Kahanah Care

Miramar

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

The inspection took place on 23 and 25 February 2016 and was unannounced. We last inspected the service in July 2013 and there were no breaches of regulations at that inspection.

Miramar is registered to provide accommodation and personal care for up to 14 people who may have a learning disability, dementia or mental health needs. This includes supporting people living with addictions, schizophrenia, bipolar disorder and autism. When we visited, 11 people lived there with an age range between 44 and 95 years, and one person was in hospital.

The service had a registered manager who has been working worked across two registeredlocations, spending time at each service. However, these arrangements were about to change, which meant the registered manager would be working full time at Miramar in the near future. 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.

Staff knew people well, understood their needs and care was personalised to their individual needs. However, people's needs and some risks had not been fully assessed and care plans did not adequately describe how to support people. Care records were inconsistent and lacked sufficient detail about people's care and treatment and about decision making. Where health needs were identified, detailed care and treatment plans were not in place to instruct staff how to meet those needs. This meant there was an increased risk people would not receive all the care they needed.

People were not fully protected because the quality monitoring systems in place were not fully effective. Although there were a variety of systems in place to monitor the quality of care provided, these did not identify the risk management improvements needed. However, there was evidence of making continuous improvements in response to people's feedback, the findings of audits, and of learning lessons following accidents and incidents.

Staff worked closely with local healthcare professionals such as the GP, community nurse and members of the local community mental health team. Health professionals said staff sought advice appropriately about people's health needs and followed advice.

Staff were aware of signs of potential abuse and knew how to report concerns. A robust recruitment process was in place to make sure people were cared for by suitable staff. People knew how to raise concerns and were confident any concerns would be listened and responded to. The service had a written complaints process. Any concerns were investigated with actions taken to make improvements.

People received person centred care. Staff knew people well, understood their needs and cared for them as

individuals. People were relaxed and comfortable with staff that supported them. Staff knew what mattered to people, about people's lives their families and their interests and hobbies. Staff were discreet when supporting people with personal care, respected people's choices and acted in accordance with the person's wishes. People were involved in developing and reviewing their care plans.

There was a family atmosphere at the home. Although the home cared for people of very different ages, this had positive effects for several people who lived there. People spoke with fondness about people they had made friends with. Friendships had developed between people of similar ages and interests and also between people of very different ages.

Staff had undertaken training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty safeguards. People were offered day to day choices. Staff sought people's consent for care and treatment and ensured they were supported to make as many decisions as possible. Where people lacked capacity relatives, friends and professionals were involved in best interest decision making.

People, relatives and staff said the home was organised and well run. The culture was open and honest. Staff worked well together as a team and felt supported and valued for their work.

The care environment had been improved to meet the needs of people living at Miramar, although further improvement to the rear outside space were needed.

We found three breaches of regulations at this inspection. 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

Not all aspects of the service were safe.

People's risk assessments did not identify all risks, and did not adequately assess and manage how people's individual behaviours might impact on the safety of others.

People's risk of suspected was reduced because staff knew how to recognise signs of abuse and how to report abuse.

People receive care and support at a time convenient for them because there was sufficient staffing levels.

Staff had been recruited safely to meet people's needs.

People received their medicines on time and in a safe way.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Detailed care and treatment plans were not in place in response to people's identified health needs. This meant there was an increased risk people would not receive all the care they needed, or would receive inconsistent care.

People were cared for by knowledgeable and experienced staff. Staff received regular training and support with practice through supervision and appraisals.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS).

People experienced a level of care and support that promoted their health and wellbeing. Staff recognised any deterioration in people's health, sought professional advice appropriately and followed it.

Is the service caring?

Good

The service was caring.

People said they liked living at Miramar and enjoyed the homely family atmosphere.

Staff were kind and compassionate towards people, and had developed warm and caring relationships with them.

Staff supported and involved people to express their views and make their own decisions, which staff acted on.

The service was organised around people's individual needs.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

People's written care records were inconsistent and lacked sufficient detail about their individual care and treatment and about decision making.

People received personalised care from staff who knew each person, about their life and what mattered to them.

People were encouraged to socialise and to pursue their interests and hobbies.

People knew how to raise concerns and complaints. Any concerns raised were investigated, and the provider took action to address.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

People were not fully protected because the quality monitoring systems in place were not fully effective.

There was a registered manager and the culture was open, friendly and focused on each person as an individual.

People, relatives and staff expressed confidence in the leadership and said the home was well run.

People, relatives and staff views were sought and taken into account in how the service was run and suggestions for improvement were implemented.

Miramar

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 23 and 25 February and was unannounced. An inspector carried out this inspection. Prior to the inspection, we reviewed all the information we held about the service. This included the provider information return (PIR) and notifications we had received. A notification is information about important events, which the provider is required to tell us about by law.

We met with 10 of the 12 people who lived at the service and observed staff interactions with them in communal areas of the home and with three relatives/friends. We looked in detail at five people's care records. We spoke with 10 staff which included the registered manager, provider and eight care staff. We looked at recruitment records of two staff and at staff training, supervision and appraisal records of five staff. We looked at the provider's quality monitoring systems which included audits of medicines, care records, health and safety checks and a provider visit report. We sought feedback from health and social care professionals such as district nurses, community mental health staff and local GP's and received a response from four of them.

Requires Improvement

Is the service safe?

Our findings

Most people said they felt safe living at Miramar. One relative said, "I feel he is 100% safe here, he has got to know and trust people." Some people's risks had not been identified and planned for. Where risks were identified, they had not put clear plans in place to instruct staff how to reduce them as much as possible. For example, recently the registered manager notified the Care Quality Commission (CQC) about an incident during which staff had called the police in relation to two people who were involved in a physical altercation. When we looked at the incident report, the individual risk assessments and care plans, we found they lacked detailed instructions for staff about how to reduce further similar incidents. This could increase the risks for others and staff.

One of the people involved in the incident had been under the influence of alcohol when the incident happened. Although the person's risk assessment showed they sometimes drank excessively, the action identified was for staff was to 'monitor and advise on quantity consumed.' And that staff should, 'discuss on a daily basis how alcohol and drugs can be detrimental to their health and recovery.' This plan did not demonstrate there was an effective strategy to manage this person's needs in relation to alcohol use. Also, it did not identify any risk they might pose to others when they were under the influence of alcohol.

Staff said they made people aware of the 'house rules' about alcohol. Staff said people were not allowed to bring spirits into the home, but could bring in four cans of beer or lager. However, staff said it was very difficult to monitor people's alcohol intake in their rooms or when they went out to the pub. Staff tried to balance risks for individuals with the freedom to make their own decisions. However, where people were making risky choices this might have an impact on the safety of others, or themselves, these risks were not adequately assessed or managed to reduce them as much as possible.

We followed up with the registered manager what action had been taken in response to this. They said the police had been very supportive and worked with both people to get them to recognise and address their differences (a process known as restorative justice). The registered manager said things had settled down since then, and there had been no further incidents and a review of incident reports confirmed this.

All staff had been trained on managing any behaviours that might challenge the service but care plans did seen not include any strategies for managing aggression or other challenging behaviours. This meant some people would be at increased risk if these behaviours recurred or escalated. Although staff knew people well, and were aware of possible triggers for people and could describe ways they managed them, these were not all well documented. The lack of clear plans meant staff did not have clear information about how to manage people, who behaviours might pose risks to others. Regular reviews of risk assessments and care plans lacked evaluation of how well those risks were being managed.

This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had completed safeguarding training and were aware of the signs of potential abuse and knew how to

report concerns. Details about how to contact the local authority safeguarding team were on display at the service. No safeguarding concerns had been notified to CQC since the last inspection.

People received their medicines safely and on time. Staff were trained and assessed to make sure they had the required skills and knowledge to support people with their medicines. Staff completed a medication administration record (MAR) to document all medicines taken. We checked two people's medicines records and found that all doses prescribed were signed for as having been given. However, when we tried to sample some medicines to see if the tablets used were accounted for, we found we could not check this (this is known as medicines reconciliation). This was because when additional supplies of tablets were obtained during the month, these were not added to the tablet count recorded at the beginning of the month. We discussed this with the registered manager, who amended their system to add any additional tablets received to the total count. This meant the tablets used each month could be more accurately monitored.

Where people had medicines prescribed, as needed, (known as PRN), individual prescriptions indicated when these should be used and how often. MAR charts were audited regularly so any discrepancies or gaps in documentation were immediately followed up. Medicine errors were reported with and action taken to improve medicines management and people's safety.

People were supported by enough staff who could meet their needs at a time and a pace that suited them. The registered manager said there were at least two care staff on duty each morning, (and one extra for trips and appointments), two staff in the afternoon and two awake night staff. Staff rotas confirmed this and showed staff worked their hours flexibly according to people needs. All staff said the staffing levels meant they could spend time with people, and talk to them. For example, several people liked to stay up late, so an extra staff member worked from six till nine in evening. This level of staffing meant staff were able to spend time in the evening talking with people and playing board games.They could also accommodate the personal care needs of other people who wished to go to bed early. Staff worked flexibly to cover sickness and staff leave, and did not use agency, which meant people had continuity of care.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed at the service. All staff had police and disclosure and barring checks (DBS), and checks of qualifications and identity and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

People were cared for in a clean, hygienic environment and there were no unpleasant odours in the home. Staff had access to hand washing facilities and used gloves and aprons appropriately. Staff had suitable housekeeping cleaning materials and equipment.

Environmental risk assessments highlighted any risks in the environment of the home and were managed to reduce them as much as possible. For example, hazardous chemicals such as cleaning products were kept locked away. The registered manager carried out monthly health and safety checks, which identified any maintenance and repairs that needed addressing. For example, the external lighting had recently been improved so that people could use the outside space more safely in the evening and so staff could see people when they were outside.

A member of staff responsible for the maintenance worked at the home three days a week. They undertook repairs, maintenance and a programme of redecoration throughout the home. This included checking water temperatures, carrying out regular checks to reduce risks of Legionella, (water borne bacteria). Equipment was regularly serviced and tested as were gas, electrical and fire equipment.

In July 2015, following a food hygiene visit awarded the kitchen a three star rating (highest is five), following which the provider made the recommended improvements, and were awaiting a follow up visit. Following recommendations from a visit by the fire authority on 2 February 2016, new fire doors had been installed and the service was awaiting delivery of the final fire door for the boiler room. These improvements had improved the safety of the building.

Regular checks of the fire alarm system, fire extinguishers, smoke alarms, and fire exits were undertaken. People and staff had regular fire drills so they could practice how to respond in a fire. Each person had a personal emergency evacuation plan (PEEP). This took into account the individual's mobility and showed the support they would need from the emergency services to be evacuated in the event of a fire. Contingency plans were in place to manage people safely in emergencies such as the loss of electricity, gas or water supply. These measures helped to ensure the environment of the home was safe.

Requires Improvement

Is the service effective?

Our findings

The registered manager undertook an assessment of each person before they came to live at the home, and used a care needs assessment tool. As part of that assessment, they assessed if staff could meet the person's individual needs, alongside those of existing people living in the home. The service used evidence based assessment tools to assess people's risks in relation to falls, malnutrition and dehydration and to identify people at increased risk of developing pressure ulcers due to their frailty and reduced mobility. Where individual health needs were identified, such as people with diabetes or mental health needs, there was a lack of detailed care plans about how those care and treatment needs were being met.

For example, one person's care plan about helping a person when they became agitated said, 'If (person) becomes agitated, staff to reassure him and suggest he calms down.' This person's medicines chart showed the person was prescribed medication to manage their anxiety and agitation each day. However, their care plan did not have any information about other methods staff might use to encourage the person to manage their anxiety. This meant different staff may use different ways to reassure the person, and the care provided could be inconsistent.

When we asked staff about this person, they told us about how they helped the person manage their agitation. For example, by talking to the person and making time to listen and reassure them. Another staff said this person attended a community mental health support group twice a week, which they found helpful. A third staff member said the person knew whenever they needed a tablet for their anxiety and asked staff for it. However, as there was no detail in their care plan to instruct staff about how to support this person with their anxiety, it was not clear how well these methods were working. Their care records showed recently the person's dose of prescribed medication for anxiety had been increased by their GP, which suggested their care plan needed reviewing and updating. Other people with mental health disorders similarly had no clear care plans about how to manage them.

One person was at increased risk of pressure ulcers because of their frailty and reduced mobility. Although there was no care plan in place to instruct staff about their pressure area care, the person had the appropriate moving and handling and pressure relieving equipment. Staff were following the district nurses advice about the person's skin care, which meant they were taking the appropriate steps to reduce this risk. Staff were trying to encourage two people to manage their weight. One person was underweight and the other person was overweight. Although both people had a nutritional assessment completed, which showed they were at risk, there were no detailed care plans to instruct staff about how to manage this.

This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff described how one person had a poor appetite and needed to gain weight. They saw their GP regularly and had food supplements prescribed. Staff told us about the various methods used to tempt the person to eat. For example, by offering them their favourite foods, and presenting food on a small plate, which they preferred. Staff were trying to encourage another person who was overweight to eat more healthy choices

and to reduce the amount of fizzy drink and snacks. Where there were concerns about people being over or underweight, people were weighed weekly and staff recorded daily what the person ate at each meal. Any concerns about people's health needs were discussed with the person's GP or other community health professionals such as district nurses. For example, for blood tests and to administer medication by regular injections. The district nurse team were supporting three people at the service with their health needs.

All health professionals we spoke with said people were referred to them appropriately and staff carried out their advice. One said they thought the service had improved and commented, "Staff are on the ball". A second professional said staff had managed another person, with complex mental health needs, well for a number of months when they lived at the home. For example, staff persuaded the person to go to the hairdressers, and to have dental and nail care. They said the person responded positively to living in an environment where they had more freedom, and had enjoyed going out on day trips.

People were supported to access healthcare services such as attending regular appointments with their dentist, optician and any hospital appointments. Several people were encouraged to take responsibility for their own health needs and arranged to visit their GP at the surgery.

Staff understood the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. The provider had a consent policy which was in accordance with the requirements of the MCA. People's initial assessment included assessing that the person could understand what was communicated to them, although the assessment tool used did not cover all aspects of the first stage capacity assessment outlined in MCA code of practice. For example, the tool did not assess whether the person could retain or assess the information to make a decision, or communicate their decision. This could mean the assessment of the person's capacity might not be accurate. We discussed this with the registered manager, and made them aware of the local authority tool, which they decided to adopt instead.

The registered manager said most people who lived at the service had capacity to make decisions for themselves. Where a person had a poor memory, staff told us about examples of how they helped the person to make as many decisions for themselves as possible. For example, about what they wanted to wear, food choices and how they wished to spend their day. Where the person lacked capacity to make more significant decisions about their care and treatment, there was evidence staff worked with the person, other family members and health professionals to make decisions in the person's best interest. For example, when a person said they didn't want any further investigations or treatment for a health condition, relatives, staff at the home and the person's GP discussed and agreed this was in the person's best interest.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered manager said no one who lived at the home was deprived of their liberty. However, some people who lived at the home were subject to community treatment orders under the Mental Health Act. This meant they were required to comply with their mental health treatment plans, and were visited regularly by mental health professionals to review this.

People gave us very positive feedback about the food choices at the home. One person said, "The food is

good, if I didn't like it, I could have something else." Some people helped themselves to drinks of their choice throughout the day and staff ensured others were offered drinks regularly. People were consulted about menu options and menus were displayed, so people were aware of food choices at meal times. The cook had a list of people's food likes and dislikes, and low sugar squash and yogurt alternatives were available for people with diabetes.

People felt well supported by staff who had qualifications in care or were undertaking them. Staff undertook regular update relevant training such as safeguarding adults, health and safety, and infection control. During the inspection, staff attended update training on the Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLs), which was provided at the home. Staff were enthusiatic about the training and there was lots of debate and discussion. Staff had also undertaken other training relevant to the needs of the people they supported, for example, dementia, mental health disorders and managing challenging behaviour.

Three new staff had been employed since we last visited the home. Staff confirmed they undertook a period of induction, when they first came to work at the home. This included working alongside the registered manager and more experienced staff to get to know people and about their care and support needs. The most recently recruited staff members were undertaking the national care certificate, a nationally recognised set of standards that health and social care workers are expected to adhere to in their daily working life.

Staff received support through regular one to one supervision. This included observing staff practice around the home and providing constructive feedback and one to one discussions. Staff had an annual appraisal where they had an opportunity to discuss their practice and identify any
further training and support needs.

The environment of the home was adapted to meet the needs of people who lived there. Corridor areas were kept clear so people with mobility equipment could move around the home more easily. A stair lift had beenfitted which enable people with limited mobility to go up and downstairs. One person who was a wheelchair user lived downstairs and had a toilet and shower in their room, although staff said they no longer wished to use this, and preferred a wash instead. A second person with limited mobility also lived downstairs, but could use the stair lift to access the first floor toilet and bathing facilities.

There was an ongoing programme of upgrading and refurbishing all areas of the home. The lounge area was very homely, bright and comfortably furnished. The dining area had recently been upgraded with new flooring and windows and there were further plans to improve the laundry area. However, the rear patio area was uninviting because there was a range of obsolete equipment and broken furniture stored there. Several people who lived at the home used this area throughout the day, they smoked outside and spent long periods there chatting to one another. The registered manager said the provider was planning to address this and plant up this area with tubs and baskets for the summer.

Good

Is the service caring?

Our findings

People said they were happy living at the service. One person said, "It's very nice, they are ever so kind." A relative and friend both said the person praised the care staff provided, they said, "Staff are very good to her." In the provider information return (PIR) the registered manager said the staff team did not wear uniforms as they felt this fostered better relationships with people.

People were consulted and involved in decisions made about their care treatment and had signed their care plans to confirm this. Where a person had limited capacity, family members supported the person and was involved in their care plan reviews. During our visit, a person told the registered manager they wished to make some changes to their care plan, who responded by saying, "We'll do it the way you want to do it." They agreed to meet up in a few weeks away from the home to discuss it.

People confirmed staff respected their privacy, for example, knocking on the person's bedroom door and waiting for a response before entering. Where people wanted to discuss issues in confidence with staff, they were able to discuss them in private. Staff respected each person's right to privacy, one person's care records said. '[The person] likes to keep himself to himself and will access support when he wants it.' Where people needed support with personal care, care records showed what aspects the person could manage themselves and what they needed staff support with. For example, that one person needed help to shower but could dress themselves and that another person could brush their own hair if prompted to do so. This showed staff supported people to remain as independent as possible.

There was a relaxed family atmosphere throughout the two days we spent there. People wandered in and out between the dining room and rear patio, making drinks and chatting to one another and to staff. One person was sitting at the table telling the registered manager about their day, where they had gone on the bus and what they had seen and done. Other people watched TV in the lounge and others wandered in and out and chatted to them. There was lots of jokes and laughter, and staff were interested in what people had to say.

Mealtimes were a very sociable occasion, most people ate lunch together in the dining room where they chatted with others and staff. Staff offered people choices about what time they got up and went to bed and how they spent their day. Some people chose to spend most of their time in their room and staff respected their decision.

Staff supported people to keep in contact with family and friends. One person was just returning from a stay with relatives when we visited. Another person met their sister and went into town for coffee with them each week. Relatives were welcomed in the home, and the registered manager kept in regular contact with several relatives by phone and e mail.

People's religious and cultural preferences were respected. For example, one person liked to attend their local church every week and staff prompted them to catch the bus to do so. Where an issue was raised about the person, the registered manager worked with the local church to educate them about the person's

learning disability. They agreed a plan with church representatives and the person, which protected their right to continue to attend church.

Although the home had people of very different ages, this had positive effects for several people who lived there. People spoke positively and with fondness about people they had made friends with. Friendships had developed between people of similar ages and interests and also between people of very different ages. Two older people enjoyed chatting in the lounge with a younger person about subjects of mutual interest. Another person chatted to an older person who preferred to stay in their room. This was beneficial to both people and helped the older person to avoid social isolation. Several people were musical and played instruments and everyone enjoyed getting together regularly for music sessions.

Requires Improvement

Is the service responsive?

Our findings

Staff knew people well, understood their needs and care was personalised to their individual needs. However, people's written records were inconsistent and lacked sufficient detail about their care and treatment and about decision making.

People's daily records included good details about people's physical and mental wellbeing and how they had spent their day. However, where significant entries were made and suggested the person's care plan or risk assessment might need updating, this had not occurred. This meant relevant information was not being used sufficiently to inform care plans and risk assessments. People's care records were reviewed regularly, although these reviews rarely resulted in any significant changes. This meant it was not clear the care plans reflected the care people were receiving.

People's care plans and risk assessments lacked detail, and did not include any agreed goals the person was working towards. This was despite the fact several people did not plan to live at the home permanently and were getting support to regain their independence. For example, one person was concerned about their finances and managing their money and became quite agitated when they ran out of money. Staff told us about ways they were working with the person to help them make sure their money lasted, and avoid getting into further debt such as by getting them to use e- cigarettes, nicotine patches and suggesting they change to a cheaper brand. However, there was no care plan in the person's care records about managing this. The registered manager said each person's named key worker was responsible for writing a monthly report about the person's progress. However, there were lots of gaps where people's monthly reports had not been written in records we looked at.

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

When we discussed this with the registered manager, they explained they were working with the local authority quality monitoring team to improve their care plans and risk assessments. For example, they had provided detailed guidance and prompts for staff about the detail needed in each person's care records. Following the inspection, the registered manager told us they planned to visit another service which had excellent care records to get ideas.This showed the registered manager was committed to making further improvement in care records.

Other aspects of people's care records included individual information about each person such as about their likes and dislikes and their interests. For example, that one person liked reading and was interested in history and philosophy. Some records also had good details about people preferred morning and night routines. For example, that one person liked a hot drink before bed and for staff to place their soft toys near their pillow.

Each person had an allocated care worker to act as their keyworker. The keyworker was responsible for ensuring they were a key contact for the person, spent time talking with them and checking they had

everything they needed. People were encouraged and supported to be actively involved in developing their care plans as much as they wanted to be. However, where people made suggestions about things they'd like to pursue, it wasn't always clear how those suggestions were being taken forward. For example, one person wanted to find voluntary work and another person expressed an interest in doing yoga.

Each person had their own room and were encouraged to have their things around them. For example, family photos, pictures, ornaments and plants. In the provider information return(PIR), the registered manager outlined that some people had been involved in decorating their own room, which they had enjoyed.

A noticeboard showed a range of activities on offer in the home, these included board games, music, an exercise class and regular trips out. The registered manager said they organised trips out regularly which lots of people enjoyed and some people had enjoyed shows staged at the seafront pavilion. Several people who lived at the home were very independent. A relative said, "(Person) has blossomed since he has been here …they don't take away his freedom."

In the provider information return the registered manager said they encouraged people to pursue hobbies that they may have done before they came to live at the home such as cycling, walking and going to the cinema. They also said they took people on holidays and encouraged people to have holidays away with families or friends. One person had a bicycle and enjoyed cycling in the local area and visiting friends and relatives. Another person explored the local area by bus. Several people regularly visited the local shops, pubs, played pool and spent time in Exmouth visiting shops and walking on the beach. Several people attended local clubs and day services. A couple of people who lived in the service did some voluntary work. For example, one person helped out at a local museum during the summer season. A couple of people liked gardening and would be involved in planned improvements to the patio area. A few people said they sometimes felt bored.

People and relatives said they had no complaints about the home. They said if they had any concerns, they felt happy to raise them with the registered manager and were confident they would be dealt with. The provider had a written complaints policy and procedure. Written information about how to raise concerns or complaints was on display in the home. The complaints log showed no complaints had been received since 2012. Where people or relatives raised any concerns, or incident had occurred, these were discussed with the staff team, so lessons could be learned and care continuously improved.

Requires Improvement

Is the service well-led?

Our findings

The culture of the home was open, person-centred and inclusive. Staff were universally positive about working at the home and said they worked well together as a team and there was good communication.

The registered manager described the home as, "Like a normal family home, with a very relaxed atmosphere." The registered manager had been working at the service for over 30 years, so knew people really well. Over the last four years they had also been managing another of the provider's homes. However, the provider had recognised they needed to have a registered manager in day to day charge at both locations, and had recruited another manager. This meant the registered manager was returning to work full time at Miramar in the near future. Several people and all staff expressed confidence in the leadership and management skills of the registered manager. They were pleased about this change. One staff said "We are really looking forward to having her back."

The provider had a range of quality monitoring systems in place. However, some of these were not fully effective because they did not identify the three breaches of regulations found at this inspection.

For example, regular audits of care records were also carried out. These identified some missing dates and staff signatures and that some records needed updating. However, this audit was not fully effective, because it did not identify the concerns about risk management and the quality of care records. Also, the timescales for addressing some issues were too lengthy, for example, plans to update all care plans within six months. The provider used the 'Safer food, better business' tool to monitor cleanliness and fridge temperatures in the kitchen. However, the daily checks in the kitchen were not being kept up to date.

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

The registered manager had been working with the local authority quality monitoring team at the other location they managed to improve their quality assurance arrangements. They explained how they were also using the information and support provided to make improvement and had developed a service improvement plan for Miramar. For example, they had started using tools for identifying people at risk of malnutrition and dehydration. They were working with staff to use prompts to review people's care records, and check they included all aspects of the person's care needs. They had also improved individual moving and handling care plans for people with mobility needs and introduced cleaning schedules.

A member of staff had a lead role for managing and monitoring medicines management at the home. Medicines were checked daily each time the staff team changed and regular audits were carried out. The service had cleaning schedules and records kept of daily, weekly and monthly cleaning.

The registered manager met with the provider regularly and said they were undertaking regular quality monitoring visits at each home. This included meeting with the registered manager, looking at audit findings and reviewing accident/incident reports.

Staff had a handover meeting each day to communicate any changes in people's needs. Essential messages between staff were captured in a communication book that all staff were aware of. There was a system in place to monitor and ensure staff received regular update training and supervision. A senior staff meeting held on 4 February 2016, showed people's individual care and treatment needs were discussed.

The registered manager visited the service unannounced, particularly at weekend to meet staff and residents and check on the quality of care. At the last visit, they had asked people for feedback about the food, cleanliness and activities. Out of hours they were available by phone to advise staff and had come in during the recent incident when the police were called. The provider used a questionnaire to seek the views of relatives but had a very low response rate. However, we saw written feedback from one relative and spoke to two relatives and a friend who were all very positive about the care staff provided to their relative.

Accident/ Incident reports and any complaints received were monitored to identify any trends and identify people at increased risk. The reports showed what actions were taken to try and reduce risks.

People and staff were involved in decisions made about the home. Regular residents meeting were held and minutes showed a range of issues were discussed. For example, at a residents meeting on 27 January 2016, people discussed the menu and agreed some changes. At a senior staff meeting on 16 January, staff discussed prompts to improve care plans and documentation, as well as nutrition and medicine management issues. At the staff meeting, on 19 January 2016 the altercation between two people was discussed and the registered manager outlined the actions taken in response.

Where concerns were identified about staff performance, these were managed appropriately. Individual staff supervision was used to re-enforce the values and behaviours expected of staff. It was also used to discuss people's feedback and any lessons learned from accidents/incidents or other concerns.

The registered manager was up to date with regulatory changes and used the CQC website to keep up to date with regulatory changes. They worked closely with the registered managers of other homes within the group for mutual support.

Where areas for improvement were identified and discussed during the inspection, the registered manager was open to feedback. Since the inspection, they have e- mailed us about further actions already underway to make improvements in relation to the breaches of regulations we identified. This showed they were committed to making continuous improvements. Since the inspection they have made contact with other providers and joined a provider network, sponsored by Skills for Care. This group enables registered managers to get together and discuss issues, share ideas and get updates from guest speakers.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Where individual health needs were identified, there was a lack of detailed care plans about how people's care and treatment needs were being met. This is a breach of regulation 9 (3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Where health needs were identified, detailed care and treatment plans were not in place to instruct staff how to meet those needs. This meant there was an increased risk people would not receive all the care they needed. This is a breach of regulation 12 (1) (2) (a), (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected because the quality monitoring systems in place were not fully effective. People's care records were inconsistent and lacked sufficient detail about their individual care and treatment needs and

about decision making.

This is a breach of regulation 17 (2) (a), (b), (c), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.