Signature At The Miramar (Operations) Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Signature at the Miramar provides accommodation and personal and nursing care for up to 122 older people and people living with dementia. The service is a large purpose built property. Accommodation is arranged over three floors. Two lifts are available to assist people to get to the upper floors. The service has 10 single bedrooms with ensuite bathrooms and 69 apartments for one or two people. There were 72 people living at the service at the time of our inspection, the registered manager was not able to tell us how many people were receiving a personal care service.

A registered manager was working at the service and was supported by a management team and the providers. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the care and has the legal responsibility for meeting the requirements of the law. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We inspected the service sooner than we had planned because we had received a number of concerns about people's care from relatives and staff. One person's relative told us, "The service was sold to us as 'they do everything', but it hasn't turned out that way". People had very different experiences of care at the service. People who required frequent support or had complex needs told us they did not receive their care when they needed it and often had to wait for assistance when they rang for help. Other people who required very little support found the service met all their needs. One person told us, "I have no concerns at all, I am well looked after".

The registered manager did not have the required oversight of the service. They had not supported staff to work as a team and staff were demotivated and did not feel supported. Concerns staff had raised with the management team had not been listened to and acted on. Staff, including nurses, had not met with a manager to discuss their role, any problems they were experiencing or their personal development. Staff shared a vision of a good quality care but had not been supported to achieve this all of the time. Checks and audits of the service had been completed but these had not identified all the shortfalls we found during our inspection.

A system was in place to consider people's needs when deciding how many staff were required to support them at different times of the day. This was not effective and there were not enough staff available to provide the care people needed when they needed it. Some people had to wait f to receive support to meet their basic needs, such as going to the toilet. People and staff had raised their concerns about staffing with the registered manager but action had not been taken to address them.

At our last inspection we recommended that the provider contact the local fire and rescue service for advice about keeping people safe in an emergency. This action had not been taken and detailed plans and equipment were not in place to assist people to evacuate in an emergency. We informed the local fire and

rescue service of our concerns and they arranged to complete a fire safety audit of the service.

Assessments of people's needs and risks had been completed. Risks to some people, such as weight loss which was not planned had not been identified. Action had not been taken to mitigate the risks and people continued to be at risk. Care had been planned with people to meet their needs. However, detailed information was not available to staff about people's preferences and people told us that agency staff did not always provide their care in the way they preferred.

Staff had not completed all the training they needed to fulfil their roles including the nursing skills required to meet people's needs. Some staff held recognised qualifications in care.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Several people were the subject of a DoLS authorisation at the time of this inspection. Other people were not restricted and went out alone or with the support of staff if they preferred.

Some people and their relatives had raised complaints and concerns with the registered manager. These had been investigated and responded to. However, action had not been taken to resolve complaints some people had made and prevent them from occurring again, including delays in providing the care people needed.

The requirements of the Mental Capacity Act 2005 (MCA) had been met. Staff supported people to make decisions and respected the decisions they made. When people lacked capacity to make a specific decision, decisions were made in their best interests with people who knew them well. Staff making decisions with others in people's best interests did not know who had the legal power to make decisions about people's health and welfare.

At our last inspection we found that not all the required checks had been completed to make sure new staff were honest, trustworthy and reliable. Action had been taken complete all the required checks including obtaining a full employment history with dates of employment. Disclosure and Barring Service (DBS) criminal records checks had been completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Changes in people's health were identified and staff contacted people's health care professionals for support. People's medicines were managed safely and people received their medicines in the ways their healthcare professional had prescribed. People were offered a balanced diet and food they liked.

Staff were kind and caring to people. However, some people told us they were not always treated with dignity and respect. Staff knew the signs of abuse and were confident to raise any concerns they had with the provider. People had enough to do during the day. Records in respect of each person were accurate and complete.

We found breaches 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?

Requires Improvement

The service was not safe.

Risks to some people had not been identified and staff had not supported some people to be as safe as possible.

There were not enough staff available to provide the care people needed.

People were protected from the risks of unsafe medicines management.

Staff knew how to keep people safe if they were at risk of abuse.

Checks were completed on staff to make sure they were honest, trustworthy and reliable before they worked alone with people.

Is the service effective?

Requires Improvement

The service was not effective.

Staff were not supported and did not have all the skills they required to provide the care people needed.

Staff followed the principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards. Staff supported people to make their own decisions.

People were offered a choice of food to help keep them as healthy as possible.

People were supported to have regular health checks and to attend healthcare appointments.

Is the service caring?

Good

The service was not consistently caring.

People were given privacy but were not always treated with dignity and respect.

Staff were kind and caring to people.

People were supported to be independent as possible.

Is the service responsive?

Requires Improvement

The service was not responsive.

Complaints and concerns people had made were not always resolved to their satisfaction and had not been used to improve the service.

People had planned their care with staff. They received their care and support in the way they preferred.

People participated in activities they enjoyed.

Is the service well-led?

Requires Improvement

The service was not well-led.

Checks were completed on the quality of the service. However, they had not identified all the shortfalls at the service.

People and staff shared their views and experiences of the service but these were not acted on and used to improve the service.

Staff shared the registered manager's vision of a good quality service but were not supported to provide care to the required level.

Staff were demotivated and did not feel supported by the registered manager and management team. They had not been supported to fulfil their roles and responsibilities.

Signature at the Miramar (Operations) Limited

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 was a comprehensive inspection.

This inspection took place on 2 and 3 May 2017 and was unannounced. The inspection team consisted of two inspectors, a pharmacy inspector and two experts by experience in older persons care. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the Provider Information Record (PIR). The PIR is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications we had received from the service. Notifications are information we receive from the service when significant events happen, like a serious injury. We spoke to the local authority safeguarding team and a lead clinical nurse specialist for older people.

During our inspection we spoke with 23 people living at the service, 5 people's relatives and friends, a GP, the registered manager and staff. We looked at care records and associated risk assessments for 13 people. We looked at management records including staff recruitment, training and support records, health and safety checks for the building, and staff meeting minutes. We observed the care and support people received. We looked at their medicines records and observed people receiving their medicines.

Some people were unable to tell us about their experience of care at the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

This last inspected Signature at the Miramar in February 2016 and rated the service Good.

Requires Improvement

Is the service safe?

Our findings

Before and during our inspection staff told us there were not enough staff available at times, especially in the morning, to meet people's needs. They told us people were upset and angry about having to wait for their care. People we spoke with had different views, some people felt there were enough staff to meet their needs, while others thought there were not.

People had raised their concerns about staffing numbers and the time taken to answer call bells with the registered manager over the previous six months. During our inspection people gave us examples of situations when they had waited for their care. These included, "The night before last, I needed Paracetamol at 2 am. I had no water to take the tablet. I can't get out of bed so I pressed the red button. No-one came and I had to shout for about 20 minutes. I felt terrible about having to shout for help". Having to wait for support made people feel frustrated, angry and anxious. Another person told us, "I have to be helped out of bed, so I am helpless until staff can get to me which can take up to an hour if they're busy. Meanwhile my breakfast, which has been left on the table, gets cold and this is most frustrating and upsetting". Other people told us staff came when they needed them.

The provider's analysis of call bell usage showed approximately ten percent of calls were not answered for more than 15 minutes. This was a total of 748 calls in March 2017. The number of emergency calls not answered for more than 5 minutes had increased to a total of 102 in March 2017. Some people told us they had had to wait for their call bells to be answered for over an hour. The provider did not include calls that took more than 30 minutes to answer in their analysis as they assumed they were incorrect. The registered manager had not completed checks to reassure themselves that people had not had to wait for more than 30 minutes for the care they needed.

Staffing levels were planned around the number of minutes of care people needed each day. The registered manager told us there were enough staff to meet people's needs at all times. During the inspection the provider told us they would review the deployment of staff at different times of the day to make sure people received the support they needed when they wanted it.

The service had a large number of care staff vacancies, approximately 20 percent in March 2017, which were covered by agency staff. People and staff told us regular agency staff knew people and their needs well but other agency staff did not. People had raised this with the registered manager at several residents meetings. One person told us, "Recently there has been a flood of agency staff. I don't know some of them. Most are doing their best in a difficult situation". The provider was advertising and recruiting to staff vacancies, including nurse and management vacancies.

The registered persons had failed to deploy sufficient numbers of staff to meet service users' needs. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action had not been taken to mitigate risks to some people. For example, one person had lost 10 percent of their body weight in 10 months, including 3 kgs in March 2017. Their nutrition risk assessment had identified

that there was a 'cause for concern' but no action had been taken to reduce the risk of the person losing more weight. The visiting GP told us they would expect to be informed when people's weight loss was not planned. The person's care plan stated they enjoyed biscuits and cakes between meals. The person was not offered these snacks. Staff completed a monthly nutrition report to identify people at risk of malnutrition. This had not identified the person had lost a significant amount of weight.

One person's moving and handling risk assessment had not identified the correct size of sling required to move them safely and the person had slipped to the floor while being moved. The risk of people falling from a hoist sling is increased when the incorrect sling is used to move them. The person's relative told us that they were anxious the person may slip again each time they were moved using the hoist. The correct size sling had been ordered a week after the accident and was in use at the time of the inspection. Guidance was not provided to staff, including agency staff about how to move people safely. For example, one person's risk assessment stated they required two staff to support them to move in bed but no guidance was provided about the techniques to be used to assist the person to move safely. There was a risk that the person would not be supported to move safely.

Some people took Warfarin to stop their blood clotting. Guidance was not available to staff about how to manage the risks that people may experience when taking warfarin, such as excessive bruising or prolonged bleeding.

Other risks to people had been identified and action had been taken to reduce them, including the risk of people fallings out of bed or developing skin damage. People used pressure relieving equipment such as special cushions and mattresses to help keep their skin healthy. Accidents and incidents had been recorded and the registered manager had analysed the information to identify any trends. People who had fallen had been referred to the 'falls clinic' for support.

At our last inspection we found detailed plans were not in place to keep people safe in an emergency, including plans and equipment to evacuate people from the building. The registered manager told us following the inspection they would obtain advice from the local fire and rescue service. At this inspection we found that this action had not been taken and detailed plans and equipment were still not in place to evacuate people in an emergency. A fire evacuation plan was in place but staff were not aware of the action required of them. Staff told us they would leave the building and wait for the fire brigade to evacuate people. We shared our concerns with the local fire and rescue service following the inspection and they arranged to visit the service to complete a fire safety audit.

The registered persons had failed to assess and mitigate the risks to people's health and safety. They provider had failed to assess and manage risks associated with major incidents and emergency situations. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines at the correct time, which was important to them, but not always in the way they preferred. One person told us, "I get my medication on time. Sometimes I get it in the middle of a meal. I don't like my meal being interrupted". Staff knew certain medicines needed to be given on time and prioritised these. For example, medicines for Parkinson's disease were given on time to avoid symptoms occurring.

People's medicines were managed safely. Staff had completed medicines training and their competency to administer medicines had been assessed. Effective systems were in place to order, store and dispose of

medicines. Temperatures where medicines were stored, including those requiring refrigeration, were recorded daily and were within the safe range. We observed staff administering peoples' medicines safely and in a caring manner.

Guidance was available to staff about some 'when required' (PRN) medicines people were prescribed, for example pain relief. Some of the guidance did not give full details of when the medicine should be given. For example, where two types of pain relief medicines were prescribed to be taken when required, it was not clear if they could be given together or if one should be given first.

We recommend the registered persons review each person's 'when required' medicines guidance to ensure that enough detail is provided to enable people to receive the best outcome from their medicines.

Some people had their medicines without their knowledge, known as covert medicines. Staff followed safe covert administration practice, which had been agreed with the person's health care professionals. People got the maximum benefit from their medicines, which helped them to remain physically and mentally well. Advice from a pharmacist had not been sought about crushing or mixing medicines in certain foods or drinks which may alter their effectiveness. While this was not an issue for people currently, staff should be aware of this when considering administering medicines covertly to other people.

People were supported to manage their own medicines if they wished to, including assessments of any support needed. They were able to order their own repeat prescriptions and signed when their medicines were delivered to them.

At our last inspection we found that a full employment history, dates of employment and reasons for any gaps in employment had not been obtained for all staff. Information about staff's conduct in their last employment had been obtained; however, information about staff's conduct in other care roles had not always been obtained as the provider's policy required. At this inspection we found that the required recruitment checks, including two written references had been completed. Any gaps in staff's employment history were recorded. Disclosure and Barring Service (DBS) criminal record checks had been completed before staff began working at the service. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care services. Checks on the identity of staff had been completed.

People had been involved in selecting new staff and were part of the interview team. They told us they enjoyed this role, which gave them the opportunity to use skills from their previous employment. One person told us, "I love interviewing staff. It's nice to be needed and use my experience. Hopefully it improves the service for everyone".

Staff knew how to keep people safe. They were trained and understood how to recognise signs of abuse and what to do if they suspected incidents of abuse. Staff knew how to raise any concerns they had with the management team and the local authority safeguarding team. Staff were aware of the whistle blowing policy and had raised concerns they had with the providers senior managers.

Requires Improvement

Is the service effective?

Our findings

Staff had received an induction when they started work at the service to get to know people, the care and support they needed and to understand their roles and responsibilities, including shadowing more experienced staff. A training programme was in operation and new staff had obtained the basic skills they needed to complete their role. Other staff attended these training sessions to keep their skills and knowledge up to date including practical moving and handling training. Some staff had acquired diploma level 2 or 3 qualifications in social care. Nurses had not been supported to develop and maintain their clinical competence. The provider had recognised this and was developing a training plan to address this. We will review the action the provider has taken at our next inspection.

Some staff told us they did not feel supported to fulfil their role. At our last inspection we found that the provider's process to support staff through regularly meetings with their supervisor had not been followed. The registered manager had put plans in place to set up regular meetings for all staff, however these had not been followed through and staff had not meet regularly with their supervisor. Staff had not had the opportunity to discuss their practice, any concerns they had or their development needs.

Checks had not been completed on staffs' competence to complete tasks to the standards the provider required. Shortfalls in some staff members practice had not been identified and staff had not been supported to carry out their roles to the required standard. One person told us, "I was left completely naked on my top half, then waited like that for about 40 minutes. They did a bit of me, then the person next door".

Nurses had not received regular clinical supervision. The purpose of clinical supervision is to provide a safe and confidential environment for nursing staff to reflect on and discuss their work and personal and professional responses to their work. A clinical nurse specialist for older people had offered clinical supervision to nurses in relation to a specific incident to support their learning and development. This had not been arranged and nurses had not had the opportunity to reflect on their practice and develop their skills to reduce the risk of a similar situation occurring again.

Action had not been taken since our last inspection to meet with staff to complete the provider's appraisal process. The purpose of an appraisal is to review each staff members practice and development over the previous year and set goals for the next year.

The registered persons had failed to make sure staff received appropriate support, training, professional development, supervision and appraisal to fulfil their role. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff supported people to make decisions in ways they preferred, such as showing people items and offering them a limited number of choices at a time. For example, one person living with dementia was shown three packets of crisps and supported to choose the flavour they wanted. The person told us their crisps were "delicious".

At our last inspection we found people's capacity to make decisions had not been assessed before the decisions were made in their best interests to check if they had capacity and could make the decision with support. At this inspection we found that people's capacity to make complex decisions, such as using bedrails to prevent them from falling out of bed, had been assessed. When people were not able to make a decision, decisions were made in their best interests by people who knew them well, including staff, their relatives and health care professionals.

Records of best interest decisions were maintained but were not clear about who had been involved. Recording who had been involved in making best interest decisions is an area for improvement. Some people had appointed a Lasting Power of Attorney to make decisions about their finances when they lacked capacity. Staff told us some people had also appointed a lasting power of attorney to make decisions about their health and welfare but records of these were not available to staff to make sure they always involved the right people in make decisions in people's best interests.

Some people had fluctuating capacity and staff only acted in their best interests when people lacked the capacity to make the decision. For example, staff offered people their medicines in ways they preferred and only administered them covertly when they lacked the capacity to make the decision to take them at the time they needed to take them.

The registered manager was aware of their responsibilities under DoLS. People were not restricted and were free to come and go as they pleased. Some people went out on their own and other people went out with staff, friends and family. Some people had DoLS authorisations in place and applications had been made to the local authority for other people.

People told us they were able to see a GP when they needed. One person told us, "The doctor is here a couple of times a week and he will come to my room if requested". GPs held a clinic at the service twice each week and most people chose to see the GP at the service. People who wanted to visit the GP surgery were supported to do this. A GP told us staff referred people to them appropriately and acted on the advice given. People told us staff supported them to attend health care appointments, including health checks. People had regular health care checks including eye tests. One person told us, "I have my eyes tested regularly and the chiropodist was here today".

Most people told us they liked the food at the service, they had enough to eat and a choice of foods. People's comments included, "The menu is wonderful and if you fancy something that's not on it you only have to ask, it's all freshly cooked" and "There is always plenty to eat and someone will pop their head around the door to see if I'd like a tea or coffee which is comforting".

People had told staff about their likes and dislikes and how much they liked to eat and drink; meals and

drinks were prepared to people's preferences. One person told us, "People have different likes and dislikes. For example some like crisp vegetables and some soft. The girls know what I like. They try to give me what I want".

People had been involved in improving the food on the menus, including the porridge and soups. However, concerns they had raised about the quality of the fruit and fruit salad over several months had not been addressed. People were offered a choice of drinks and snacks throughout the day. Catering staff planned menus to meet people's dietary needs, including diabetic and soft diets.

Good

Is the service caring?

Our findings

People and their relatives told us care staff were kind and caring. Their comments included, "I feel I've got good care", "I cannot speak highly enough of the staff. I cannot believe how caring they are it sometimes brings a tears to my eyes", "There are some magnificently devoted staff. One carer stays on through hell or high water. Some staff return at the end of their shift if it is really busy", "Care staff are wonderful. They go above and beyond and are caring and supportive", "I can say hand on heart staff look after my relative as if they were their own family, they are so caring" and "I simply cannot fault the staff, caring, polite and sensitive to my needs".

Some people told us staff did not have time to spend chatting to them and were often distracted by their 'phone', a small handheld mobile device used to access and record information about the care people received. One person told us, "The staff are not encouraged to chat. At first, we could chat about this and that. Now every second is documented. It's de-humanising". Another person told us, "Staff are positively discouraged from chatting" and that they were often "still entering up the last job" on their mobile device when they arrived to support the person. The provider told us they would review how staff were deployed.

We observed staff spending time chatting to people living in the dementia unit. Other people who chose to spend their time in communal areas chatted to each other and spoke with staff as they passed by.

People told us they had privacy and decided how much privacy they had. People's comments included, "When I want a little privacy I just have to say and my wishes are respected" and "Staff are very conscientious and will always knock before entering and pop their head around the door. They respect my privacy and wishes". We observed staff draw a person's curtains and shut their door before providing their personal care.

People were encouraged to bring personal items into the service such as furniture, pictures and ornaments to help them feel at home. One person's relative told us, "I have made it as close to what it was at home as I could and the staff have been amazing helping me do this so my relative feels safe".

People told us they were able to have a bath or shower when they wanted but had to wait at times for staff to support them. People were able to choose the gender of the staff member who supported them. Staff referred to people by their preferred names. People were relaxed in the company of each other and staff, they shared jokes with staff and laughed together.

Staff supported people to remain independent for as long as they wanted. One person told us staff helped them with their back as they were unable to do this but did not wash other areas they were able to wash themselves. Another person said, "I am as independent as I wish to be".

Staff knew how people let them know about the care and support they wanted. For example staff told us one person would 'fidget' when they needed support to use the toilet and another person would push an object away if they did not want it. Information about people's communication was available for staff to refer to in people's care plans.

Staff offered people assistance discreetly and were not intrusive. For example, one person needed support to drink. A staff member sat with them and chatted to them as they supported the person. Staff helped the person use a straw to drink giving them as much as independence as possible.

People's relatives and friends were free to visit them whenever they wanted. Some people's relatives chose to stay at the service overnight if their relative preferred.

Personal, confidential information about people and their needs was kept safe and secure. People were able to view records held electronically when they required. People who needed support were supported by their families or solicitor. The provider knew how to refer people to advocacy services when they needed support. An advocate is an independent person who can help people express their needs and wishes, weigh up and take decisions about options available to the person. They represent people's interests either by supporting people or by speaking on their behalf.

Requires Improvement

Is the service responsive?

Our findings

People told us the registered manager did not always listen to complaints they had and resolve them to their satisfaction. People's comment included, "I have complained to the manager a few times as I had quite a few teething problems and he appeared to listen but perhaps not as much as I would have liked, the results were negligible", "I don't like to make a fuss and I don't want to be a nuisance but I have raised concerns and I don't feel they have been resolved which really does upset me", "My concerns appeared to be dealt with promptly at first and then things just slipped" and "I have not had to complain much at all but when I do I feel it is taken seriously and I get a prompt response".

Complaints and some concerns received were logged and investigated. Other concerns were not logged and records of any investigations or actions were not recorded and could be included in reviews of the effectiveness of the complaints process There had been five complaints and 18 recorded concerns raised by people and their representatives in the first four months of 2017. People had raised complaints and concerns about different areas of the service including, people not receiving the care they needed to keep them safe, staff not responding to call bells for a long time and information missing from people's care plans. Appropriate action had not been taken to resolve complaints some people had made and prevent them from occurring again. For example, one person had complained about waiting for half an hour for their call bell to be answered. This had not been resolved and they told us they continued to wait for up to an hour for staff to respond to their calls for assistance and this caused them anxiety. Another person's relative told us had raised their concerns with the provider as they felt the registered manager had not resolved their concerns to keep their relative as safe as possible. They were waiting for a response from the provider at the time of our inspection.

The registered persons have failed to take proportionate action in response to failures identified by complaints. This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that although staff were not always able to provide the care they required when they needed it, they did receive their care in the way they preferred. One person told us, "I am incredibly fussy and woe betides if things are not being done my way. There is general knowledge amongst the staff and they respect my wishes to the letter". Another person told us, "The girls [staff] will always check in with me to see what care I require or help I need for the day". Care plans had been reviewed each month by staff and were current and up to date.

A manager met with people and their representatives to talk about their needs and wishes, before they moved into the service. An assessment was completed which summarised people's needs and how they liked their support provided. People or their relatives visited the service before moving in to make sure it was the right service for them. One person told us, "My children helped me to move in and the staff were most welcoming and helpful".

People had planned their care with staff. They told us staff provided their care in the way they preferred.

People's comment included, "My daughter helps to organise my care plan but I am always included when it is discussed" and "I prefer to attend to my own personal care even if it takes all morning but I can ask for help whenever I need it"

Care plans contained information about people's abilities and how they preferred their care provided. Basic information about people's preferences and how they liked their care provided was available for staff to refer to. Permanent staff knew people and their care preferences well. They prompted and encouraged people to do what they were able to do for themselves and helped them to do other things. One person told us, "I am as independent as I wish to be, just the right balance for lazy days".

Support was not flexible to people's daily choices, such as how they spent their time. One person told us they had been unable to attend residents meeting and art classes as staff were not able to support them to get washed and dressed in time. This upset the person who wanted to join the meetings and activities. We told a senior manager about the person's concerns during our inspection and they met with the person to try to resolve the problems.

An activities plan was in place and people were able to join in if they wanted. People told us they had enough to do during the day and followed their interests. People's comments included, "There is always quite a bit going on here, there is an exercise class here today and there is usually something you can join in with" and "The activities are organised very well and we can also make our own groups such as the crossword group that meets once or twice a week so there is always something we can join in with should we wish to".

Staff supported people living with dementia on a one to one basis to do things they enjoyed. We observed one person singing along to their favourite music while another person looked a photographs and chatted with a member of staff. Both people enjoyed what they were doing and smiled as they were doing it.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had been managing the service for a year and was working their notice at the time of the inspection. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was supported by a team of managers. Before our inspection staff had told us they did not feel supported by the registered manager and management team and felt 'bullied' at times. Staff we spoke with during the inspection also told us they felt the same way. They told us the registered manager's management style was "regimented and dictatorial" and not flexible to people's needs and preferences. Staff told us this made them "tense and stressed" at times as they were not able to provide the care people needed when they needed it. One person's relative told us, "One day my relative waited and waited for staff to come. Eventually the carer came in tears because they were so busy and upset about being late".

Some staff were not clear about managers' roles and responsibilities. They told us they were not able to speak to a member of the management team about any worries or concerns they had as they were not approachable. Other staff told us managers were not consistent in their response to queries and questions. One staff member told us, "There are too many chiefs and not enough Indians", referring to the management team. Another staff member told us, "You don't always see them when you need them [managers and senior carers] because they are off doing other things".

All the care staff we spoke with said they felt demotivated. They told us they enjoyed caring for people but did not enjoy working at the service as they did not feel valued or appreciated. One staff member told us, "I don't feel I'm worth anything at times. I put my all into my job and there is no gratitude. A simple thank you would be nice".

Before and during our inspection staff told us they did not work together as a team to meet people's needs and worked in small groups. Some staff told us they were isolated from the team by other staff members. One staff member told us, "If you face doesn't fit, you have no chance". The registered manager was not aware of the problems within the staff team.

The registered manager and staff had a clear vision of the quality of service required however this had not been achieved. Staff told us concerns they raised with the registered manager and management team were not listened to and no action was taken. One staff member told us they felt the management team made excuses when they had raised concerns with them and their concerns had not been considered. They told us, "It's put me off raising things". Some staff had raised their concerns with the provider before the inspection. Following our inspection we received information from the provider about action they planned to take to investigate the concerns raised.

Some people were involved in planning what happened at the service and attended monthly residents meetings. However, systems were not in place to make sure everyone was invited to share their views each

month, including people who were not able to attend meetings. Concerns raised by people and their relatives, such as not receiving the support they required in a timely way were not always acted on. People's comments included "He [the registered manager] is a nice guy. Very kind. He is just not adequate for the complexity [of the service]. It's a difficult job to run a home and make a profit. He's never here after 5pm", "If we think things could be done better there is always a listening ear. If it involves money or extra staff of course that ear is sometimes deaf" and "There is never a problem that cannot be discussed at least, whether the management can do anything about it is a different matter. On occasions I have had to get quite persuasive to get anything done".

People and their relatives had been asked for their feedback about the service annually. One person told us, "The registered manager thinks he is improving things. I disagree". The last survey was completed in December 2016. People had raised concerns about staff not being available when they needed them and their views of the service not being acted on. An action plan had been developed and members of the management team had been given responsibility to addressed specific concerns. This had not been effective. The deadlines for completion of the actions had passed and people continued to be dissatisfied with the service they received.

Staff had fed back their views during an annual employee survey. The 2016 survey showed staff felt the quality of the service had decreased. This included a reduction in the number of staff who felt valued or received 'clear feedback' from their manager. Staffs' comments included, 'More staff! Less pressure, more recognition', 'Respect and better treatment from managers', 'Having enough staff all of the time' and 'Listen to staff'. An action plan had been developed to address the shortfalls. Again this had not been effective, people continued to wait for the care they needed and staff continued to feel demotivated. A range of stakeholders, including visiting professionals had not asked for their views of the service.

The management team completed regular checks on all areas of the service including the environment, medicines and the support people received. The provider's nominated individual and other senior managers also completed regular checks of the service. These had identified some of the shortfalls we found during our inspection, including a lack of detail in some people's care plans and missing information about who was able to make decisions on people's behalf.

The registered persons had failed to effectively act on feedback from relevant persons on the services provided, for the purposes of continually evaluating and improving the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accurate records were kept about the care and support people received and about the day to day running of the service. All the records we asked for were available and up to date.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service like a serious injury or deprivation of liberty safeguards authorisation. This is so we can check that appropriate action had been taken. Notifications had been sent to CQC when required.

Services are required to prominently display their CQC performance rating. The provider had displayed the rating for Signature at the Miramar in the entrance, as well as on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to assess and mitigate the risks to people's health and safety. They provider had failed to assess and manage risks associated with major incidents and emergency situations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered persons have failed to take proportionate action in response to failures identified by complaints.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons had failed to effectively act on feedback from relevant persons on the services provided, for the purposes of continually evaluating and improving the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons had failed to deploy sufficient numbers of staff to meet service users' needs.

The registered persons had failed to make sure staff received appropriate support, training, professional development, supervision and appraisal to fulfil their role.