were not adhered to by all staff at all times. Staffing levels did not meet people's needs and placed them at risk especially around meal times. Staff had not been given the right skills and knowledge to manage risk and provide effective care. People were not consistently treated with respect. The language used to describe people was degrading as it referred to them as tasks rather than individuals. We made a recommendation that the provider and registered manager review and take action to improve the process of involving people in making decisions about the service.

Medicines management had improved although the provider was introducing a new system for medicines at the time of inspection. As such we were unable to assess the safety and effectiveness of this. Recruitment processes had improved and were now safer. There had been no complaints since our last inspection and the provider had a policy in place and on display.

Consent was sought and the understanding of the Mental Capacity Act 2005 had improved, although the records regarding this were at times confusing and not accurate.

People had access to health professionals when these were requested. They were supported to maintain a balanced diet and additional support was requested when they were found to be losing weight. However, people's feedback of the food varied and they felt more choice was needed. Some people knew they had a care plan and were involved with this. Care plans varied in detail with some being very person centred and others lacking information needed.

Management support was inconsistent leading staff to feel unable to approach them at times. Quality systems were in place but these were not effective in identifying areas that required improvement. Records remained inaccurate and were not up to date.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. CQC is now considering the appropriate regulatory response to the shortfalls we 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 safe. People were placed at risk because the assessment and management of risks was not effective. Staffing levels were not appropriate to meet the needs of people. Recruitment practices had improved and were now safe. Medicines management had improved but a new system was being implemented at the time of the inspection.	**Inadequate**
Is the service effective? The service was not always effective. Staff were not always provided with the training to support them to deliver effective care. Consent was sought and the principles of the Mental Capacity Act were applied, however the records needed improving. People had access to healthcare professionals. They were supported to maintain a balanced diet although their feedback about the food varied. Support at meals times was impaired by the lack of staff availability.	**Requires Improvement**
Is the service caring? The service was not always caring. Staff did not consistently demonstrate kind, compassionate and respectful care. Language used by staff and the registered manager was degrading at times and privacy was not always maintained.	**Requires Improvement**
Is the service responsive? The service was not always responsive.	**Requires Improvement**

The service had responded to some people's change in needs.

Some people knew and understood they had a care plans and felt involved in this but this was not consistent.

There was a complaints procedure in place but no complaints had been received since our last inspection.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor and assess the quality and safety of the service remained ineffective.

Communication needed improving and records were not up to date and accurate.

Management support was inconsistent leading staff to feel unable to approach them at times.

Care Quality Commission

Merry Hall Nursing and 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 is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by notification of an incident following which a person using the service died. This incident is subject to a police investigation and as a result this inspection did not examine the circumstances of the incident. The information shared with CQC about the incident indicated potential concerns about the management of risk of choking. This inspection examined those risks as well as looking at the whole service.

This inspection took place on 22 and 23 March 2017 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience who had experience of caring for persons living 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.

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 13 people who lived at the home and two visitors. We observed the care and support people received in the shared areas of the home. We spoke with the registered manager and their support manager, the deputy manager and 11 staff including nurses, care staff and ancillary staff.

We looked in detail at the care plans and associated records of eight people and sampled a further six

people's records. We looked at medicines administration records for 11 people who lived at the home, staff duty rotas, and four new staff recruitment records. We looked at supervision and training records as well as a variety of quality assurance records. These included records of complaints, accidents and incidents, meeting minutes, policies and procedures, safeguarding and audits.

Following the inspection we asked the registered manager to send us confirmation of the action taken to address some of the concerns we found. We also requested further information regarding quality assurance processes, some care records and an action plan to address our concerns about the immediate risks to people. We received this.

Inadequate

Is the service safe?

Our findings

Feedback we received from people who lived in the home was mixed. They told us staff were kind but felt they were too busy and there was not enough of them. Three people told us they didn't like living in the home.

At our last inspection in February 2016 we found that appropriate numbers of staff were not available to meet people's needs at all times. We found this again at our inspection in October 2016. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and asked the provider to send us an action plan by 3 January 2017, telling us how they would rectify this. We did not receive this by 3 January 2017.

At this inspection we remained concerned about staffing levels in the home. The registered manager told us they felt the staffing levels were appropriate to meet the needs of people. They used a dependency tool which suggested they were providing sufficient numbers of staff. However, people provided us with feedback which indicated that staffing levels may not be sufficient to meet their needs. They told us staff were kind but busy. One said they did not feel well looked after because "People [staff] just did not have the time." Another said "Some [staff] answer the bell and then leave saying I'll be back in a minute, and then they don't come back.... they have too much work and not enough staff". Staff told us they did not feel there were enough staff to meet people's needs at all times. They told us the people's needs had increased but the staffing levels had not. They told us the registered manager was looking to recruit more staff. One staff member told us how they didn't have time to spend with people, to talk to them or to sit and do their nails. A relative told us they were required to ask four times for their loved one's nails to be cleaned.

Some of our observations reflected that staffing levels did not meet people's needs. On the second day of our inspection we observed a person calling for help and clearly needing support. They waited 18 minutes until they received the support they needed. At lunch time another person waited approximately an hour for their meal. They repeatedly told staff they had not had their lunch and staff acknowledged that they knew this but, were too busy to provide the support the person needed to ensure they received their meal safely. A third person was supported to the communal lounge and given their breakfast at 11:40. The person told us and staff confirmed they were "running late".

The failure to ensure staffing levels met the needs of people living at the home at all times was a continued breach of Regulation 18 of the Health and Social Care Act 20014 (Regulated Activities).

We alerted the local authority responsible for safeguarding to our concerns. We received an action plan from the registered manager following our inspection. This said they planned to introduce a new dependency tool to assess the number of staff needed to support people. They also said they had increased staffing levels throughout the day.

At our last inspection in October 2016 we found an ongoing breach of Regulation 12 as the management of medicines was not safe. This was a breach at the inspection in February 2016. CQC had imposed a condition

on the provider following the February 2016 inspection which required them to take weekly action to make the improvements needed. CQC considered this condition remained appropriate for breaches of Regulation 12 following the October 2016 inspection. At this inspection we found the management of medicines had improved and this was no longer a breach of this part of Regulation 12.

At the inspection in October 2016 we found medicine errors which had not been identified and investigated. This had improved at this inspection and we did not find this concern. A medicine error had occurred in January 2017 but appropriate action had been taken to address this. One person told us "The nurses are lovely and they make sure I get my medicine on time so that I'm not in pain."

A new electronic system for medicines was being introduced at the time of our inspection. The plan was that due to the setup of this system, it would prevent errors occurring and alert the deputy manager to near misses or errors immediately should they occur. Staff were being trained and the system set up so we were unable to assess the safety and effectiveness of this system. However we reviewed previous medicine administration records (MAR) for 11 people, and looked at storage of medicines, controlled medicines and care plans.

Storage was safe, temperatures of locked trolleys, rooms and fridges were checked daily and were in safe ranges. Disposal of medicines was clearly recorded and undertaken promptly. The deputy manager told us there had been some issues with overstock due to prescriptions but the new system would prevent this. We noted that some medicines prescribed on an 'as required' basis (PRN) had PRN protocols to guide staff to the administration of these whilst others did not. However we noted these medicines had not needed to be administered. The deputy manager told us they would review all PRN protocols to ensure these were implemented. We found no gaps on MAR charts and where a medicine had not been given an explanation was provided. However, for one person we noted that this was due to the home running out of stock of this prescribed medicated cream. A request had been made for this to be provided but the deputy manager told us the pharmacy had had problems getting the stock. This was to be delivered on the second day of our inspection.

At this inspection the assessment and management of risks associated with people's care was not effective or safe.

We found that for two people who had been identified as at risk of skin breakdown, records demonstrated that repositioning was not carried out in line with care plans. One of these people told us they were not well looked after because staff did not move them when they needed this. We found records which reflected the frequency of staff support to move was not in line with their care plan. Some people were cared for using a specialist mattress which helped to reduce risks of skin breakdown. These mattresses need to be on a specific setting in order to be fully effective. We found pressure relieving mattresses were set inappropriately for one of these two people and another person. We made the registered manager aware and they checked these and all others during our inspection. For a third person we heard their pressure relieving mattress alarming, indicating this was not working. A night worker told us this was not working and had been reported. We observed this person remain laying on this mattress for approximately three hours after we first heard it alarming. Staff told us another mattress was being inflated and they would support this person to get up into a chair for lunch.

Following the inspection the provider's action plan told us this person had not wanted to get up. Alternative measures to mitigate the increased risk of skin breakdown for this service user had not been considered, while a new mattress was being inflated. For a fourth person we saw that they were cared for on a pressure relieving mattress, however the use of this did not feature in their plans of care and there was no guidance

for staff about this mattress, how it should be set and checked. We spoke to a staff member about how these were checked and they told us by "pushing on them." When we asked how staff knew which setting they should be on they said it would be in the care plans.

For some people whose 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. For example, two people's care records indicated they could display behaviours which presented risks however, no assessment of these risks had been undertaken or plans developed to mitigate any risks. We identified and reported this concern for one of these people at our last inspection in October 2016 however, no action had been taken. For three people, care records indicated they were living with health conditions that posed risks to them. However, no assessment of any risks associated with these conditions had been undertaken or plans developed to mitigate any risks. The registered manager could not tell us what one of these conditions was or what it meant for the person.

This inspection was prompted in part by an incident that we were notified about in which a person had apparently choked and passed away. Prior to the inspection we asked the registered manager to provide us with confirmation of the action they had taken and planned to take to ensure all other people in the home were as safe as they could be from the risk of choking. They provided us with an action plan which recorded how they had identified six people who could be at risk of choking. This detailed the action they said they had taken.

Whilst we saw some action taken we remained concerned about the risk of choking to people living in the service. On occasion we observed care staff not providing the support that was needed to reduce those risks. For example, we observed one person who had been assessed as being at high risk of choking, was left alone whilst siting at an angle in bed, drinking a thickened drink. They should have been supported at all times with any drinks or food but no staff were present.

On another occasion we saw this same person had been left with a yogurt and a drink on the table next to them. A staff member told us this person would reach over to the table to get themselves a drink or food. On another occasion we observed another person who had been assessed as at risk of choking asleep at the table with a drink in front of them. We roused this person and their drink spilled out of their mouth as this had not been swallowed. This increased the risk of choking for this person and staff had not followed the care plan which said they should check this person had swallowed each mouthful.
In addition to our observations we found risk assessments had not been completed for everyone identified as at risk of choking and there was a lack of consistent and accurate guidance for staff. At times care plans lacked the detail staff needed and where there were risk assessments they were generic. These risk assessments also stated that all staff should have first aid training, however less than half the staff had this at the time of the inspection. Despite supporting a number of people whose conditions presented them with risks of choking and other health conditions, no staff had received training around dysphagia (a condition which affects a person's ability to swallow placing them at risk of choking or further health complications). At times some people had chosen not to follow advice around their eating and drinking and the registered manager told us they had chosen not to be supervised. Whilst their ability to make this decision had been assessed, no contingency planning had been implemented to mitigate this increased risk.

We alerted the local authority responsible for safeguarding people who took action to ensure people's safety. In addition we made the provider aware of our concerns about the safety of people and required them to send us a comprehensive plan on how they had started to and would continue to address our concerns. We received this.

The failure to ensure people were safe through the effective assessment and management of risks associated with their care and treatment and failing to ensure staff had the correct skills and competence to deliver safe care was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

However, we did note some good risk assessment and planning for some people. One person who lived with a condition that resulted in seizures had a good plan in place to reflect how this presented and the action staff should take. For another person who lived with diabetes they had a good plan in place which provided clear instructions for staff. Staff had some knowledge of this condition and knew they needed to inform a nurse should they be concerned.

At our last inspection in October 2016 we found that safe recruitment processes were not operated effectively and pre-employment checks were not always carried out. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
We issued a requirement notice and asked the provider to send us an action plan by 3 January 2017, telling us how they would rectify this. We did not receive this by 3 January 2017.

This had improved at this inspection and was no longer a breach. Records for four staff who had started employment since our last inspection were reviewed. Applicants completed an application form and were subject to an interview. Following a successful interview, recruitment checks were carried out to help ensure only suitable staff were employed. We did note that gaps in the employment of two of these staff had not been explored. Staff confirmed they did not start work until all recruitment checks had taken place. Enhanced Disclosure and Barring Service (DBS) checks had been carried out.. References were present, including the previous employer. These help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. Prior to our inspection we had been made aware of concerns that the registered manager may not have held records confirming that appropriate checks had been carried out on agency workers used in the home. At this inspection we looked at records of all agency workers who had worked in the home over the past month and found these records to be in place.

The provider had a number of policies in place regarding safeguarding people and staff's knowledge of the signs to look for and the action to take if they were concerned was good. They all said they would report any concerns to the registered manager who they felt would report these appropriate to the local authority and take action to address these. Record showed the registered manager investigated and reported concerns. Learning was taken from these and care records updated. For example, for one person who sustained an unwitnessed injury, measures had been implemented to reduce the risk of this reoccurring and care records had been updated. We saw these measures were implemented at the time of our inspection.

One member of staff raised a concern with us about an allegation made by a person about a member of staff. They told us they had reported this to the registered manager via a written report, however the registered manager was not aware of this and told us they would investigate the allegation. We referred this concern to the local authority responsible for safeguarding.

Requires Improvement

Is the service effective?

Our findings

People said the staff treated them well but gave varied feedback about the food. One said the food had gone downhill recently and others said that the choice was limited. Most people felt staff asked for their permission to provide care although one said "I can't say whether they ask before washing me, it just all seems to happen - I expect they do."

At our last inspection in October 2016 we found that the skill mix of staff on shift was not effective and there was a failure to ensure staff were appropriately supported through induction, supervision and effective training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and asked the provider to send us an action plan by 3 January 2017, telling us how they would rectify this. We did not receive this by 3 January 2017.

At the last inspection the allocation of staff on shift did not always ensure appropriately experienced, skilled and trained staff were available. At this inspection we found the providers policy for staffing stated that at least half of the staff on duty would be qualified to at least a level 2 vocational qualification or equivalent, however we found that this had not been applied for 14 shifts over 11 days.

The registered manager told us how they had begun to introduce training via the use of workbooks. They said that to date no competency assessments had been carried out following any training delivered to staff. We found that staff had not always received the training required to ensure they delivered effective care. For example, only one part time member of care staff and the registered manager had completed care planning training. There was no record of anyone having completed risk assessment training. Registered nurses and seniors were required to complete and review care plans and risk assessments. At times we found the care plans were not accurate and reflective of people's needs. At times risk assessments and care plans had not been developed when a need was identified.

Whilst we saw people's decisions being respected, records indicated that this may not be fully understood as even when a person had provided consent a mental capacity assessment document was completed. Mental capacity assessments are only needed when a person may lack capacity to consent to the relevant decision. The registered manager told us they felt they needed more training to be able to understand this.

23 of 31 direct care staff had not received any training in privacy and dignity and some observations throughout the inspection reflected that staff did not ensure treat people with dignity and respect. For example, we observed one person calling for help. They were uncovered and unclothed, in the process of removing their incontinence aid, their door was open and two staff walked past them twice and did not respond to their call for help, or acknowledge their calls. These staff left this person in an undignified position.

The failure to ensure staff had the training required to support them to deliver effective care was a continued breach of Regulation 18 of the Health and Social Care Act 20014 (Regulated Activities).

We found that the supervision of staff had improved. All care staff had received a supervision since the beginning of the year, although we noted that not all registered nurses had. Records reflected two way discussions about people and staff needs. Staff confirmed this.

At our last inspection in February and October 2016 we found that appropriate consent was not always sought and the application of the Mental Capacity Act 2005 was not understood. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued a requirement notice and asked the provider to send us an action plan by 3 January 2017, telling us how they would rectify this. We did not receive this by 3 January 2017.

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 Mental Capacity Act, and whether any conditions on authorisations to deprive a person of their liberty were being met.

At this inspection we found improvements had been made. This was no longer a breach of Regulation 11 but needed further improvements were needed.

Consent forms showed staff sought consent regarding issues such as sharing information and the use of photographs. However, records were unclear and inconsistent. Seven people's records confirmed that they had a cognitive impairment. However, mental capacity assessment records for decisions relating to sharing information, personal care, and medications had been commenced and recorded that no impairment was present. For four of these people further capacity assessments identified the impairment and the full assessment had been completed, suggesting the first part of the assessment in other records was not accurate.

For four of these people they had provided consent to these areas of their care on the same day as the capacity assessment document or the day before. It was not clear why staff had commenced the capacity assessment. We asked the registered manager to explain why assessments had commenced when people had capacity to consent and why the records were not accurate. They told us their knowledge of MCA was weak and they needed more training. They told us they were looking to book further training and the local authority were helping them with this.

For two people, capacity assessments had been appropriately completed in relation to sharing information and care plans. Best interest decisions had been made involving their families. However, capacity assessments had also been completed and determined these two people lacked capacity to consent to care and treatment. Care and treatment is not time or decision specific as required by the Mental Capacity Act when completing an assessment. The best interests decision recorded that staff or the person's family would sign consent forms if needed for these people. However, no one can sign consent on behalf of another person without the appropriate legal authority. Staff were aware they were not able to sign consent forms on behalf of people.

Staff understood the need for consent and understood people had the right to make their own decisions. 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. The registered manager described a situation whereby they were supporting a person to make their own decisions and approaching the office of public guardian for advice. Staff spoke to us about taking action in people's best interests and using least restrictive approaches such as gentle encouragement.

Whilst the service was working within the principles of the Mental Capacity Act 2005, their records were not accurate and had the potential to create confusion about a person's ability to make decisions. This was a breach of Regulation 17 of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014.

The registered manager understood their role and responsibility in relation to Deprivation of Liberty Safeguard (DoLS). Applications had been made and copies of these were held in people's care records. One application had been approved and no conditions were attached with this.

People gave varied feedback about the food at the home. Some described this as lovely while other felt it had deteriorated over the last few months. When asked whether a person enjoyed their meal they said "No, it was rotten". One person, when given their meal said "It looks a mess." This person did not eat all their meal. People told us that the choice of food was limited and a kitchen member of staff told us that three days a week only one choice was available. One the first day of our visit the only option was a roast dinner, whilst there were three choices available on the second day. The registered manager told us there should be a choice every day and said they would discuss this with the kitchen staff.

One member of the kitchen staff had a very good understanding of each person needs, likes and requirements when it came to their dietary intake. They knew what type of food they should have, the consistency of this and any allergies. We saw they guided care staff to people's needs when trays of food were given to care staff. However, a second member of kitchen staff's knowledge was limited due to their length of time in employment.

The risk of malnutrition for people was monitored and their weights checked regularly. Staff told us if they were concerned about a person's weight loss they reported this to the registered nurses. We saw dietician and GP input had been sought, supplements were provided if prescribed and the kitchen staff ensured meals were fortified (the calorie content was deliberately increased).

People chose where to eat their meals and who to sit with, some chose to eat in the dining area whilst others remained in their rooms. Those who required physical assistance to eat their meals were provided with this and those who benefited from additional equipment such as plate guards were supported to use this. Staff supported people without hurrying them or reducing their independence. However, at times people who needed supervision to eat their meals and drink their drinks safely were not provided this level of supervision as staff were supporting others. Due to the staffing levels people did have to wait for their meals. Whilst a nurse was also available, we observed they were carrying out the medicines round at this time so were not able to provide support with meals. This was the same concern we identified at our inspection in October 2016. Although staff supervised people with their meals or provided physical support, in the communal areas there was very little interaction or conversation provided by staff to encourage a more enjoyable experience. On one occasion, a member of staff brought a plate of food to one person at this table and offered to cut up their meat. However, they were unable to cut up their roast potatoes and although the member of staff sat next to them at the table, no offer of further help was made until we commented that we thought help was needed.

Records showed health and social care professionals visited the service as and when staff requested their input. Care records held feedback from GP's, dieticians, chiropodist, specialist nurses and speech and language therapists. People told us they were supported to access GP's and hospital appointments as needed.

Requires Improvement

Is the service caring?

Our findings

Generally we received positive feedback about the staff although some people told us they did not like living in the home. People said they were supported by staff who were kind but busy. One person said "I think it's very good here and most of the nurses are very helpful. One is lovely - very good, always gentle with you - that kind of kindness is rare. A second person said "We are treated with such kindness and respect. They always knock my door when they come in, I wouldn't mind if they just walked in but it's nice that they do that. The staff are very willing to help you with anything you want." A relative told us about their loved one "I've never seen them treat her with anything but the utmost respect and kindness and she's never said anything that made me have any concerns about the way she is treated."

Our observations reflected that people were not consistently treated with dignity and respect and their privacy was not maintained. The language used by staff when referring to people demonstrated a lack of respect. People were often referred to as "feeds" or "tilts". This was language we often heard the registered manager use when referring to people. This type of language showed a lack of respect towards people as individuals as it identified them as tasks. When talking to one member of staff about the support one person who was very unwell needed with their meals the staff member said when the person was sitting up they would feed themselves but if they were laying down "they can't be arsed".

On the second day of our inspection, a person was given their breakfast at 11:40 and then given their lunch about one hour later. They did not eat all of their lunch but no one offered them this at a later time of day or recognised and acknowledged that they may not be hungry.

A second person waited about an hour for their lunch whilst every other person in the room had been given their meal and a pudding. They told staff they hadn't had their meal several times and were repeatedly told that staff knew and would get this to them as soon as they could. On one occasion when told this person hadn't had their meal a carer called "I know" and walked away. At the same time this person was telling staff they had not had their meal yet, a member of staff was sitting in another lounge area eating their own meal.

A third person wasn't offered a meal until we pointed out they hadn't been given one. The registered manager said the person usually chose to eat later in the day, however when the person was offered a meal they said they wanted something to eat.

One the second day of our inspection we observed a person calling for help and clearly needing support. They were laying on their bed, calling for help. Their door was open and they had no covers on them. They were removing their incontinence aid and asking for the toilet. They waited 18 minutes until they received the support they needed. During this time two members of staff walked past this person twice and did not respond or acknowledge their calls for help. A third staff member entered their room but did not provide the support they needed before leaving them. They left them uncovered with the door open.

This person records showed they did not like tea or coffee, however we saw this was the drink they were

provided with.

The use of degrading language, lack of acknowledgement to calls for help and failure to maintain privacy was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We did also observe some kind, caring a respectful support being provided by staff. For example, on one occasion we saw that a person who appeared to be confused was supported by a staff member who was kind, gentle and reassuring. We heard staff provide care to one person behind a closed door. The person and staff were chatting about a variety of subjects and there was laughter from them both.

At our last inspection resident meetings took place monthly to ensure people could be involved in making decisions in the home, however the registered manager confirmed that this had not happened as frequently as they had wished and the last meeting took place in January 2017. People had provided feedback and made requests however we could not see that any clear action plan was developed as a result of this feedback and there was no record of actions having been taken. For example, one person had requested more physical exercise. Their activity records for the month of March 2017 did not reflect physical exercise and they confirmed to us that in a previous home they were supported to walk around the grounds but that this did not happen at Merry Hall. The activities co-ordinator had not been in post long and told us that this person often did not join in when they had physical activities planned. Two people we spoke with told us they were not aware of resident meetings but a third said they had attended these. They told us they didn't happen often. The registered manager told us they always read the meeting minutes and took action when people made requests or raised concerns but did not record this.

We recommend the provider and registered manager review and take action to improve the process of involving people in making decisions about the service.

Requires Improvement

Is the service responsive?

Our findings

Out of the five people we asked, four knew about their care plans and said staff had discussed this with them. One said "They talk to me about what help I need and check whether there's anything extra I want". A relative told us if they have been concerned about their loved one's health they have discussed this with the manager and it has been dealt with quickly.

Records and discussion showed that the service responded to people's change in needs. For example, for one person whose weight was very low, regular contact with the dietician took place to review this. For a second person the service had liaised with the GP in an attempt to stabilise their diabetes. Another person had requested their nutrition be provided in a specific way. The staff had liaised with specialist nurses and the hospital to arrange this procedure, although this had been unsuccessful.

Care records varied in content, some of these were personalised whereas others contained generic information with no guidance about the support needed and were not accurate. For example, two people were living with dementia but no care plans had been developed in relation to this need.. The registered manager told us they did not have care plans for this need. This meant there was a lack of personalised information about how this condition affected the person and the support they may need.
Staff were knowledgeable of people's preferences, likes and dislikes. They told us how one person's needs had changed and they were now much more independent and preferred no staff support with their personals care needs. Whilst this was not reflected in their care plan the staff were aware. They said they continued to offer but respected the person's choice.

People provided varied feedback about activities. One person told us "Nothing happens, no one comes to see me" and a second said "I get bored through, there's nothing to do". Whilst another person said "We have games in the afternoon and sometimes a quiz it's a good laugh. We have some lovely singers come in to sing to us sometimes and we all join in." A fourth person told us the activities coordinator was "very good" and "brightens everyone life".

We observed that activities did not tend to take place in the morning, although a hairdresser was present on the morning of our inspection. The activities co-ordinator told us they used the mornings to write up their records from the day before and activities tended to take place in the afternoon. They said the activity board in the communal lounge was not up to date. They said they produced a typed list of the planned activities for the month and gave a copy to everyone which we saw in their rooms. People that did join in the activities in the afternoon during our inspection were encouraged to do so by the activities co-ordinator and appeared to enjoy these. They were engaged with the activity and each other throughout.

A complaints procedure was in place and an easy read version was on display. People and their relatives knew how to use this. People and their relatives were confident to speak to the staff to raise concerns. A complaints folder was maintained 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.

Inadequate

Is the service well-led?

Our findings

At the last inspection in October 2016, we found three breaches of regulations which required the provider to send us an action plan telling us what they would do to become compliant with these regulations. This action plan was not sent to CQC in the timescale provided and was sent to us at this inspection.

At the inspection in February 2016 we found that systems in place to drive improvement were not effective. Records were not accurate and always available. Feedback from others was not always used to make changes. This was a breach of breach Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and informed the imposed condition on the provider's registration. This condition required the provider to undertake weekly audits of people's needs, care plans, risk assessments and medicines management and send the Commission a monthly report. In October 2016 we found this had not improved and remained a breach. CQC considered the imposed condition remained appropriate.

At this inspection we found improvements in the management of medicines indicating that the auditing system for medicines was working well. However we remained concerned about the system in place to monitor the effectiveness of the service and audit of care records.

The provider had a number of systems in place to monitor the quality and safety of the service provided. This included monthly provider audits, weekly care plans audits, weekly medicines audits, resident meetings, surveys and staff meetings.

Weekly care plans audits remained ineffective and as such records remained inaccurate. For example, the weekly care plan audit carried out week ending 12 March 2017 did not identify gaps in the assessment and planning of care needs. For example, this asked the question "The individual's care plan contains the following care plans and information: Breathing and Circulation Assessment". This recorded 'NA' for three service users whose care records indicated they were living with a condition that could impact on their breathing. One of these service users was diagnosed with diabetes but the care plan audit had failed to identify that no risk assessment or care plan had been developed to ensure accurate guidance for staff. For two people whose records indicated they could display behaviours which presented a risk for them and others, the care plan audit had not identified that a risk assessment and care plan had not been developed to ensure staff knew how to manage this. For another person who was living with dementia, the audit had failed to identify the lack of care planning for this need.

The audit failed to identify inconsistent and inaccurate information. For example, the registered manager confirmed that one person was having their medicines crushed however this was not included in their care plan and the audit had not identified this. This person also required thickened fluids but no mention of this was made in the medicines care plan which described the support they needed to take their medicine. This had not been identified in the audit.

We were unable to check on the accuracy of the provider audits in relation to care records as those looked at during the visits were not identified in the audit report. However, whilst we saw the provider visits

identified issues to be addressed and set actions to be completed, with timescales, these were not always done. For example a February 2017 audit instructed the registered manager to complete a resident survey immediately. This had not been done and the last survey was prior to our last inspection in October 2016. This also identified some training needs and set timescales which had not been met. The provider's action plan sent to us following the inspection gave reasons for these specific actions not being completed and action they were taking to address these. However the reasons were not recorded in the service

The staff dependency tool was not effective in identifying the needs of people and ensuring appropriate numbers of staff were available. We found that whilst the dependency tool showed that appropriate numbers of staff were available, we shared concerns about our observations of staffing levels. The registered manager and their support manager told us that they did not feel the tool took account of the number of people who remained in their rooms and the layout of the building.

The service was using agency workers to cover shifts. These are occasional workers not employed by the provider. An accurate and comprehensive handover would be needed to support agency workers to understand people's needs and the support they should provide. Handovers took place at every shift with all staff. A handover sheet was provided to staff at this time which gave some basic information about their needs. The handover record was not completely accurate at the time of the inspection. For example, it did not identify one person was living with diabetes; it did not consistently identify who required supervision for all meals. Whilst the handover sheet recorded people who were at risk of aspiration (Breathing in a foreign object, sucking food into the airway), it did not specifically record those who were at risk of choking. We sat in on two handovers and found that the registered manager was required to prompt a nurse to share information about the risk of people choking. Staff told us that communication was poor. One told us that handover was good for day to day issues but if they had not been at work for a few days they often found out about issues by overhearing conversations between other staff.

Following CQC receiving the initial concerning information about a person's death in the service we asked the registered manager to send us confirmation of the immediate actions they had taken to ensure that people had been identified as at risk of choking and that appropriate actions had been taken to ensure their safe care and treatment. We were concerned that this action plan identified a number of required actions that the care plan audits completed the week ending 12 March 2017 should have identified but had not. We reviewed this action plan during our inspection. We found that this action plan was not always accurate. This action plan identified to CQC six people who were at risk of choking, however during the inspection we found there were actually nine people at risk. The action plan recorded that the capacity assessment and care plan for one person had been reviewed and updated following a screening of the risk of choking. We found no evidence that these actions had been done. We raised this concern with the registered manager and received an updated action plan and an updated handover sheet from them immediately following our inspection. This provided conflicting information as one record identified ten people at risk and the other identified nine. We were required to ask the registered manager to clarify. We were not confident that the information that had been sent to CQC was completely accurate. As such we wrote to the provider sharing our immediate concerns, which we also shared with the local authority. We received a detailed action plan from the provider. This told us of the action they had taken to address our immediate concerns about risks to people.

The ongoing failure to ensure systems used to assess quality and safety of the service were effective and ensure accurate, up to date and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

A person had been appointed to be the manager following the inspection in February 2016, however this

person had left and another had been appointed at the last inspection in October 2016 but had not become registered. This person had worked in the home for an extensive period of time in a variety of roles. At this inspection they had become registered with CQC. They had been registered since 15 February 2017.

The registered manager told us they felt they were learning management skills all the time. We were concerned by some comments made to us by the registered manager throughout the inspection. For example, when asked how they ensure the effective management of risk in the service the only example they provided us with was handovers. When asked about records relating to the Mental Capacity Act 2005 they told us they felt they lacked knowledge in this area. The registered manager also used language such as "tilts" and "feeds" when referring to people. During the inspection the registered manager told us that they could be abrupt with staff. feedback we received indicated that there was an inconsistent approach in management support and at times staff did not always feel able to approach them.

Some minor improvements had been made. Staff meetings were taking place more frequently and we saw these provided an opportunity for staff to raise any issues/ concerns.

All incidents which had occurred between November 2016 and March 2017 except the recent death had been investigated fully by the registered manager. The records held included details of the incident/accident, body maps where necessary to identify any injuries sustained as a result of the incident/accident and actions that had been taken to minimise the risk of reoccurrences. We saw actions had been implemented and care records updated, although records could improve as we identified that the date of an incident for one person was different on different records.

Merry Hall Nursing and Residential care home is a service that CQC has inspected on three occasions in 13 months. We have identified and reported on concerns at all three of these inspections. We have taken enforcement action and issued requirement notices. However the provider has been unable to demonstrate to CQC over these three inspections, their ability to learn from our feedback, achieve compliance with the fundamental standards of care and sustain a sufficient level of improvement.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person had failed to ensure service users were treated with dignity and respect at all times. Regulation 10(1)(2)(a)

The enforcement action we took:
We cancelled the managers registration with CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had failed to ensure safe care and treatment at all times. Regulation 12 (1)(2)(a)(b)(c)

The enforcement action we took:
We cancelled the managers registration with CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to ensure effective systems were operated to assess the quality of the service and ensure accurate records. Regulation 17(1)(2)(a)(b)(c)(e)(3)(b)

The enforcement action we took:
We cancelled the managers registration with CQC.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to ensure sufficient numbers of suitably trained staff to meet service users needs at all times. Regulation 18(1)(2)(a)

The enforcement action we took:

We cancelled the managers registration with CQC.