Four Seasons (No 10) Limited

Murrayfield Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 12 and 13 December 2018 and was unannounced.

We last inspected the service on 21 November 2017 and was rated 'Good' overall with the key question of responsive rated as 'Requires Improvement'. This was because we found that further improvements needed to be implemented in the provision of meaningful activities, staff understanding of person centred care and the timely completion of daily records in response to people's needs.

At this inspection we found that the service had not made the required improvements in areas such as the provision of meaningful activities and the timely completion of daily records in response to people's needs. We also found that the provider implemented management and staffing structure within the home may affect the safe and effective management of the home.

This means that the service is no longer rated 'Good' and has been rated as 'Requires Improvement'.

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

Murrayfield Care Home accommodates up to 74 people. Within the building there were three floors, each of which had separate adapted facilities. Lifts were available within the home giving people access to all areas of the home. One of the units specialises in providing nursing care to people and the two other floors specialised in providing care and support to people living with dementia and physical health needs. At the time of this inspection there were 72 people living at the home.

A registered manager was in post at the time of 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.

Activities provision within the home did not always stimulate or engage people. Where scheduled activities were organised and facilitated by designated activities co-ordinators, people were seen to enjoy these. However, very little meaningful activity was initiated and delivered by care staff in the absence of activity co-ordinators.

Monitoring charts and records were not consistently and comprehensively completed by care staff to ensure people received care and support that was responsive to their needs.

End of life preferences and wishes were not always clearly documented within people's care plans.

Quality assurance processes in place allowed the registered manager and the provider to oversee the quality of care provision, identify issues, learn and implement improvements where required. However, where actions were identified, which were similar to those identified as part of this inspection, these had not been actioned effectively and improvements had not been made.

We found that the management and staffing structure implemented by the provider did not always support the effective management and running of the home.

Staffing levels were determined based on individual people's levels of need. We saw that there were sufficient number of staff available around the home at the time of the inspection.

People and their relatives told us that they felt safe living at Murrayfield Care Home. All staff demonstrated a good understanding of safeguarding people from abuse and the actions they would take to report their concerns.

People's care plans contained detailed risk assessments people's identified risks associated with their health and social care needs. Further information was also documented to guide staff on how to support people to be safe and free from harm.

Staff told us and records confirmed that they felt supported in their role and received regular supervisions and annual appraisals.

Recruitment processes ensured that only those staff assessed as safe to work with vulnerable adults were recruited.

People received their medicines safely, on time and as prescribed. Medicine policies and processes in place supported this.

Accidents and incidents were recorded, reviewed and analysed to ensure that where things had gone wrong improvements and further learning were considered and implemented.

Staff received an induction when they first started work at the home with regular on-going training which enabled them to deliver effective care and support.

People's needs and preferences were assessed prior to their admission Murrayfield Care Home so that the home could confirm that these could be effectively met.

People had access to a variety of snacks, drinks and regular meals which helped them to maintain a healthy and balanced diet. Where people had specialist diets and support needs in relation to their dietary intake this was appropriately catered for.

People were supported to have maximum choice and control in their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People had access to a variety of health care professionals to ensure they were able to maintain a healthy lifestyle. The home worked effectively within as well as with other healthcare professionals so that people had access to specialist and relevant services which addressed and met their identified health and care needs.

We observed positive and caring interactions between people and staff. Staff knew the people they supported well and treated them with dignity and respect at all times.

People were supported to be involved in all aspects of the delivery of their care and support where possible. Relatives also confirmed that the home always involved them in every aspect of their relative's care.

Care plans were detailed and person centred which gave specific information and guidance to staff on how to meet people's identified needs and wishes.

People and relatives knew who to speak with if they had any concerns or complaints to raise and were confident that their concerns would be dealt with appropriately.

At this inspection we found a breach of Regulation 9 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?

Good

The service remains safe. People felt safe living at the home. Care staff knew who to report to if they noted any signs of abuse.

Risk assessments for people and their health and social care needs gave clear information and guidance to care staff on how to keep them safe and free from harm.

Medicines management and administration was safe.

Recruitment processes followed by the service enabled the safe recruitment of staff. We observed sufficient numbers of staff available throughout the inspection.

Accidents and incidents were documented with details of actions taken and learning outcomes to prevent future re-occurrence.

Is the service effective?

Good

The service remains effective. People's needs were assessed prior to admission to the home so that the home could confirm they were able to effectively meet those assessed needs.

Care staff received an induction, regular training and the appropriate support to carry out their role effectively.

People were supported to eat and drink appropriately in order to maintain a balanced diet.

People were supported to access a variety of health care professionals and services to live a healthy life. Staff and professionals worked effectively in partnership to achieve this.

The service and all staff understood the principles of the Mental Capacity Act 2005 and how this was to be implemented as part of people's care and support provision.

Is the service caring?

Good

The service remains caring. People and their relatives told us that care staff were caring, polite and respectful.

People and their relatives confirmed that they were actively involved in making decisions about the care and support that they and their relative received.

We observed people's privacy and dignity being respected and upheld at all times. Care staff demonstrated various ways in which this was done.

Care staff understood the diverse needs of people and ensured that they were supported in a way which was respectful of those needs. However, care plans did not specify or detail people's needs around their personal relationships and sexuality.

Is the service responsive?

Requires Improvement

The service was not always responsive. People did not always receive care and support that was responsive to their needs.

Monitoring charts that required completion to ensure people received the appropriate care and support were not consistently or comprehensively completed.

Other than scheduled activities facilitated by designated activity co-ordinators, there was very little care staff initiated activity provision which promoted stimulation and engagement for people.

End of life care preferences and wishes were not always documented.

Is the service well-led?

Requires Improvement

The service has deteriorated to requires improvement. The management and staffing structure implemented by the provider did not always support the effective management and running of the home.

Quality assurance processes in place allowed the registered manager and the provider to oversee the quality of care provision, identify issues, learn and implement improvements where required. However, where actions were identified, which were similar to those identified as part of this inspection, these had not been actioned effectively.

Staff told us they felt well supported and were happy working at Murrayfield Care Home. However, they expressed concerns with recent changes implemented around staffing structures within the home.

People and their relatives knew the registered manager and the nurses in charge and were complementary of the way in which the home was managed.	

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

This inspection took place on 12 and 13 December 2018 and was unannounced.

The inspection team consisted of two inspectors, an assistant inspector, a CQC specialist advisor nurse, a CQC specialist advisor pharmacist and four experts-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.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we observed how staff interacted and supported people who used the service. We spoke with 24 people using the service, 20 relatives and 17 staff members which included the registered manager, a regional manager, a resident's experience support manager, the clinical lead, nurses, senior care assistants, day and night care staff.

We looked at the care records of 13 people who used the service. We also looked at people's medicines administration record (MAR) charts and medicines supplies and the personnel and training files of seven staff. Other documents that we looked at relating to people's care included risk assessments, handover notes, quality audits and a number of policies and procedures.

Good

Is the service safe?

Our findings

At the last inspection in November 2017 we found that not all staff were able to explain their understanding of safeguarding and whistleblowing and the actions that they would take to protect people. At this inspection we found that all care staff received annual safeguarding and demonstrated a good awareness and understanding of the different types of abuse and how to identify and report signs of potential abuse. Care staff understood the meaning of whistleblowing and listed names of agencies including the CQC, police and the local authority who they could contact to express their concerns. One staff member told us, "Any incident that happens I would contact the nurse, then [registered manager] and tell them what happened. I would write down the incident. If nothing happens in the office, I would inform the Local Authority or the police."

People and their relatives told us that they and their relative felt safe and happy living at Murrayfield Care Home. People's responses included, "The night staff are pretty good. I feel pretty safe here", "I feel safe here. I can't complain really about anything" and "I do feel safe." Relatives told us, "I do like it. He likes it too. Most of the staff are very good. I feel he's safe here" and "Yes the staff are fantastic, they do know how to keep my relative safe."

The home followed appropriate systems and processes to report and investigate all safeguarding concerns that had been identified by the home or reported to the home. Where outcomes of investigations highlighted any improvements to be made by the service, we saw evidence that these were implemented to ensure going forward people remained safe whilst living at the home.

Risk assessments in place identified and assessed risks associated with people's health, care, medical and social needs. Information was clear and detailed which guided staff on how to support people with their identified risks to keep them safe from harm. Identified risks included falls, moving and handling, pressure wounds, bed rails, swallowing difficulties and behaviours that challenged. Risk assessments were reviewed on a monthly basis or sooner where a person's support needs had changed.

At the last inspection in November 2017 we noted that the total fluid intake for people had been calculated incorrectly which meant that people's recommended daily intake may not have been achieved and required action may not have been taken. During this inspection, although some improvements had been made in consistency of recording these were not always being sustained. Recording continued to be inconsistent. We found gaps in recording and total fluid intake within a 24-hour period had not been recorded. This meant that where a person may have had low fluid intake this would not be identified and therefore actions would not be taken to address this. We highlighted these omissions in recording to the manager who stated they would discuss these issues with the staff team to ensure going forward recording was clear and reflective of the support the person actually received. This has been further reported on under the sections of 'Responsive' and 'Well-led'.

Recruitment processes followed by the service ensured that only staff assessed as safe to work with vulnerable adults were recruited and employed. Documents seen which confirmed this included criminal

records checks, conduct in previous employments, proof of identification and nurses' registrations with the Nursing and Midwifery Council (NMC).

We asked people and their relatives about whether they felt there were sufficient numbers of staff available to support them and their relative. Feedback that we received was mixed with people and relatives making comment about the high use of agency staff in addition to not enough staff being visible around the home. One person told us, "They don't seem to stay very long. I don't think they are treated very well. I get on with most people. There's lots of agency staff. They wash and dress me. Some are better than others." Relatives feedback included, "Something that could be done better. There should be someone in the sitting room with the group. Most of the time there are staff but occasionally there is no one there", "Not noticed a shortage of staff there are generally three or four staff around. There are always two staff in the lounge keeping an eye on the residents" and "I do feel they need more staff. They seem to not be able to keep staff. A lot of agency staff."

Throughout the inspection we observed there to be sufficient number of staff to meet people's needs safely. Staff did not seem rushed and at mealtimes there were appropriate numbers of staff available to ensure people who required one to one support or chose to have their meals in their room received this in a timely manner. The service assessed people's needs and dependency levels which allowed them to calculate and allocate the required numbers of staff based on those assessed needs. The registered manager explained that staffing levels could be adjusted if people's needs increased. However, the provider had recently reviewed and made changes to the current staffing structure. We have reported further on this under 'Well-led'.

People received their medicines safely and as prescribed. Medicines were stored securely and medicines stocks were well managed. We did highlight some concerns around recording of temperatures of the areas where medicines were stored. We found that staff did not record minimum and maximum temperatures to ensure that medicines were stored at the required optimum temperature to ensure their safe use. This was fed back to the management team for action.

'As required' (PRN) medicines were administered safely following clear directions on when and how they should be administered. PRN medicines are administered on an 'as and when required' basis and include medicines such as pain relief. A number of people received medicines which were disguised in food or crushed. Where this was the case mental capacity assessments with best interest decisions had been completed for people lacking capacity to make this decision, which involved the home, the GP, the pharmacist and the person's relative. Clear guidance had been documented on how the covert medicine should be administered. Controlled drugs were stored appropriately and were signed by two staff when administered. Controlled drugs are medicines that the law requires are stored, administered and disposed of by following the Misuse of Drugs Act 1971.

We looked at medicine administration records for people living at the home and found these to be clear and fully completed. The records showed people were getting their medicines as prescribed and any reasons for not giving people their medicines were recorded. Nurses responsible for the administration and management of medicines had received regular training in safe medicine management which included the completion of a competency assessment on an annual basis. Nurses, the registered manager, senior managers, the provider and the supplying pharmacist completed weekly, monthly and annual medicine audits which identified and addressed any gaps in recording or errors to ensure the safe administration of medicines.

The provider recorded all accidents and incidents through an electronic system. Each accident record

detailed the nature of the accident, how it happened and the actions taken as a direct response to the incident as well as any follow up actions taken. Each accident or incident was then recorded within the provider's system where the manager and senior manager held regular oversight. This enabled them to review and analyse to ensure that improvements and further learning could be implemented to prevent future re-occurrences.

We observed that the home was clean and free from malodours. All staff received infection control training and had access to a variety of Personal Protective Equipment (PPE) such as disposable gloves and aprons. We saw that all food preparation and storage areas were clean and appropriate food hygiene procedures had been followed.

The safety of the building was routinely monitored and records showed appropriate checks and tests of equipment and systems such as fire alarms, emergency lighting, gas and electrical safety, legionella and hoisting equipment were undertaken.

Individualised Personal Emergency Evacuation Plans (PEEPs) were in place for each person and the provider had a clear plan to help ensure people were kept safe in the event of a fire or other emergency.

Good

Is the service effective?

Our findings

People and their relatives told us that care staff at Murrayfield Care Home were well trained and experienced to deliver their role effectively. Feedback from relatives included, "Very much so. They [staff] appear committed, they work with a purpose and offer assistance when its needed", "I would say the regular staff are." and "The regular staff are good, they are skilled and trained."

Staff told us and records confirmed that they received training which was refreshed on an annual basis. All newly recruited staff were required to attend a two-day induction which covered topics including orientation to the home, residents, health and safety, policies and procedures. In addition, all staff received training in certain mandatory and non-mandatory topics which included fire safety, moving and handling, first aid, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and dementia awareness. Electronic records enabled the registered manager to monitor staff training profiles so that where staff were due specific training this could be arranged in a timely manner.

Nurses and care staff were also supported through regular supervisions and annual appraisals. Records detailed that care staff were given the opportunity to discuss their concerns, work practices and training support that they required. One care staff told us, "Yes we have supervision all the time. We talk about tasks and actions set for the month."

A pre-admission assessment was completed for each person who had been referred to the home so that they could assess and determine that the home was able to meet the needs of the person. Once this was confirmed a care plan was compiled which detailed people's identified needs, likes, dislikes and preferences and direction on how staff were to support the person to meet their needs effectively. Where people were assessed to have specific health care needs which required the use of specialist equipment, the service ensured that the equipment was ready an available in time for the person's admission. Care plans were reviewed on a monthly basis to ensure that they were current and reflective of the person's needs.

People and their relatives were complementary of the food that was presented to them and the choices on offer. Throughout the inspection we observed that people ate and drank well and always had access to drinks and snacks. People told us and we observed that they were always given choice of what they wanted to eat. Pictorial menus were available for people to look at and decide what meal they wanted to eat. Where people did not like what was available an alternative was always available. We observed positive and caring interactions between people and staff where people required one to one support when eating their meal. People's comments about the food included, "The food is right. Everything is right", "They do nice breakfast. I don't eat a big breakfast. I only have toast and coffee" and "They used to have one type of food they changed it to another it's variety. On Saturday it's a cooked breakfast. The foods good."

Relatives feedback about the meal provision at the home included, "Food fantastic, freshly prepared and varied", "Every item of food pureed separately for [relative] Staff now help to feed [relative]. I have noticed that the home have a Caribbean menu which can to be pre ordered" and "My relative has a good menu. If she does not like what is on the menu she is given other options. She has never complained."

Where people required specialist diets due to identified needs or cultural requirements, the home made sure that people received the required support. People's specialised dietary requirements were clearly recorded within their care plan and the chef had this information made available to them in the kitchen. Records and guidance were available where people had been assessed to require specialist assistance with their meals such as a pureed diet or thickening agents to be added to their meal or fluids.

The home and all staff worked well in partnership with each other and other health and social care professionals to ensure people received effective care, support and treatment. Daily handovers and weekly manager and nurses meetings enabled discussions about people's care and support, specifically highlighting concerns or changes in need and the actions that needed to be taken to meet the desired outcome for the person. Staff also maintained daily records for each person which detailed the support that had been provided, changes in people's wellbeing, activities that people had participated in and how well they had eaten. However, not all records that were in place were consistently and comprehensively completed. This included poor recording of people's repositioning, fluid intake, hourly checks and topical cream application. We have further reported on this under the section of 'Responsive'.

People's care plans documented health care professionals involvement, the reason for the involvement and actions to be taken as a result. Involved professionals included GP's, chiropodists, speech and language therapists, social workers, nutritionists and the Care Home Assessment Team (CHAT). The CHAT visited people regularly who had complex health needs or who were at risk of deteriorating and liaised with the wider multidisciplinary team and supported care staff and nurses to coordinate care and minimise hospital admissions. This ensured that peoples' health and medical needs were effectively met so that people could maintain and live a healthier lifestyle.

However, for one person who had a specific need, referral to the appropriate healthcare professional and follow up action had not taken place. This had impacted on the person's quality of life. We brought this to the attention of the registered manager who immediately took the appropriate action to ensure referrals were made.

People and relatives were happy with the support that they and their relative received in relation to their healthcare and were confident that any identified concerns would be addressed immediately. One person told us, "I've seen an optician that comes around. A chiropodist and a hearing aid person. I go out to the hairdressers and I'm going to Christmas dinner." One relative said, "Staff contacted me when [relative] was poorly and wasn't eating. Staff watched [relative] and when there was no improvement, staff promptly called the doctor."

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. During the inspection we found that the service had considered the key principles of the MCA and DoLS authorisations had been requested and where authorised, these had been clearly documented within the person's care plan, along with any specific conditions that needed to be

adhered to.

Care plans clearly documented consent to care. Where people had capacity, they had been given the opportunity to consent to their care and support provision. Where people lacked capacity, assessments had been completed and best interest meetings conducted to further determine the level of support that the person would require that would be in their best interest. This included decisions around administration of covert medicines, do-not-resuscitate authorisations and support with personal care. Records confirmed the involvement of the home, relatives and any associated health care professionals in best interest decisions.

All staff demonstrated a good understanding of the MCA and DoLS and gave clear examples of how people were supported in line with the key principles of the MCA. One care staff explained, "People who had no understanding, where they cannot make their own decision. I will look at their DoLS and speak to the manager for advice."

The home was adapted in a way which supported people's individual needs. A lift enabled people to access all areas of the home. Where specific moving and handling equipment was required including hoists, wheelchairs and adapted shower chairs and baths, these were available. People's rooms were personalised as they so wished. Use of dementia friendly signage and pictorial aids were visible around the home.

Good

Is the service caring?

Our findings

People and their relatives all made positive comments about the care staff that supported them and their relative. "Caring", "Polite", "Respectful" and "Professional" were all words used to describe all staff at Murrayfield Care Home. One person told us, "Everything is right. She's [activity co-ordinator] absolutely lovely. She's so good to me." Another person stated, "[Name of nurse] is marvellous." Comments from relatives included, "They respect her needs. Caring, polite and culturally respectful as well", "Yes always, they are really good with my relative. I also had a mini breakdown when my relative had to come to the home. They supported me really well, they were brilliant. I have now the confidence to keep my relative here" and "Staff look very caring and kind. Staff always talk to her directly and [relative] appears happy to see them."

Care plans detailed people's cultural, religious and personal diversity needs with information about how people were to be supported with these needs. Weekly church services took place within the home for people who continued to practice their faith. However, we did note that although care plans had a section that requested information about people's sexuality and relationships and any identified needs in relation to this, this section had not always been completed. This meant that staff would not have any insight or understanding into people's personal relationships and sexual needs to be able to support them in a safe and caring way. This was an area that required further work and that had been highlighted to the registered manager at the last inspection in November 2017. We again brought this to the attention of the registered manager who assured us improvements would be made going forward.

When we spoke with care staff about this they told us that they always promoted equality and diversity within the home and always tried to support people to maintain their relationships regardless of their identified sexuality. One staff member said, "They have come here to be looked after so it does not make a difference to me."

Throughout the inspection we observed that people had established positive and caring relationships with staff at the home. Care plans detailed people's preferences on how they wished to be supported. We saw staff asking people what they wanted and how they wished to be supported. People were observed to be actively involved in day to day decisions about their care where possible. Relatives confirmed that staff always took the time to speak with their relative. Feedback included, "Staff are very caring, they will sit and chat with [relative]. Staff are keen to get to know [relative] better" and "[Relative] likes the staff, appears to have a good relationship with staff."

When we spoke with people about their involvement in the planning of their care and support most people told us that it was their relative that dealt with the care plan. One person told us, "I don't know about the care plan, my son speaks to the manager, he's lovely, kindness itself." However, relatives confirmed that the service always involved them in all aspects of care delivery for their relative. Relatives told us, "We have been through the care plan. They work as a team with us", "Yes we were involved. They listen to our thoughts of what my relative will need, her needs and what she likes and dislikes" and "Right at the start we were asked about [relative's] likes and dislikes, how they liked to be dressed and family background. Since then we have had two care reviews with manager, social services and hospital social worker."

We saw care staff respecting people's privacy and dignity through a variety of actions and interactions such as knocking on people's bedroom doors before entering, speaking to people with respect, greeting people, asking people's choices and maintaining confidentiality. People and their relatives confirmed that their privacy and dignity and that of their relatives was always maintained. Relatives gave us examples which included, "When [relative] is having personal care we are asked to leave the room. [Relative] looks washed and well groomed", "Yes, they do. My relative prefers a male care worker, this is provided. The care workers always give respect and dignity to my relative. I have actually seen this" and "At all times. They know my relative cannot see is fragile. They always respect her dignity and privacy."

Care staff understood the importance of respecting people's privacy and dignity which included always involving the person and giving them choice on how they wished to be supported. One care staff told us, "I would make sure the door is closed, and the curtains are closed for their privacy. Before, I go into to their room, I will knock and wait for their response." Another care staff explained, "We have to give privacy when family visit, close the door, when we give personal care we have to make sure curtain is closed, no outsider is there."

During the inspection we observed that staff supported people to promote their independence as far as practicably possible. We saw people were able to access all areas of the home including outdoor areas whenever they wished. We spoke with staff about people's independence and how they support people to achieve this. One staff member told us, "It is in their best interest for themselves. If they want to do it they can do it. We have to observe and give them a chance to do something, let them try."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in November 2017, the service was rated 'requires improvement' under this section as we found that further improvements needed to be implemented in the provision of meaningful activities, sound staff understanding of person centred care and the timely completion of daily records in response to people's needs.

During this inspection we found that although further improvements had been made around people's mealtime experiences and person-centred care, we continued to find issues with the provision of meaningful activities and people receiving care which was responsive to their needs.

There were activity boards displayed on each level of the home which listed scheduled activities due to take place. During the inspection we saw these activities taking place. However, concerns remained around the provision of stimulation and activity outside of the scheduled plan. Staff initiated very little activity or stimulation and where we did observe some activity this largely involved sitting in a lounge and watching television.

On the first day of the inspection we saw people sat in the lounge watching television. A care staff member was present in the lounge playing a game with another person. One person was observed colouring from morning through to lunch on their own. One staff member told us, "I do some of the activities, which isn't part of my job. I feel the activities need to be more person-centred."

On the second day of the inspection we again observed people had been taken into the lounge area and sat in front of the television, set on a programme called 'The Simpsons'. Not a single person sat in the lounge was watching the programme and most were sat in their chairs dozing or appeared to be bored and disengaged. In the same lounge, in the opposite corner, a staff member was using an electronic hand-held device to play Christmas songs and was singing and dancing along with the songs. Nobody was engaging with the staff member. We brought this to the attention of the registered manager and showed them what we had seen.

We saw scheduled activities happening around the home that were initiated and delivered by the activities co-ordinator on duty. These included cheese and wine sessions, baking, bingo and children from a local school singing carols that had come into the home to entertain people. We saw posters advertising forthcoming Christmas parties and events leading up to the festive seasons. However, on the first day of the inspection, where arts and craft activities had been listed as a scheduled activity this did not take place. We also noted that with only one activity co-ordinator available for the entire home, an activity could only take place on one unit and not everyone in the home were able to attend.

People and their relatives gave mixed feedback about the provision of meaningful activities within the home which included very little care staff initiated activity. One person told us, "We don't get a lot of activities. Cheese and wine was cancelled. I don't know why. They don't do anything for Christmas. The day before each section have a party, a Christmas dinner, presents, children coming to sing. Christmas day itself is very

boring. They have bingo on Thursday afternoon. We have a singer. For two and a half weeks when the activities girls were on holiday there was no activities at all." Another person said, "I don't take part in any activity. I come here and I watch TV. I watch anything."

Relatives feedback included, "I would say this has got worse. Most of the time activities are cancelled. They have 73 residents and only two activity persons. They are overstretched. They seem to concentrate only on the dementia floor. They are too busy for my relative who does not have dementia", "There are photographs around the home of parties and what people have been involved. Not seen any activities when I have been visiting, I would like staff to try to get [relative] more involved in activities" and "Enjoys drawing, listening to music, bingo and colouring. Big improvement geared to dementia patients. Plenty of things to do. Watched two young girls involved playing music and getting residents involved."

Care plans were detailed and person centred and provided information about how people wished to be supported, their likes and dislikes. Information and guidance included in the care plan covered moving and handling, personal care, eating and drinking and mental health needs. Care plans were reviewed monthly or sooner where any changes had been noted.

Where people had identified needs that required monitoring, this was clearly documented with charts in place to ensure the required monitoring took place in response to people's needs. This included re-positioning charts, food and fluid intake charts, hourly checks and the application of topical creams. However, we found that these charts were not always consistently and regularly completed with significant gaps seen in recording. This meant that people may not have been receiving the appropriate care and support that was responsive to their needs.

We noted for one person that a care staff member had retrospectively completed an hourly checks chart, after we had already inspected the chart. We checked the hourly check chart at 10.16am and saw that the last entry was at 07.12am. When we went back to check the chart again at 15.09pm we saw that retrospective entries had been made by staff for 08.05am and 09.01am. The issue we identified was similar to an issue we found where care staff were found falsifying records at the last inspection in November 2017. This meant that records completed may not have been a true and current reflection of the care and support people received.

End of life preferences and wishes were not always clearly documented within people's care plans. End of life care plans were either not completed or lacking in detail such as if a burial or cremation were the wishes of the person. There were advanced directives in place which had been completed by the community matron and the Lasting Power of Attorney for health and welfare. This was an issue that had been highlighted as requiring further improvements at the last inspection.

All of the above is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where appropriate, a person-centred life story booklet had been completed which gave detailed information about the person and included their family tree, their wishes and aspirations, their working life, hobbies and interests, what they enjoyed doing most days and memorable dates and special days. One relative told us, "They [home] have asked us about their life history." The information enabled care staff to gain a better understanding and appreciation for the person that they were caring and also equipped them to provide care and support that was responsive to the person's needs and preferences.

Regular care staff we spoke with and our observations of care practices were positive and assured us that

care staff knew the people they supported well. However, discrepancies in practice were noted by people and relatives during the times where the home commissioned agency staff to work at the home. One person told us, "They are very nice but some of the agency staff are not good."

A complaints policy was available and displayed around the home which detailed the processes in place for receiving, handling and responding to comments and complaints. Where complaints had been received these had been documented with details of the actions taken to resolve the complaint. People and relatives we spoke with told us that they felt able to complain if they needed to and were confident that their complaint would be dealt with appropriately. One person told us, "Complaint, first the floor manager, I talk to him. Then the home manager." Relatives feedback included, "Any concerns I would speak with the person in charge of the dementia floor they have always been very helpful", "Yes the manager. We have complained in the past and the issues have been resolved" and "We would complain or speak to the manager. She always asks if there are any issues and of course we know about the CQC."

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us that they knew the registered manager and the nurses in charge and were complimentary of them and the way in which the home was managed. Relatives told us, "Manager is accessible most times for any issues. She has an open-door policy", "Manager is very good and friendly, appears to be doing a good job. Responsive and sympathetic with relatives", "[Name of registered manager] the manager is lovely. All the staff are very helpful" and "Excellent manager, very approachable."

At the last inspection we found that further improvements needed to be implemented in the provision of meaningful activities, staff understanding of person centred care and the timely completion of daily records in response to people's needs. At this inspection we found that the service had not made the required improvements in these areas.

The provider and the registered manager had a wide range of checks and audits that allowed them to monitor, evaluate, learn and improve, where required, the care and support that people received. Audits and checks looked at medicine management and administration, care plans, mealtime experiences, health and safety, food safety and the environment. Where issues were identified an action plan was compiled with details of the actions to be taken and a timeframe within which the actions should be completed by. This was monitored monthly by the registered manager and at provider level. The audits and actions plans we looked at had highlighted some of issues that we had found as part of this inspection. However, we found that the appropriate actions to implement improvements had not be taken in a timely manner and improvements to areas identified at the last inspection had not been implemented and sustained.

We found that the management and staffing structure implemented by the provider did not always support the effective management and running of the home. The home had been managed solely by the registered manager without a supporting deputy manager for the last 12 months.

Although we found that there were sufficient numbers of care staff allocated within the home, we noted concerns with only one nurse lead allocated on each floor to support up to a maximum of 28 people and at a minimum 21 people. The nurse in charge was responsible for ensuring all medical and clinical needs of each person was met including administration of medicines, care planning and review, staff supervision and clinical care provision. This meant that where we found issues with the completion of people's monitoring charts, nurses in charge, did not always have sufficient time to oversee the completion of these charts, ensure they were completed fully and take forward any required actions.

We were informed that the provider had recently reviewed staffing levels in November 2018 which had resulted in the reduction of nursing staff on the second floor where 28 people lived from two nurses to one nurse. We were shown the dependency tool which assessed people's needs and calculated the required number of staff to ensure people's needs were met safely and effectively. However, we were not assured that this tool correctly determined the required nursing and staffing level that the home required. This was fed back to the registered manager and the regional manager at the time of the inspection.

Staff also told us about the impact of there not being enough nurses and staff to support people. One staff member told us, "We are understaffed now in afternoon down to three carers." Another care staff said, "The service is not well run, as we are understaffed, and we do not have enough time." Staff that we spoke with stated that they were always rushed as there was not enough staff and only one nurse. They also added that most of the people they supported were highly dependent and needed a lot of care so they were always busy and did not have enough time to do any activities or one to one with people. In addition, staff also confirmed that due to there only being one nurse on duty who had to do medication for 28 people, people may not always receive their medications in a timely manner.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All staff that we spoke with were positive and were happy to work at Murrayfield Care Home. Staff told us that they were well supported in their role by senior managers. Comments included, "[Name of nurse] is a gentleman, he is very supportive. [Name of registered manager] is very welcoming", [Name of registered manager] is very supportive. Since she has started he role she made improvements for Four Seasons" and "[Name of registered manager] is a great person. She is very supportive."

Care staff told us and records confirmed that they were supported through a variety of processes including supervisions, appraisals and team meetings. Discussions at team meetings included team work, recording, training and completion of care documentation. We saw that meetings were held every three to four months. The registered manager told us that where required additional meetings could be organised. Care staff told us that they felt able to express their views and concerns and that they were listened to. One staff member told us, "Yes I do attend sometimes. We talk about everything, mistakes to improve, different things we talk about, staff arguments, they listen. I can say my opinion."

Residents and relatives were supported by the home to engage and give feedback about the quality of care that they received and by having input into certain aspects of care provision which they could give comment on and influence such as activities and meal choices. Relatives confirmed that meetings for relatives and residents did take place which they were encouraged to attend. One relative told us, "I attended the relatives meeting over a year ago. Some people had complaints about the food. People were able to raise anything they wanted."

The home had systems in place to monitor quality through surveys that people, relatives and visiting professionals could complete. This was an electronic quality survey. The regional manager and registered manager explained that they asked people, relatives and visiting professionals who visited the home to complete a questionnaire on the home's iPad and they did this so that feedback could be obtained on an on-going basis. Feedback received from people, relatives and visiting professionals was overall positive. One relative stated, "I completed a questionnaire at the home about six weeks ago. Overall, I say [relative] is good, no specific worries."

The service worked in partnership with a variety of healthcare professionals and community organisations. We noted that that the service maintained positive links with healthcare professionals including the GP, physiotherapists, speech and language therapists, psychiatrists and social workers. The service encouraged visits from the local community and during the inspection had organised school children to visit the home and sing Christmas carols to people. This partnership approach ensured that people living at the home had access to a range of holistic services which supported their health and well-being. The service also engaged with the local authority quality team to work together in monitoring and improving the quality of care and support people received.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care and support needs were not always appropriately responded to especially where people had been identified with specific needs and concerns which required regular monitoring. The provision of activities was poor and did not always provide people with stimulation, engagement and participation in meaningful activities as per their choice and preference. End of life preferences and wishes were not always clearly documented within people's care plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Management structure and oversight processes in place did not always assess, monitor and improve the quality of care for people using the service. People may have been placed at risk of receiving care and treatment that was not safe, effective and responsive.