Caring Homes Healthcare Group Limited

Miranda House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Miranda House is a nursing home for up to 68 older people some of whom live with dementia. At the time of our inspection there were 48 people living at the service. Accommodation was provided over two floors which are accessed by stairs and a lift. There were various communal facilities such as dining rooms and lounges. There was a garden for people to access from the ground floor.

People's experience of using this service and what we found
Incidents and accidents had not been managed safely or effectively to identify causes and work to prevent reoccurrence. Incident forms were not always completed, reviewed or followed up to make sure action was taken. We had not been notified of all incidents and events as required by law.

Staff had not been provided with training they needed to carry out their roles safely. There were a number of people living at the home who experienced distressed reactions which lead to behaviour that challenged the service. Staff were not able to consistently support people safely and had experienced incidents of physical aggression.

Quality monitoring systems were not effective in assessing and monitoring the quality and safety of the service. Not all injuries had been investigated to determine causes which meant action could not be taken to mitigate risks or to make sure relevant agencies were informed. The provider did not have an accurate oversight of the service to make sure it was able to monitor and mitigate risks.

Since the last inspection there had been changes in management at the home and on a regional level. This had caused a period of instability which had affected communication with relatives and staff.

Staff told us there were not always enough of them working on the first floor of the home. When staff were asked to carry out 1-1 work this had impacted on how the shifts were managed. We have made a recommendation about staffing numbers.

One area of the home had been identified for new people moving in to enable a period of isolation to reduce the transmission of COVID-19. We found this was not being used safely as staff had not moved people out of this area to their permanent rooms following their period of isolation. The provider took action during the inspection to address this unsafe practice. Prior to moving into the home people were tested for COVID-19 and only able to move in when results were negative.

People were living in a clean environment overall but there were areas of the home that required redecorating and updating. The provider had commenced decorating the ground floor and planned to complete the first floor. We were told new furniture had been ordered for the home.

Staff had the required personal protective equipment (PPE) available to them and were seen to be using it

safely. Staff had been given training on how to use the PPE and on working safely during the pandemic.

Visiting was permitted but had to be pre-booked with the home. This enabled staff to support visits safely. A breakdown in communication had resulted in relatives not being able to visit at a weekend, the provider told us they would address this without delay.

The home was carrying out the required testing for COVID-19 as per the government guidance. This included people living at the home and the staff working there. Vaccinations for COVID-19 had commenced.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 27 November 2019).

Why we inspected
The inspection was prompted to seek assurances about the safety and care of people following information received as part of ongoing safeguarding concerns and a police investigation. As investigations were ongoing this inspection did not examine the circumstances of those incidents. We undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Miranda House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to providing safe care, management and provider oversight and failing to notify CQC of notifiable incidents at this inspection.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We met with the provider following our site visits and will continue to meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Miranda House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by five inspectors, one of whom worked remotely and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Miranda House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. A registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

There was a manager employed we have referred to them as the manager in the report.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We limited the amount of time we spent at the service due to the pandemic so arranged for telephone calls to be made to people and relatives after day one of the inspection. We reviewed a range of records. This included 10 people's care records, multiple medication records and five staff files in relation to recruitment. We spoke with four members of staff, the manager and the regional manager.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

After the inspection
We spoke with three people and nine relatives on the telephone about their experiences of care and support. We also spoke with a further 14 members of staff and had further discussions with the manager and regional manager. We reviewed a range of records and documents which included meeting minutes, risk assessments, quality monitoring information and policies and procedures. We contacted Healthwatch for feedback about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse; Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were not always safe as there were not effective measures in place to assess and mitigate risks from others living at the service.
- There were a number of people living at the service with dementia and mental health conditions who experienced distressed reactions. A high number of those reactions resulted in physical altercations with others which at times caused injuries.
- Staff had not been trained to work with people with behaviours that were challenging to others and had experienced incidents of physical aggression on a regular basis. We were not able to see any measures taken to investigate all of these incidents or mitigate risks. Comments from staff included, "Just learn as you go along. Do what you see fit at the time, what you think is right. Haven't had any training, would be good to have", "I had training, but it was e-learning and not specific to here and the residents. Call on the nurses if finding things difficult and learn from how they manage things" and "There is training but it's not really been happening due to COVID. Need to get it started again."
- Measures put in place to monitor incidents such as behaviour charts were ineffective in identifying any causes and were not being used to analyse the incidents. This meant action had not been taken to reduce risks when patterns were identified. For example, staff had noted there were more incidents in the evening, but this had not been recorded or acted upon. Staff told us they had requested more activities to take place in the evenings, but this had not happened.
- Incident and accident forms had been completed for some incidents, but we were not able to see what action the provider had taken to prevent reoccurrence. The manager had little oversight of all the incidents and accidents taking place which meant follow up actions had not been carried out. Lessons were not being learned and incidents kept happening which placed people at risk of harm.

The provider had failed to put into place measures and take action to keep people safe from harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We were not assured that the provider was admitting people safely to the service. The home had identified an isolation area for people who were newly admitted into the service. This area was not being used safely and for its purpose. People had not been moved out of the area once their isolation had finished and people from the main home had accessed the area putting themselves and others at risk. The

provider informed us they had taken immediate action to address this shortfall.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Using medicines safely
● People had their medicines as prescribed. People's medicines administration records (MAR) did not have any gaps and had the required information recorded.
● People who had their medicines covertly did not always have the records this type of administration requires in place. The provider took immediate action to address this shortfall.
● Where people were prescribed 'as required' medicines, there were protocols in place to guide staff to know when and how to administer this type of medicine.
● Medicines were stored safely, and staff checked the temperatures of the storage areas daily.

Staffing and recruitment
● Staff were supporting two people on a 1-1 basis which put a strain on the team. Following our site visit the provider told us one person requiring 1-1 support had moved out of the home which alleviated some pressures.
● Staff told us there were not enough staff at times due to short notice sickness. Comments included, "Sometimes short staffed, we generally start off with enough staff but it's when staff go sick at short notice. Often difficult to get cover so work with less staff until someone comes in" and "Have been really short staffed, particularly upstairs. One resident needs one to one so staff spend hours at a time with him due to aggression. It gets in the way of personal care and takes you away from people."
● Comments from relatives about the staffing included, "The carers have a really good relationship with [relative] but even before the pandemic I never thought there were enough staff. Everyone was always rushing with no time to spend with the residents", "Judging by how difficult it is to get through at weekends I would say they are not well staffed but without going in it is so hard to tell" and "They are very good but if I could improve something apart from visits and letting us know properly it would be staff. Before the pandemic staff never had time to sit with residents so I doubt that's better."
● On the first day of our site visit there were not enough staff to support people safely at all times. One member of staff had to escort a person out of the home to a hospital appointment which left the team one member of staff short. Whilst the manager did take action to address the shortfall, staff told us this was a regular occurrence.

We recommend the provider review staffing numbers following a review of feedback from people, relatives and staff to make sure experiences of care and support are considered when calculating staffing numbers.

- Staff had been recruited safely with all pre-employment checks carried out.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- We found a number of incidents that were not notified to CQC. Providers are required by law to notify CQC of specific events, incidents and injuries. This had not happened consistently.
- The provider took action during the inspection to complete some notifications, but we saw further incidents in people's notes that had not been notified or reported to the local authority. The provider told us they will review notes and incident forms to submit the required notifications.

Failing to notify CQC of all notifiable incidents prevented us from carrying out our regulatory role, this placed people at risk of harm. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- Since our last inspection the management of the home had been inconsistent. The previous registered manager had moved to a different home and a new manager had been employed. There had also been a change of regional management.
- Comments from staff about the management included, "I heard through the grapevine about the regional manager leaving. Not informed formally, not told so not sure of the ladder now, who you would go to if need be", "Don't have much to do with him [manager], haven't really spoken to him. Doesn't come up to the floor unless he's showing someone around for a job. He says hello but that's about it" and "Don't see much of them [manager]. He doesn't know what staff have to do or the pressures they face, he's not supportive."
- Systems were not effective to assess, monitor and mitigate risks to people or staff. Systems to record and report incidents were not robust to ensure the provider had oversight of all incidents that had occurred. This meant action could not be taken in all instances to review and mitigate risks.
- Where people had sustained injuries, we did not see evidence that these had all been investigated fully to find out the cause. This meant the provider could not take action to prevent reoccurrence. We asked the provider to investigate some injuries to determine the cause.
- Quality monitoring taking place did not identify the numbers of incidents in people's daily notes which had not been recorded on incident forms. This meant the provider did not have an accurate oversight of the number of incidents happening. This placed people at risk of harm.
- Systems were not effective in identifying and monitoring safe use of covert medicines. There was an ongoing safeguarding investigation into one incident of unsafe use of covert medicines, however, we identified a further unsafe use of this type of medicines administration. The provider took action during the

inspection to address this unsafe practice and informed us of a further incident.

The provider failed to have in place effective systems to identify, assess and monitor quality and safety which placed people at risk of harm. This was a breach of Regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2017.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Relatives told us they were struggling to plan and book visits at the home as there was no visiting permitted at weekends. The provider told us this was an oversight and weekend visits would be started without delay.

● Relatives told us communication with the home was a concern for them. Comments included, "The communication is dreadful, not just to families, sometimes even staff didn't know what was happening", "I'm not sure who the manager is. They never communicate changes, you get letters/emails from head office but that's general stuff for all the homes" and "Communication wasn't good even before the pandemic. They just don't keep in touch with people and it is a courtesy to keep families in touch with what is going on and any changes." We shared these concerns with the provider.

● Staff told us the management and provider did not always listen to them. Comments included, "We are not listened to, it is hard to voice opinions, no one listens. Staff on the floor are working hard, they don't have a voice, they know what is going on better than anyone" and "I don't feel listened to, this is going back some time. I have said we need more activities especially in the evening, that is when we need someone, this would help dissipate the issues in the evening."

● During the inspection the provider commenced some 'listening events' with the staff. A member of staff from HR visited the home to talk with staff and listen to how they were feeling. The provider had also made sure following a COVID-19 outbreak staff had access to counselling in order to have support if they wanted it.

Working in partnership with others

● People had been able to see a GP or other healthcare professional when needed. This helped to make sure people's health needs were met.

● The home had experienced a significant outbreak of COVID-19 in 2020. Staff worked with local and national public health organisations to follow safe guidelines.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify CQC of all notifiable incidents as required to do by law. Regulation 18 (1) (2) (a) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to have in place effective systems to identify, assess and monitor quality and safety which placed people at risk of harm. Regulation 17 (1) (2) (a) (b) (f)

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to put into place measures and take action to keep people safe from harm. Regulation 12 (1) (2) (a) (b) (c)

The enforcement action we took:

We served a Warning Notice.