Mr and Mrs S Cooppen

Merok Park Nursing Home

Inspection report

Park Road, Banstead SM7 3EF
Tel: 01737 352858

Date of inspection visit: 28 November and 1 December 2014
Date of publication: 12/02/2015

Ratings

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

Overall summary

Merok Park is registered to provide care and accommodation for up to 29 adults living with dementia, an acquired brain injury or mental health disorder. On the day of our inspection 25 people were living in the home.

This inspection took place on 28 November and 1 December 2014 and was unannounced. Due to the concerns identified during the inspection we also carried out spot-checks on the home on 29 and 30 November and 5, 6 December and 7 December 2014.

The home had been without a registered manager for four months. 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 and associated Regulations about how the service is run.

The home was being managed by an interim manager who was also one of the registered nurses on duty each day.

People were not protected from abuse and avoidable harm as staff were not trained in how to recognise abuse and what they should do if they had any concerns.

The provider had not ensured there were enough staff to meet people's needs. Staff said, "There are not enough staff. Staff are rushed and people don't get the care they

Summary of findings

need." We observed this during our inspection. Staff were rushing around trying to complete tasks and ignoring people calling out because they did not have time to stop.

The provider had not ensured there were the right mix of skills and competencies of staff on duty each day or the minimum number of staff. Although the provider was on the rota as the second nurse each morning, staff told us that until the middle of November 2014 the provider had not been on duty at the home which meant there had been only one nurse to look after 27 people.

There was no contingency plan for the home which meant people would not be protected in the event of an emergency.

Safe recruitment practices were not followed to help ensure only suitable people worked in the home. Not all staff had received a criminal records check and the provider could not provide us with evidence that all nurses were registered with the Nursing and Midwifery Council.

Staff did not monitor people's risks appropriately, although we saw risk assessments in people's care files we found staff did not always follow relevant guidance. People were left at significant risk of developing skin sores as they slept in old beds or divan beds with mattresses which were not fit for purpose. Pressure sore mattresses were not set on the correct settings for people.

The provider had failed to maintain the environment in the home. We found mould on walls, broken taps, stained carpets and only cold or tepid water coming from the taps in some people's rooms. Furniture in people's rooms was old and falling apart and people did not have suitable curtains at their windows. The smell of urine was overpowering in the home.

The provider and staff did not understand their responsibility in relation to infection control. The home was dirty. Some bathrooms had run out of hand wash and we saw stained toilets, toilet seats and dirty toilet brushes. The two sluice rooms (rooms where clinical equipment is washed) were not fit for purpose and the cleaner was seen to give a quick rinse to a commode in the basin of a toilet.

Staff (including the cleaner) had not had infection control training and there were no cleaning checklists. Staff had left soiled clinical waste in open bags in a bathroom and the outside clinical waste bin was unlocked which was a serious infection control risk.

The provider had not met the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). People had been unable to get downstairs for approximately one month when the lift was broken, but the provider could not give us evidence they had submitted DoLS applications to the Local Authority. Although the lift had been repaired it was not used as the interim manager told us it was "Unreliable", meaning people were restricted in accessing downstairs.

Staff did not receive an induction when they started working in the home and the provider was unable to show us any evidence of up to date training in respect of staff. Records we did read showed staff had not been provided with regular training appropriate for their role. The provider failed to support staff or ensure they did not work excessive hours. Staff regularly worked over 50 hours a week and some staff worked as much as 84 hours.

People were rushed by staff to eat and people who required encouragement were not provided this as staff were too busy. Some people did not eat their lunch at all although staff failed to notice this. Although the chef told us no one living in the home had an allergy, we read in people's care plans this was not the case.

People did not have their health needs met. We heard from one visitor how their friend had not received the dental treatment they required despite asking staff to arrange this on numerous occasions. One person required treatment from the GP but staff had not arranged this.

We did see some examples of kind and compassionate actions from staff. However, we saw many examples of people being treated in an uncaring manner by staff. We observed staff being rough with people and ignoring people who were in distress. Staff did not treat people as though they mattered. One person said no one ever listened to them. Other people sat for long periods of time and staff did not acknowledge them. People's

Summary of findings

dignity was not maintained as people were being washed in cold water. People's bedrooms did not have appropriate curtains fitted which meant their privacy was not upheld.

The provider had not ensured people had the opportunity to participate in regular activities or social interests relevant to them. People had two hours of activities a week and in between were left sitting with nothing to do and no social interaction from staff.

The provider did not respond to people's complaints. One relative told us they had given up complaining and we read a complaint from October 2014 which had not been addressed by the provider.

The provider did not have a hold on the day to day management of the home. The provider admitted to us they had not come to the home as much as they should have since the registered manager had left. They were unable to find paperwork when we requested it and did not know if any quality assurance checks had been carried out. Although the provider was the responsible person for the home, they did not delegate responsibility in an appropriate manner. Instead they left the running of the home to the interim manager, but gave them no support to do this.

We raised our concerns about what we'd seen and found during our inspection with the provider. The provider failed to take action in response. The provider did not take any action to ensure people who lived at Merok Park Nursing Home were treated with care, respect and dignity and lived in an environment that was caring, fit for purpose, free from risk and free from infection.

We found the provider had breached the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in 12 areas. You can see what action we took at the end of the full report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were at risk of significant harm from staff who were not trained to recognise the signs of abuse or how to move people appropriately.

Staff did not follow guidance in people's risk assessments which left people at serious risk of receiving poor care.

The home was run down and equipment was not suitable. This was a serious risk to people's safety and well-being.

The home was dirty with no infection control procedures in place, leaving people at significant risk.

There were insufficient nursing and care staff to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

Staff had not received appropriate induction, training, supervision or appraisal to ensure they were able to meet people's needs and were working excessive hours.

People who required support or encouragement to eat did not receive it.

The provider was not complying with the legal requirements in relation to the Mental Capacity Act and were depriving people of their liberty.

People's health was affected because staff did not access health care professionals in a timely manner.

Is the service caring?

Inadequate

The service was not caring. People were not treated with dignity and respect by staff or the provider.

Staff did not make people feel as though they mattered. The views of people were not regularly sought.

People were ignored by staff and at times staff showed little compassion towards them.

Is the service responsive?

Inadequate

The service was not responsive to people's needs, there were insufficient activities taking place in the home.

People received very little social interaction from staff and people's individual needs were not being met.

People did not always have their individual needs regularly assessed, recorded and reviewed.

The provider did not respond appropriately to complaints made about the service.

Summary of findings

Is the service well-led?

Inadequate 

The service was not well-led.

The provider had no oversight of the home and did not act to address the urgent concerns that were raised.

The provider did not ensure people were involved in the running of the home.

The provider had no systems in place to carry out quality audits or reviews of the home in order to monitor trends or make improvements.

Merok Park Nursing 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.

This inspection took place on 28, 29, 30 November and 1, 5, 6, 7 December 2014 and was unannounced. The inspection team consisted of three inspectors.

During the inspection we spoke with 11 people who lived at Merok Park Nursing Home, eight staff, three relatives, the interim manager, the provider and a visitor. We also spoke with health and social care professionals prior to and following the inspection and have used some information from reports. This included the Designated Nurse for Safeguarding, Surrey Downs Clinical Commissioning Group (SDCCG), Lead Nurse Safeguarding SDCCG, Infection Control Lead, Surrey County Council (SCC), Quality Assurance Manager SCC, Surrey Safeguarding Adults Team, an occupational therapist and Surrey Fire & Rescue Service. We observed care and support in communal areas, during meal times and looked around the home including people's bedrooms.

We reviewed a variety of documents including four people's care plans, six staff files, training information, medicines records and policies and procedures in relation to the running of the home.

This inspection was carried out as a result of receiving concerning information from partner health and social care agencies about the poor care, and threat to the welfare and safety of the people who lived in the home.

We last carried out an inspection to Merok Park Nursing Home in September 2013 when we had some concerns in relation seeking consent from people, the safety and suitability of the premises and a lack of quality assurance monitoring. A follow up inspection was carried out in January 2014 during which we found the provider had taken appropriate action to address the shortfalls.

Inadequate

Is the service safe?

Our findings

Some people told us they felt safe in the home. One person told us staff made them feel safe because, "They check on me." Other people said staff were around to support them when they needed help. However another person told us they did not feel safe in the home. Despite these comments, our observations and the concerns we had during our inspection told us people were not safe living at Merok Park.

There were not enough staff to meet people's needs. The provider did not know how they assessed and monitored staffing levels to meet peoples needs. The provider told us they had two registered nurses and five care staff on duty in the morning and one nurse and four care staff during the afternoon. One nurse and two care staff were on duty at night. They told us, "This is the way we've always done it." The interim manager told us, "There is no mechanism in place (to determine staffing levels)." Staff told us one member of care staff was taken off the floor each morning to act as a kitchen assistant. This meant for a period of time each day there were only four care staff to care for 26 people most of whom required nursing care. Staff said, "There are not enough staff and there is not enough for people (who live here) to do. I worked 54 hours in the last week. Staff are rushed and people don't get the care they need." One person told a healthcare professional they sometimes only had one care staff to hoist them instead of the required two.

There was a shortage of nursing staff on duty to provide clinical care to people. For a period of 15 days between the 15 November and 29 November 2014 on 14 occasions there was only one nurse on duty during the morning shift instead of two. On seven occasions, there were less than five care staff on duty in the morning. During the afternoon shift, on five occasions there was no nurse on duty and on 11 occasions there were less than four care staff. At night, on 12 occasions there were less than one nurse and two care staff on duty.

The provider often included himself on the rota as the second nurse, but never worked at the home. A healthcare professional was told one member of staff was working 66 hours a week and another staff member worked 12 hour days for seven days in a row due to the lack of care staff being available. Another healthcare professional visited and found an agency nurse on duty for 26 people. They had very little knowledge of people.

We continued to monitor the staffing levels at the service over the next five days and found that staffing levels remained low with a continued shortage of nursing staff on most shifts. These are breaches of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Throughout our inspection staff rushed around, and had no time to sit and socially interact with people. During a 30 minute period we saw staff walking in and around the lounge area but only one member of staff took time to respond to a person calling out to them. On another occasion we heard one person calling to staff for almost an hour before staff responded to them. When people needed prompting or encouragement during meals times we did not see this being done and as a result people were not eating their meals. One person was being assisted by a member of staff but they were rushing the person to eat so quickly they were having difficulty swallowing their mouthful before being given another.

Staff did not monitor people's risks appropriately. There were risk assessments in people's care files which included risk of malnutrition, food and fluid intake, mobility and personal care. However these were not being monitored to make sure people were safe.

People were not kept safe as staff were not able to recognise the signs of abuse and had not received appropriate training. Two members of staff understood the different types of abuse and were able to describe the action they would take if they suspected abuse was taking place. However, one member of staff wasn't able to tell us what safeguarding people meant and the training records confirmed only three of 19 staff had received any safeguarding training. A visiting healthcare professional was not asked to sign in when they arrived at the home, meaning people could be a risk as staff would not know who was entering the building.

People were not protected from the risks of abuse and avoidable harm. On the first day of our inspection we witnessed staff transferring one person from their chair using a hoist. Staff had not explained what they were doing and as a result the person became anxious and lashed out

at them. We saw staff grab them by their wrist We intervened and the interim manager assisted staff, however the person fell on the floor as staff were unable to carry out the correct manual handling procedures. We asked the provider and interim manager whether they had raised the incident with the local authority safeguarding team as we had asked them to and they told us they had not. They had also not recorded what had happened in the accident and incident book. This is a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not have a plan in place in the event of an emergency, such as a fire. People did not have individual evacuation plans. The interim manager told us that the requirements of a fire service inspection in November 2014 where concerns were highlighted had still not been completed. The fire service told us actions set by them in September 2013 had not been completed by the provider. The fire risk assessment for the home was two years out of date. One person was in a room in which the windows did not open at all because there was a bar screwed to the windowsill to prevent it opening. Regular fire drills had not been completed the last fire drill carried out was in January 2013. This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider did not make sure safe recruitment practices were followed to help ensure only suitable people worked in the home. The provider was unable to give us personal files for all staff employed in the home. They were unable to evidence they had checked qualifications of the nursing staff to ensure they were suitably qualified. The provider had lost recruitment files for all the new staff which contained references; application forms and criminal records checks completed by the Disclosure and Barring Service (DBS). One nurse had not had a full DBS check. The provider said they wouldn't have anyone working at the home without suitable references. However one new member of staff told us they had not been asked to provide references and the provider had not undertaken a DBS prior to them starting work.

People were being cared for by staff who did not have their PIN numbers as they were not registered with the Nursing and Midwifery Council (NMC). The provider told us all the registered nurses working in the home had their PIN numbers and the one nurse who was waiting for their PIN number was not working. However, we found this not to be the case. During our unannounced visit on 29 November 2014, we were told by a staff member, "A nurse without their PIN number was giving out controlled drugs last weekend." During a safeguarding meeting the interim manager gave the name of the nurse who was on duty. We checked the staff signing in sheets and confirmed this was the nurse who did not have their PIN number. This is a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were at high risk of developing pressure sores. A healthcare professional had written, "There is a risk that those who might have or be at high risk of pressure sores are not cared for adequately." They recorded people only had one pillow on their bed and hospital blankets. People were sleeping in old beds or divan beds and the mattresses were not fit for purpose. One person told us, "The bed is getting a bit lumpy." We saw one bed where the mattress was too short for the bed and pillows had been put in the gap between the mattress and the headboard. Where people required nursing care, they had a specialised bed to reduce the risk of them developing pressure sores. However, a healthcare professional had recorded, 'the carers did not all seem to know how to use these bed controls'. Health care professional's reports stated that four people's air mattresses were on the wrong setting which could have a significant detrimental effect and increase the risk of pressure sores. One person told us they needed to keep their legs raised due to their medical condition. The bed they slept on did not allow for this as their legs slipped off the sides at night. This is a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider failed to address accidents and incidents and develop guidance for staff to reduce these. We read in the accident and incident book that 15 falls had occurred between late October 2014 to 1 December 2014. Of these, one person had fallen six times. There were no actions taken by staff to reduce or to determine why the falls were happening. This put this person at significant risk of harm.

People did not have easy access to call bells to attract the attention of staff when they needed to. A healthcare professional had looked in 15 bedrooms during their visit in November 2014. They recorded that seven rooms had no call bell or it was out of a person's reach. This was reported

Is the service safe?

to the provider at the time however no action had been taken by the provider to ensure people could reach their call bells. No alternative arrangements had been made for those people who had no call bell.

The premises were not maintained to keep people safe. A raised step between the lounge and dining area was a trip hazard, the floor was rotting in areas, there was a trip hazard outside one person's room and taps were missing or broken on sinks. An unlocked room which had building materials in it could be accessed by people in the home. A healthcare professional had written in their report, 'The upstairs bathroom does not meet the needs of those with mobility problems'.

People were at risk of furniture harbouring infections. The infection control lead noted in their report, 'A resident armchair noted to be worn and torn. High risk of harbouring microbes that can be transmitted to the resident especially with poor hygiene or when there is a breach in skin covering. An armchair noted to be very badly stained with dirt'. This is a breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider and staff did not understand infection control. The home was dirty and unhygienic. Sluice rooms were unclean and not suitable for staff to use, floors had not been cleaned and there was nowhere to dispose of used gloves and aprons. One of the sluice rooms had no working light and both had buckets of dirty water with mops in. The carpet was bare in places and lifting and the flooring was rotting in places. Some bathrooms had run out of hand wash and we saw stained toilets, toilet seats and dirty toilet brushes. There were bare pipes in the upstairs bathroom.

Staff had not received infection control training in the last year. We asked the provider if the cleaner had received infection control training and they told us, "I don't know." The windows of the home were dirty, the provider told us, "It's not my job to check them." There was no cleaning checklist for the home and the cleaner only worked five days a week. We found soiled waste bags were left open in one bathroom and the clinical waste bin located in the driveway of the home was unlocked meaning the provider wasn't following national guidance. One healthcare professional had recorded their concerns at the cleanliness and appropriateness of the premises, writing, 'The clinical room is not fit for purpose, there were odours in people's rooms'. They wrote that one disused bathroom was full to head height with rubbish and another bathroom was not working. They summed up their visit as, "It is the most uncomfortable care home visit I've ever done."

Wooden flooring was being laid in the corridors on the first floor to make the home easier clean and to stop odours from the carpets. This commenced on 1 December 2014. However when we looked at the corridors a few days later we found the wooden flooring had been laid on top of the old carpet and in places it was not snug with the skirting board, leaving exposed areas of the carpet or lino underneath. These are breaches of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Although there were systems in place to manage people's medicines, we did not find staff always followed these. One relative and one person said they understood what medication they were on and they were always given to them at the right time. Each person had a medication administration record (MAR) chart which stated what medicines they had been prescribed and when they should be taken. Staff dispensed medicines into individual pots before giving them to people. MAR charts had people's pictures on them to ensure staff knew they were giving medicines to the correct people. Staff checked medicines and signed to show people had been given them. Staff locked the medicine trolley each time they left it and used a monitored dosage system supplied by the local pharmacy. During our spot check on 7 December 2014, one nurse took several hours administering medicines and whilst they were away from the trolley they left medicines on top of the trolley.

Inadequate

Is the service effective?

Our findings

There were restrictions on people's movement and people could not move around freely and leave the home when they wanted. Only three members of staff had received training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). One person was subject to a DoLS authorisation as the previous registered manager had submitted an application. We spoke with the provider about DoLS and whether they had applied for authorisation for people in relation to the locked front door and during the period of approximately one month when the lift was not working and people could not get downstairs. We were told, "We have found out from the local authority what we have to do." By the end of our inspection the lift was working but was still not being used due to concerns about its reliability, however the provider had still not submitted any DoLS applications.

Staff had a lack of understanding of the MCA and DoLS. This was evident when we observed staff continually escorting people back to their seats when they got up. We witnessed staff as well as the provider do this on several occasions. In addition, we saw several people sitting in chairs with tables pushed in towards them meaning they would be unable to get up and move around whenever they wished.

Staff did not carry out the correct procedures in respect of consent for people who lacked capacity. The care files contained mental capacity assessments for people. There was some evidence of best interest meetings by staff when decisions were made on behalf of a person who did not have capacity. However people were not always asked for their consent, for example we saw staff put clothing protectors on people before meal times without asking if they wanted them. We also found that people who had bed rails fitted had not been asked for their consent. A healthcare professional had noted, 'Mental Capacity Assessment for resident had no detail as to what the capacity assessment related to'. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were not provided with sufficient and regular training. The provider was unable to provide us with an up to date training schedule to show what the mandatory training was and whether staff had received this. The provider was unable to provide us with evidence that any staff had received clinical training. We were handed a book of certificates by the provider, from these we found seven staff had received first aid training in 2013 but there was no record of other staff having this training. One member of staff had undergone food hygiene training in 2014 and only five out of 19 staff had received fire training in the last year. We found that training for most staff last took place in 2013 or 2012. The provider told us, "About 50%, or slightly less" of people in the home required the use of a hoist to transfer them, however only three staff had up to date manual handling training. We observed staff using a hoist to assist the movement of one person into a chair, the interim manager had to go and advise them on how to do it safely. On another occasion we watched two staff attempt to assist a person into a chair from their wheelchair. This took staff approximately 20 minutes and multiple attempts during which time we observed the person being moved became anxious.

Staff did not receive on-going training to meet people's needs effectively. Many of the people in the home were living with dementia, but only three staff had undergone specific training in this area. The provider had told us, "If staff don't have it (dementia training) then I ask them to do it." However, the provider said they had not had any dementia training themselves and they were unable to describe to us the different types of dementia to us.

Staff did not receive an appropriate induction or supervision to ensure they were competent in their role. One member of staff told us they had not had an induction when they started work at the service. They told us they had not had any training but that they, "Followed" another member of staff around to understand how to undertake the role. Records confirmed that staff supervision had not taken place since January 2014 and six of the 15 staff who had worked at the home for over a year had not had an appraisal.

Staff were working long hours which meant people were being cared for by staff who were overworked and tired. The provider told us they were responsible for drawing up staffing rotas however they were only able to provide us with a rota for the week commencing 1 December 2014. Two staff were due to work 60 hours and another two staff 54 hours that week. The lead nurse from SDCCG stated in their report, 'The rota evidences that many of the staff are working over full time hours. One told us they worked 39 hours, however the rota states they are working 66 hours. There is one person who is working 6 nights in one week

and one who is working 12 hour shifts for 7 days – 84 hours'. These are breaches of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Meal times were not a happy or relaxed time and people were rushed to eat. We saw staff putting food in people's mouths before they had a chance to finish the previous mouthful. We saw plates being taken away from people with most of the food left on them. We observed lunch and dinner being served and saw people who required support or encouragement by staff to eat did not receive this. One person, who was nursed in bed, was not supported to sit up in bed in order to eat their meal. We saw one person who required encouragement to eat but staff were too busy to help them. Although the menu was in pictorial format staff did not show this to people to give them choice.

The chef had no written record of people's dietary needs but said they knew them well. They told us no one had allergies; however one person was allergic to fish. On the day fish and chips were served we observed this person was not offered an appropriate alternative. People who needed prompting or encouragement during meals times were not receiving this and as a result people were not eating their meals. One person who needed prompting at mealtimes had lost a significant amount of weight over a three month period. We saw people being offered drinks throughout the day and if they asked for drinks staff would provide them. People who spent time in their rooms had jugs or water or juice available for them and within reach. However, a visitor told us during the summer they had been to the home and found people sitting in extremely hot weather with no drinks available. They told us drinks were only provided to people when they alerted staff. This is a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Menus were a four-weekly rolling menu but people were not consulted in developing it. People said the chef would come and ask them what they would like to eat and we saw a menu board in the lounge which had the day's date and the choice available. The cook showed us plenty of fresh fruit and vegetables were used for meals. People said the food was good and those who were able to eat independently were enjoying it. One person said, "It's beautiful, it's lovely thank you." Another person told us the food was nice and they had a hot meal for lunch and sandwiches at tea time which is what they preferred.

Staff did not always monitor people's dietary requirements appropriately or record correct information in terms of the food people ate. One person had, 'allergic to fish and strawberry' written in their care plan and yet we noted that staff had written this person had eaten fish and chips for their lunch. Staff told us this was a mistake and they had written this because they were in a hurry. For one person it stated that they required encouragement to eat and drink. This person's food intake was not monitored and they ate very little at lunchtime during the two days of our inspection. Records completed on the first day of inspection stated they, 'ate well'. Staff told us they had made a mistake and had written an incorrect entry. This person's weight chart recorded they had lost weight for the last three months. The provider was unable to explain why this was not picked up by staff. Food charts were inadequate and difficult to read. We found there was some evidence of tea being given but the volumes had not been recorded and there was no separate fluid chart.

We did not find people were referred to healthcare professionals in a timely manner. One relative told us their family member had access to healthcare professionals. We read in care files that people were referred when appropriate. Evidence in people's care files stated they had involvement from other health care professionals such as an optician, hygienist or chiropodist and one person told us they could always ask if they wanted to see a doctor. However, we did not find this happened consistently. One person hadn't received mouth care from staff. Their friend carried out mouth care for this person and four of their teeth fell out. The friend told a visiting professional they had requested on a number of occasions for a dentist to visit. Staff had not been undertaking oral health care for this person, or referring them to a dentist for treatment. Another person who had lost weight had not been referred to a dietician or other appropriate health care professional for assessment or advice. One person had discomfort to their legs and were in pain however staff had not responded to this person's condition until we highlighted it, despite the person suffering for some weeks. Following our intervention, advice was sought from the GP by staff. We read in one health care professionals report they had asked staff to contact the GP to prescribe medication for one person but this had not been done. It was noted another person had diabetes and yet there was no evidence of blood glucose monitoring taking place.

Inadequate

Is the service caring?

Our findings

One person told us, “This place is going to kill me.” They said the night staff were very good, but they had two new staff that morning who, “Didn’t know what they were doing.” This person added, “I put a blanket on my head to keep warm as the room is freezing.” Some people told us, “Nice staff, very, very nice”, “Staff come quickly” and, “Staff take care of us, they are good.” A relative said there is always some help and the staff did, “Never not respond in time.” They told us, “Staff do sit with her, we’ve seen it before.” Another relative said the staff were, “Brilliant.” Other people told us they were aware they had the choice of male or female care staff to help them. Relatives said the staff seem, “Fine.”

Despite these comments it was obvious from our observations that people were not looked after in a caring, kind, compassionate way. The smell of urine in the home was overpowering when we arrived and continued throughout the day. We went into 11 bedrooms. In one room the floor was sticky underfoot and there was a strong smell of urine and mould on the walls and under the sink, which was broken. Another room only had one tap in the sink for hot water. A further room had a large number of stains on the carpet and had a strong smell of urine coming from it. Another room was cold and only had tepid water coming from the hot water tap and again the floor was sticky and dirty. Every room we went into had the curtains hanging down and one room had no curtains at all. One room had wall lights just above the bed, neither of these had lightshades and there was no bulb leaving the person at risk of burning themselves as it was within reach of them. The furniture in rooms was old and dirty. In the dining room there were stained plastic table cloths on the tables which were old and dirty. The chairs around them were wobbly and falling apart. A relative told us the home needed more staff, and in particular cleaners. Another relative said, “The furniture is old, worn and cheap, the curtains in my husband’s room are ill fitting and the room is a dump.” One member of staff told us the cleanliness was improving as it had been worse and they, “Got used to the smell.”

We did see some examples of kind and compassionate care from staff. For example, we saw staff gently rubbing people’s arms to reassure them, one person became distressed and staff immediately responded to them and one person kissed the top of a member of staffs head. We saw one person who was slipping out of their chair and staff went to assist them. We also saw staff were on hand to address one person who had behaviour which was challenging. However, on other occasions where people became anxious or upset staff did not deal with this well which meant that people became more upset.

There were many occasions where staff were not as caring. We saw two staff putting a sling on one person. They were rough with them and did not explain what they were doing and as a result the person became distressed. The same two staff were putting another person into a sling, this time the person became extremely agitated and started to hit out. One carer grabbed the person’s arm and was rough with them. Another member of staff was helping a person put their dressing gown on, they pulled their arm to put it in the sleeve and the person called out in pain. One person kept trying to attract staff attention and we saw a member of staff give this person a leaflet to look at as a gesture of interacting with them. A healthcare professional found during their visit, one person who was unable to mobilise had a full catheter bag which was only addressed when they raised this with the manager. This was because staff did not check on people regularly.

Another visiting professional found one person wandering around the home quite distressed but at no point did staff attempt to reassure them. The person then went into the garden and they raised the alert with staff. They heard staff shout, “Shut up” to one person when they became agitated and found this same person had faeces smeared on their trousers which staff did not seem concerned about when it was pointed out to them.

People were not allowed to be independent as staff were constantly moving people into chairs whenever they started to walk around the home. We saw one person who liked to walk around the ground floor of the home. Staff responded to this person by continually restricted their freedom by escorting them back to their chair every time they wanted to move.

Staff had not ensured people maintained their dignity or were treated with respect. People had clothes protectors put on them at meal times without a choice. The protectors were grubby and worn and people were left in them for some time after mealtimes had finished. The provider agreed that this was not dignified and said they would get rid of them. However, during our unannounced visit on 7 December 2014, we found staff were still using these for

Inadequate

Is the service caring?

some people without asking them if they wanted to use them. A healthcare professional reported finding people with dirty and unkempt fingernails and when the interim manager took one person to the toilet another person was slumped on the toilet with their feet up and was asleep. They also reported one person had been sleeping on a mattress on the floor for the past few months.

People did not have any privacy at night. Most of the curtains in people's room were hanging down in some way and we found curtains would not close properly. A relative told us some staff knocked before they go into their room, but some just walked in. Training files confirmed only one member of staff had received training on dignity in care. We found that two rooms did not have hot water. One person told us their wife had to wash their hair over the sink and the water was freezing. Another person said, "Staff use baby wipes on me – it's a two minute job. A few weeks ago I was forced into a bath."

People were not made to feel as though they mattered, were not involved in making decisions about their own care, or listened to. We spoke with one person at length. They told us, "Nobody understands me. I don't ask for help anymore, I sit about a lot. I sit around and cry because I'm unhappy. I never have a bath or a shower as there isn't one on the ground floor." One person was continually calling out, "Hello, hello, hello, I want to go home, no one listens to me" but staff did not respond to them at any point. We observed one person trying to attract staff attention; the provider came into the room and manoeuvred them back to their chair. This person was saying, "No, no, no." There was no reassurance from the provider, instead they just said, "Your cup of tea is coming." This person was ignored by staff for large parts of the day despite their anxiety. We asked the provider about this person and their past history but they were unable to tell us anything about them. Another person, despite being thirsty, was not brought a drink by staff when asked. These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service responsive?

Our findings

People told us they did not have any planned activities. A relative said, "Staff used to do activities with her, but now it's a waste of time as most of the time she's asleep." Another relative told us there could be more for people to do in the home.

People did not receive stimulating activities. The provider told us a person came in twice a week for one hour each time and a music entertainer came in once a month for two hours. The main living area was divided into a large and small lounge which were linked by a set of glass doors which were open. One person in the smaller lounge told us they were, "Not allowed to use the other lounge." We found the television switched on at a low volume with subtitles in one part of the bigger lounge area and on the other side of the room a radio was playing. The volume of the radio was louder than the television. Staff did not ask people what they would like to watch or listen to. There was no activity observed throughout the first day of the inspection. On the second day, an activities lady arrived in the afternoon for one hour. We saw them attempt to speak to or engage with each person in turn, but this was difficult for the short period of time they were there. The music they played and the interaction they shared with people transformed them in a positive way. We asked staff why they didn't take time to do similar activities with people and they told us it was because they were too busy. We noticed another room in the home which had a sign 'activities room' on the door. The room was dark and empty and there was no equipment in it to indicate it was used for activities. Staff told us the room was used as a staff room.

People were not supported to follow their interests or take part in social activities. We read in people's care files that people had been asked for their past histories, however the information that was completed in the files was sparse and incomplete. We read people's spiritual needs were written down but it wasn't clear how these were being met. Some people had information about hobbies and interests in their care plan, but we found no evidence that they did these things.

There was no evidence that people's needs were being met in terms of activities that were meaningful to them. There were 14 people in the lounge area. Although we did see one member of staff speak with three people, the majority of people were left sitting in their chairs all day with very little interaction from staff. One person sat in their chair from 9.30am until 5.30pm on the first day of the inspection. The only time they were spoken to by staff was to give them their lunch and their cup of tea mid-morning and mid-afternoon. They were not provided with anything to look at, feel or engage with. Another person we saw sitting in the same way. They sat and stared at their hands or around the room all day. One person who was nursed in bed had a television across the other side of their room. They told us the remote could only adjust the volume; it did not change the channel. They had to wait until staff came into their room to change channels for them but this only happened every now and then.

We found people's individual needs were not met. We saw no specific activities for people. For example, reminiscent activities, items or pictures to look at or touch. One person told us, "There is nothing to do. I love music but there is nothing here for me." The care plans were specific about people's clinical needs, but not their emotional needs. Two staff we spoke to knew nothing about one person – all they could tell us was that they had dementia. One person told us they used to go downstairs and walk around the garden, but no longer did this because people downstairs distressed them so they now stayed in their room full time. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People did not always have their individual or day to day health needs regularly assessed, recorded and reviewed because only one member of nursing staff was able to review care plans. One relative said their husband had been assessed prior to moving into the home and their husband's care was only discussed with them by staff, "Up to a point" when they first moved. We read in care plans that some people's care had last been reviewed and updated by the interim manager in September 2014.

Staff did not know people. A staff member told a visiting professional that one person used a standing hoist and they were able to weight bear. However, when they spoke with the nurse on duty they reported the person was on bed rest and not weight bearing.

Staff said they were not aware of any complaints policy and the provider did not take people's complaints seriously or respond to them. Most people told us they would speak to the interim manager if they wished to complain. A relative said they could ring the provider and speak to them or approach staff. However, one relative said they had given

Inadequate

Is the service responsive?

up complaining because they didn't feel they were listened to. We looked in the complaints log and saw there was a complaint in October 2014 about the state of one person's room. We read the action was for the interim manager to, 'monitor that the state of room be rendered satisfactory'. We went and looked at this person's room and found the carpet stained and sticky, the bed with an ill-fitting mattress, the décor in need of repainting and the furniture old and tatty. No action had been taken to address this complaint. This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Inadequate

Is the service well-led?

Our findings

People told us the provider was hardly ever in the home and only spoke to them that day because we were inspecting the home. One person said they hadn't seen the provider, "In years and years." Another person who spent all of their time in their room said they hadn't seen the provider in a "Good while" and had probably only seen them once in the two and half years they had been there. A relative told us they had, "Only seen the owner once and never seen his wife." A further relative said they saw the provider occasionally. When we asked the provider for personal information about individuals who lived at Merok Park, it was evident he had a lack of knowledge of people. For example, despite being the second nurse on duty each day, he could not tell us peoples preferred names or their clinical diagnoses.

People did not feel involved in the running of the home because they did not have the opportunity to discuss their views or suggestions. They said the interim manager was, "Great" and so were some staff. A relative said when the interim manager was there they greeted them, knew their name and had, "His finger on the pulse." However, the only evidence we saw that people or relatives were asked for feedback was a survey carried out in September 2013. We did not see any other encouragement for people to give their views and the provider told us they had not carried out a survey this year. The provider held no residents or relatives meetings and the last staff meeting was held in October 2013. One person told us, "I don't think I get asked for my views." This is a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

There was no emphasis on an open culture between the provider and staff. Although the home had an interim manager, the provider did not allow them to manage the home. The provider drew up the staffing rotas on a Sunday evening for the week ahead which meant staff did not know if they were working until the last minute. The rotas contained the first names of staff only which meant the interim manager, who was relatively new to the home, did not know who the staff were. Despite this, the provider was unable to provide us with staff rotas for the weeks previous to our inspection as they had gone missing. Although the provider was on the rota each day as the second nurse the interim manager had not seen him at the home for three months. People told us they had never seen the provider doing any work.

There was no registered manager in the home. The provider told us the home had been without a registered manager for one month. However our records showed there had been no registered manager at the service since July 2014.

Responsibility and accountability was not understood at all levels and the provider did not have any management oversight of the home. We saw evidence the interim manager had done a lot of work in the short time they had been working at the home. However, despite our serious concerns the provider did not take urgent action to address these issues.

The provider did not encourage open communication or set a good example of behaviour to staff who worked at the home. On the first day of the inspection the provider arrived at the home at 10.25am however they did not introduce themselves and did not engage with people in the home either. We observed they did no carry out any nursing or caring duties.

There were no resources or support available to interim manager and staff to drive improvement. The interim manager told us they didn't feel supported. They had developed an action plan to improve the home but no action had been taken by the provider to help them complete it. One member of staff said, "He (the provider) won't do anything. This is what we have to put up with. I was brought in to help turn things around, but nothing has changed. He's done nothing at all. Look at the (interim) manager, he's exhausted, you can see it in his face." The lift had been out of action since 29 October 2014, however despite this being known to the provider he had failed to take appropriate action to ensure it was fixed promptly. It was only when the interim manager took the matter into his own hands the lift was repaired.

People living at Merok Park did not receive a high quality service. The 'resident's rights' charter we read for the home, included, 'The right to have your dignity respected and to be treated as an individual', 'the right to receive a service which is responsive to your individual needs'. We saw no evidence of either of these happening in any way throughout our inspection.

Inadequate

Is the service well-led?

People were not protected against the risks of unsafe or inappropriate care by ensuring accurate and up to date records were kept and could be located promptly. The provider could not find paperwork necessary to ensure people were safe in the home when we asked for it. The health and safety folder they brought to us was for another home. The last quality assurance checks on the building and equipment were carried out in August 2013. They told us this was because the registered manager had left unexpectedly and they (the provider) did not know where all the paperwork was or what the registered manager had done. The provider told us it was their fault as they had, "Put too much faith in the registered manager and I have not visited the home as much as I should have." This meant the provider carried out no monitoring of the service, accommodation or care provided to ensure people lived in a safe environment and received individualised appropriate care. It also meant the provider would be unaware of any improvements that may be required to enable people to receive good quality care.

At the end of our first day of inspection we gave a list of evidence we required, the provider agreed to have this available from 1 December 2014. However, when we returned, the provider had not taken any action with regard to this request. They told us this was because they had lost it; although we later found it on his desk in the office. They had still not provided us with the requested information by the end of our second (full) day of inspection. This is a breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We fed back to the provider at the end of our two-day inspection the serious concerns we had about the lack of care people received in the home and the issues with staffing, infection control and safety. We sent the provider a summary of the key actions we wished him to address and evidence we required him to send us by 5 December 2014. By 8 December 2014 we had still not received the documentation and evidence requested, although in an email sent to us on 4 December 2014 they promised to do this.

We reviewed all the evidence we had, together with visit reports from other agencies which showed they had a similar lack of confidence in the provider. For example, agencies had noted, 'The owner has avoided meeting to plan to resolve the issues (from a previous visit)', 'Offered the home many opportunities and support to improve – yet to see any evidence of this' and, 'Submitted report to the provider in September 2014, however by 11 November 2014 none of the recommendations had been completed by the provider'.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People were at risk of receiving inappropriate and unsafe care because the delivery of care did not meet their individual needs to ensure their safety and well-being.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

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 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **The provider did not have effective systems in place to regularly assess and monitor the quality of the service they provided.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **The provider failed their statutory duty to ensure they had suitable arrangements in place to ensure that service users are protected from abuse, or the risk of abuse and their human rights are upheld.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider has failed to demonstrate they have met the requirements of the regulations as set out in the Health and Social Care Act 2008 Code of Practice on the Prevention and Control of Infections and Related Guidance.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **The provider had not ensured people were provided with suitable food and hydration, in sufficient quantities to meet their needs and people were not supported to eat and drink sufficient amounts for their needs.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **The provider did not ensure people lived in premises that were safe, secure and free from risk.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment

This section is primarily information for the provider

Enforcement actions

The provider had not made suitable arrangements to protect people who may be at risk from the use of unsafe equipment.

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

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 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The provider failed to ensure people were treated with dignity and respect.

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records The provider did not ensure that people were protected against the risks of unsafe or inappropriate care by maintaining accurate and up to date records which could be located promptly.

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers The provider did not comply with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to information required in respect of persons seeking to carry on, manage or work for the purposes of carrying on a regulated activity.

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **The provider did not fulfil their statutory duty to safeguard the health, safety and welfare of people, by taking appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of providing the service.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have appropriate arrangements in place to ensure that staff received a full induction or appropriate training.**

The enforcement action we took:
We issued the provider with an urgent Section 31 Notice of Decision to remove all regulated activities from the service with effect from 9 December 2014.