Caring Homes Healthcare Group Limited

# Miranda House

## Inspection report

High Street
Royal Wootton Bassett
Swindon
Wiltshire
SN4 7AH

Tel: 01793854458
Website: www.caringhomes.org

Date of inspection visit:
01 August 2018
02 August 2018
10 August 2018

Date of publication:
10 December 2018

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

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

# Summary of findings

## Overall summary

This inspection took place on 01, 02 and 10 August 2018. The first day of the inspection was unannounced.

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

Miranda House accommodates 68 people in one purpose built building. On the first day of the inspection, there were 54 people living at the home. The home was registered to support people living with dementia and their nursing needs, over the age of 65 years.

People's bedrooms were located over two floors. Each floor had a separate lounge, 'quiet' lounge, a dining room and adjacent kitchenette. Bedrooms had en-suite facilities and there were communal bathrooms and toilets. There was a central kitchen and laundry room.

There was a registered manager in post. 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. The registered manager was available throughout the inspection.

This service has a poor history of compliance, as this was the third time the service had been rated requires improvement. At the last inspection in July 2017, two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified. These had not been fully addressed, which meant at this inspection, there were two repeated breaches and an additional breach in regulation.

The provider had a range of action plans to improve the service. Much of the work was "in progress". The action plans did not consistently give specific timescales for the work to be completed. This did not enable development to be "kept on track" or monitored to ensure sufficient progress was being made. The plans covered areas such as the environment, person centred care, care planning and the development of social activities. Additional support and resources had been allocated to the implementation of the action plans.

Risks to people's safety were not being properly identified and addressed. For example, water from a hand wash basin in a communal toilet was excessively high and there were locks on bedroom doors that were unsafe to use. These were addressed once brought to the registered manager's attention. There was a trailing lead, which a person precariously stepped over and a heater in the dining room that had protruding edges, which increased the risk of injury if fallen against.

Medicines were not safely managed. Information about "as required" medicines was limited and staff were crushing some medicines without the prior approval of a pharmacist. Information was not sufficiently

detailed or up to date regarding medicines to be taken covertly. Covert medicines are when medicines are disguised in food or drink, without the person's consent or awareness.

The environment was not conducive to people's dementia care needs and did not promote good infection control. The layout of the home did not enable easy orientation and there was limited signage or points of interest to assist people when moving around. Items such as skirting boards and some furniture was chipped. This did not enable the surfaces to be properly wiped to be hygienically clean. The provider told us they had recognised improvements to the environment were needed and were taking action to address this.

Staff did not always have a clear understanding of people's needs. For example, staff did not sufficiently support a person who was agitated and a lunch time meal was chaotic, due to its lack of organisation. Records did not always show challenging behaviour was effectively managed.

There were sufficient staff to support people. There was a staff presence in communal areas and staff had time to sit and chat to people. There were positive interactions and staff spoke about people with fondness.

People had access to a range of health care professionals and had enough to eat and drink. Food was generally cooked "from scratch" and a varied menu was in place. Attention was given to any weight loss and specialist advice was gained as required.

There was a focus on going out and links with the community were being developed. People could use the home's minibus.

Staff had been safely recruited and received a detailed induction. They felt supported in their role and had undertaken a range of training deemed mandatory by the provider. Staff worked well as a team and were willing to learn and develop. They were aware of their responsibilities to identify and report a suspicion or allegation of abuse.

We identified two repeated breaches and a third breach 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 always safe.

Medicines were not always safely managed.

Good infection control was not always promoted.

There were enough staff to support people safely.

Staff recruitment was safely managed.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Decision making was not always undertaken in line with the Mental Capacity Act 2005.

The environment did not enable people to find their way around easily.

People had enough to eat and drink.

People were supported by a range of health and social care professionals.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

People's dignity was not always promoted.

There were positive interactions and staff spoke about people with fondness.

People and their relatives were complimentary about the staff.

### Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Staff did not always show an understanding of people's needs.

Care planning did not always show a person-centred approach.

There were opportunities for people to attend social events outside of the home on a regular basis.

## Is the service well-led?

**Requires Improvement**

The service was not well led.

There was a history of non-compliance with regulation and further shortfalls were identified at this inspection.

Improvement plans were in place to develop the service. However, many of the actions were "work in progress" and not always evident in practice.

Additional resources were in place to support the registered manager.

# Miranda House

**Detailed findings**

## Background to this inspection

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

The inspection took place on 01, 02 and 10 August 2018. The first day of the inspection was unannounced and there were three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection there were two inspectors and an expert by expert, and two inspectors on the last day.

Before our inspection visit we reviewed the Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification.

To gain feedback about the service, we spoke to nine people and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with eight relatives, 21 members of staff and one health care professional. After the inspection we wrote to four health and social care professionals to gain their feedback about the service. Three responded regarding the format of the information required but no further detail was sent.

Requires Improvement

# Is the service safe?

## Our findings

At the last comprehensive inspection on 13 and 14 July 2017, people's medicines were not safely stored within the recommended temperature range. This had initially been identified during an inspection in November 2016. At the inspection in November 2017, the provider had installed air conditioning so all medicines were stored safely. However, other shortfalls that were identified at the inspection in July 2017, had not been addressed. At this inspection, further shortfalls with the management of people's medicines were identified.

Records did not always show how staff should administer those medicines which could be given covertly. For example, some information stated, "mix with fluids" and "mix with food or drink. This was not specific and did not enable staff to administer the medicines in a consistent manner. In addition, mixing certain medicines with foods or fluids, alters the medicine's effectiveness. Records did not show this had been considered. Other instructions stated, "Please give my medication crushed in with my food." This did not show if staff were required to crush all medicines one by one, or all together. Some records appropriately guided staff in the first instance, to try other ways to enable the person to take their medicines. Other records did not do this.

Records did not show pharmacy approval had been gained to crush people's medicines. This was despite this being stated in the provider's medicine management policy and a pharmacy audit. In addition, monthly medication audits had not identified the shortfall. Pharmacy approval is required, as crushing medicines can alter the way they work. At the end of the first day of the inspection, action had been taken by the provider and a pharmacist had approved all medicines, which were being crushed.

Not all forms regarding covert medicines, at the front of the medicine administration records, were up to date. For example, one person was prescribed an additional three medicines that were not listed on the form. There was information which stated, "Tablets to be crushed" but on the medicine administration record it was written, "do not chew or crush". This gave conflicting information, which did not ensure the medicines were safely administered.

There were three occasions when staff had not signed the medicine administration record to show they had administered people's medicines. This was brought to the attention of staff and immediately addressed. However, staff had not identified these shortfalls previously.

Whilst guidance was in place to help staff administer "as required" medicines, the information was generic and not personalised. For example, one person was prescribed "as required" medicines for anxiety but there was no information about the signs of their agitation or the interventions which might help, before administering the medicines. Information about pain relief did not describe when or the reason why, a person might experience pain. The records did not show how those people who were unable to verbally communicate, might need additional medicines. A peripatetic manager had recognised this shortfall and this formed part of the home's improvement plan . On the last day of the inspection, work had begun to personalise the information to assist with the administration of "as required" medicines.

People's preferences regarding how they liked to take their medicines, were not clearly stated in their care plan. Within one plan, the information was task orientated and did not contain any person-centred information. There was no information to inform staff for example, if the person preferred their medicines placed in their hand or small pot, with water or juice.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people did not always feel safe. One relative was concerned as they said people "wandered" into their family member's room. They said their family member was vulnerable and there had been an incident, whereby a person had tried to get into bed with them. The registered manager told us they were not aware of this, although they said the management of people walking into other people's rooms was a challenge. They said they would consider and monitor this further to minimise potential risk. Not all call bells were easily accessible to people. One call bell chord had been cut off a few inches from the ceiling. Another was caught under the wheel of the chair, where the person was sitting. This did not enable people to use their call bell when needed. One relative raised inaccessible call bells as a concern. They told us, "He doesn't have a call bell on him and he can't reach the one by the bed."

Each person had a Personal Emergency Evacuation Plan (PEEP) in place. Whilst there was some information about the person's needs, the documents, lacked detail. For example, one PEEP showed the person was mobile. It did not show their mobility was variable or how their cognitive ability impacted on their movement. Another record showed the person had "low mobility" and needed "full staff assistance to mobilise." The information did not identify the reason for this, what equipment the person used or anything about their medical conditions. This lack of detail did not ensure staff had sufficient information to evacuate people safely in the event of a fire.

There were aspects of the environment, which did not promote good infection control. This included chipped paint on skirting boards, worn flooring in communal toilets and stained light pull chords. Some furniture was chipped and there was debris in the drawers of an unoccupied room. The mechanism on a foot operated waste paper bin was broken, which meant people had to touch the bin when disposing of any waste. A broken toilet roll holder meant people had to handle the toilet roll and place it either on the floor or the toilet cistern. There were splashes and debris on the framework and footplates of a person's wheelchair. An audit, which took place in July 2018, identified shortfalls in infection control. These shortfalls included carpeted areas not being clean or in a good state of repair and odours in some areas. Improvements to the cleanliness of the environment and the need for an infection control lead had been identified within the home's action plan.

One relative told us, "I'd only give the cleanliness and laundry 5 or 6 out of 10. I'm not happy about the hygiene. Two relatives commented about the odour in their relative's room.

We observed an incident when one person was being assisted by a staff member with their meal. The staff loaded the spoon and then blew on it to ensure it was of a safe temperature. This was not hygienic or dignified practice. Improvements to the cleanliness of the environment had been identified within the home's action plan.

This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite some issues with the environment we saw one member of staff cleaned the chairs in the dining

room thoroughly and methodically. They told us, "I treat the home as my home, so always wipe up spillages straight away and make sure everywhere is cleaned properly. I look up and down, not just at my eye level". The member of staff told us there were cleaning schedules, which were signed as tasks were completed. They said there were enough housekeeping staff and a clear system for 'deep' cleaning of rooms. There was also a "Job day" where additional jobs such as cleaning the windows, were allocated. Staff told us they had access to disposable protective clothing when needed.

Information showed some risks to people's safety had been assessed. This included areas such as choking, malnutrition, pressure ulceration and the use of bedrails. The information showed what action was required to enhance the person's safety.

Staff were aware of what constituted abuse and their responsibility to report any suspicion or allegation. They said they had completed safeguarding training and had regular updates in this area. There were safeguarding procedures in place and these were clearly displayed for staff reference. Staff were confident any concern they raised would be properly addressed.

There were enough staff to support people safely. During the day, there were six care staff and a registered nurse on duty on each floor. In addition, agency staff supported one person and another person had 'one to one' support from the staff team. The registered manager told us two staff were allocated to work in each area of the home. This meant people received consistency of care throughout the day. Care staff were supported by a team of ancillary staff, which included housekeeping and catering staff.

There was a staff presence and the home was calm and relaxed. Any requests or the need for assistance, were undertaken quickly. For example, one person spilt their drink. Staff identified this, told the person not to worry and quickly addressed the situation.

The registered manager told us the number of staff required was regularly reviewed. They said they used agency staff if needed to ensure there was adequate cover. The registered manager and staff told us there were "always" enough staff on duty. However, three people and three relatives did not agree with this. One person told us, "staff do what they've got to do, there's not much time for anything else." A relative said, "There have never been enough staff since day one. The impact is that they don't have time to talk to residents, or have interaction. They are continually doing the necessities." Another relative told us, "There are sometimes enough, but sometimes it's a bit light especially at weekends." Further comments were, "They are friendly and kind but there aren't enough [staff]. That's linked to the finances. There are days when they are short staffed" and, "There's not a lot of 1:1 attention. Staff sit at the tables doing paperwork."

Safe recruitment practice was being followed. Records showed various checks were undertaken such as the prospective staff member's past work performance, fitness and character. There were also checks of the prospective staff member's identity and a Disclosure and Barring Service (DBS) disclosure was completed. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) was not always followed effectively. The 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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Mental capacity assessments and best interest decision making processes had been completed. However, information was not to a consistent standard and did not show the appropriate assessment process had been followed. For example, one assessment did not show a person was supported to understand the decision, in accordance with their communication needs. It was also stated the person was unable to concentrate long enough to retain the information provided, despite concentration not being part of the assessment process. Another mental capacity assessment stated, "[Person's name] refused to accept any attempt to have any conversation regarding care and accommodation, so not able to retain." This showed capacity to consent to a decision was being confused with compliance. There was no consideration for completing the assessment on a different day, or by a different person to aid the person's ability to make the decision. Information showing best interests decisions did not always clearly identify the decision to be made or that the least restrictive options had been considered. It was recognised within the home's action plan that staff required more training in this area and assessments needed to be expanded upon.

The home was purpose built and had wide corridors, to aid mobility and any equipment used. All bedrooms had en-suite facilities which included a toilet, washbasin and shower. People could make their room homely by bringing personal possessions with them on admission. Whilst the environment was light, some areas did not enable people to find their way around easily. For example, there was limited signage to direct people where they wanted to go and some areas lacked colour and stimulation. Senior managers told us they had identified the environment needed greater attention. They said they were in the process of doing this and it formed part of the home's action plan.

People were assessed before being offered a placement at the service. Records showed a clear assessment format was used to ensure all the required information was gathered. This was then used to develop the person's plan of care.

People received a range of support to meet their healthcare needs. One person and a relative told us, "Teeth, feet and eyes are all checked and sorted". Other relatives told us their family member had been seen by the GP, chiropodist and speech and language therapist. On the day of our inspection, the community dentist was visiting a person. Records showed another person had arrived at the service with a broken hearing aid. Staff had made a referral to the audiology department to address this. Records showed details

of any consultations or interventions.

A transfer booklet was completed in the event of a person being admitted to hospital or another service. This enabled information to be shared about the person, to minimise distress and enable effective support to be provided. The booklet covered areas such as, "Things that may upset or worry me" and "How we can communicate." However, the documents were not always completed in full. Where the information was included, it lacked detailed. For example, when writing about a person's communication, staff had documented, "Can express needs, feelings, confusion." The information did not show how they did this or if the person benefitted from any specific communication techniques. Another booklet, stated, "Needs 2 staff [for support with personal care] depending on her co-operation". This did show how best to support the person. The section which highlighted "Hearing, eyesight and dentures" was not completed.

People were supported to have enough to eat and drink. This included a choice of meals and various snacks such as fruit, cake and biscuits throughout the day. Whilst snacks were offered, staff did not always record them on the person's food monitoring chart. Some charts also lacked detail in terms of what people had eaten. This did not enable a clear assessment of the person's nutritional intake. Records showed people received dietary supplements as prescribed. Those people at risk of malnutrition were being closely monitored. One person confirmed this and said, "I had a second bowl of porridge thrust at me today, fortunately I like porridge." One member of staff told us they had helped staff learn about a person's cultural food and drink preferences. They said they often made specific food and 'special' tea for the person.

People who needed assistance to eat were supported in an attentive manner. Staff informed people what they were eating, asked if everything was alright and took their time. They positioned themselves appropriately at the side of the person and remained seated. One member of staff however, mixed a person's pureed food together, whilst assisting them. The meal became brown in colour, which did not look appetising. In addition, the person was not able to taste the different flavours of their food. Some people had 'finger foods' so they could eat with minimal support.

People and their relatives were complimentary about the food. They said there was a choice at each meal time and the food was of a good quality. Specific comments included, "The food is very, very good", "Quite nice, edible, very good. I'm a bit fussy but I can eat it" and "The food is lovely. There's a choice at lunchtime, menus are on the tables and in the last month, they've started plating the choices up to show people, to help them choose."

Staff received a range of training to develop their knowledge and skills. This included topics deemed mandatory by the provider such as, moving people safely, safeguarding people from harm, fire safety and food hygiene. In addition, there were subjects related to people's needs. This included positive behaviour management and palliative care. The provider had a specific dementia care training programme, which was based on three different levels. Some staff told us they had completed the first level known as "Living in My World" but were waiting to progress to the next level. A peripatetic manager confirmed this. They told us, "The training they do is very good, there are staff that have only done one stage of the dementia training, but they want to do the rest." A relative told us they felt some staff would benefit from more dementia care training, as in their view, "Senior staff are skilled in dementia care but other staff are not." Records showed registered nurses undertook training to maintain their professional registration requirements.

Staff told us they were happy with the training they received and felt well supported. They had regular meetings with their line manager to talk about their work and any training they felt they needed. Staff showed a clear willingness to learn and develop. One member of staff told us, "I want to do the best for people, so if I can learn, I will. If there's something we're not doing, tell us and we'll put it right." They told us

they had learnt a lot from their dementia care training and had various ideas to improve people's support. Another member of staff said, "The more training we get, the more we learn, the better it is for people. That can only be good". They continued to say, "If your training hasn't expired, you can always join a course earlier, just for a refresher. They don't make you wait. They want you to learn."

Requires Improvement

# Is the service caring?

## Our findings

Shortly after the inspection, we received some information of concern about the service. The information stated people's dignity was not respected, as they were not adequately supported with their continence or covered appropriately, when being assisted in communal areas. We did not see any evidence of these concerns during the inspection. However, there were other areas which compromised people's dignity. For example, one person had debris all down their front and over their trousers. Another person had a stain on their clothing. A member of staff told another, "I'll just help [person] change their shirt in case someone comes". Other people were supported with their clothing more appropriately. A "bath list" was located within a file that was used to hold people's care charts. This allocated people specific days to have their bath, rather than promoting individual choice. A peripatetic manager told us they would remove the list and review this with staff.

People were addressed by their first or chosen name although some staff used terms such as "darling" or "sweetheart". These terms were used regularly and across a wide range of people, which did not take into account their personal preferences. In addition, some staff asked people questions such as, "Do you still love me?" This approach sought gratitude, which may be seen as inappropriate and unprofessional by the individual.

The registered manager told us supporting people with kindness, respect and compassion was "built in". They said caring for people came "from the heart" so it was essential they had the right team in place. The registered manager told us they had this. They said staff wanted to do a "good job" and were caring, kind and protective of the people they supported. The registered manager told us they nurtured these values and ensured they were applied in practice. They said this was done by observing and working with staff, discussing values in one to one meetings and training sessions. Within the home's action plan however, it was identified people were not always treated with dignity and respect. Additional training, audits and developing a Dignity lead and Dignity champions, were planned to address this.
Staff told us they enjoyed their job and worked well as a team. They said they all wanted the best for people, so worked towards this at all times. One member of staff told us, "I love my job. I'm passionate about caring. I love coming to work. I try to find the little things about people." They gave us an example and said, "Like if a person becomes emotional with a song. I try to find out why." Another member of staff told us "It's a great job. You get out what you put in so I always bring a smile with me and people react to it well. You have to think about how it feels for a person, put yourself in their shoes. Dignity is a must." Another staff member said, "I'm here for the residents. They're our focus". The member of staff continued to say, "We follow their lead, like one person gets embarrassed when eating, as they find it difficult so it's fine, they have their meals in their room."

There were positive interactions between people and staff. One member of staff asked a person what they had for lunch and if they enjoyed it. The person replied, "Fish and chips, it was lovely. Did you make it?" The staff member laughed and said, "Oh no, not me. It was the chef." There was further laughter between the person and the member of staff. Another member of staff sang with a person as they walked along the corridor. One person asked a member of the ancillary team "Where are you off to?" They replied, "I'm off to

change a lightbulb. Shall I walk with you?" The person and the member of staff then walked together, chatting as they did so. Another member of staff gave a person a cup of coffee and some biscuits. They took a sip of their drink and said, "Oh, it's too hot." A member of staff who was passing said, "Don't worry, I'll get some more milk put in it for you."

Other interactions showed staff had built relationships with people. For example, staff asked, "You like ice cream, don't you?", "You were a good cook, weren't you?" and "How about going for a walk, that's what you like, isn't it?" Staff held conversations with people about their family and any visitors they had recently had.

People and their relatives told us staff showed kindness and compassion. They said they were respectful and courteous. One person told us, "The carers are all very nice. I enjoy their company. I didn't know if it would be OK but I'm mildly surprised - they are very caring." Other comments about staff were, "Whatever they can do to help, they try to do", "They are good and understanding, they take their time" and "the carers are hardworking, very kind and they make me feel welcome". One relative was appreciative that staff had taken the trouble to ensure their family member was dressed smartly, ready for their visit on Father's Day. Two relatives told us the best thing about the service was the staff. One relative told us, "The staff are an asset". Another relative said, "They [the staff] meet her needs and preferences, and treat her as an individual." Other comments were, "[Staff] chat and are conversational", "they are alright, they chat and are kind and caring" and, "the carers are very good, if you ask for something, they come up with it".

People were encouraged to make decisions although some interventions compromised this. For example, throughout the first day of the inspection, one person told staff they wanted to go to bed. Staff tried to distract the person by offering them drinks or a walk in the garden. The person declined all offers and continued to say, "I want to go to bed and lie my head on my pillow". Staff then told the person they needed to wait until 18.30 before they went to bed. This was against the person's wishes and did not show staff were listening to what the person wanted. The person's care plan informed staff they were to assist the person to bed at the end of their shift. This was not person centred and did not consider the person's preferred choice. Once brought to their attention, a peripatetic manager told us the plan was inaccurate and would be fully reviewed. They said they would talk to staff about the person's care.

A member of staff was encouraging another person to choose what they wanted to wear. The person responded by saying, "I don't know. You choose. I'll leave it up to you". The member of staff continued to persuade the person and showed them different outfits. There was light hearted banter, such as "You chose", "No you choose". The person then pointed to what they wanted. Some people chose to spend their time in the garden. One person walked around the garden with their relatives. Another person sat at a table, chatting with a member of staff. One person was asked if they wanted their hair done. The person declined and the staff member said, "It's ok, we can come and check with you later." Another person told us the best thing about the home was, "the freedom of choice – they let you do what you want".

Requires Improvement

# Is the service responsive?

## Our findings

Staff were not always responsive or showed an understanding of people's needs. For example, one person, who was not able to verbally communicate, was very flushed and agitated. They were in bed, pulling at their bedding, reaching into the air and making different sounds. The way in which the person was presenting was brought to the attention of a member of staff. They replied by saying, "She's ok. She's always like that." This was not accurate, as the day before, the person was settled and sleeping comfortably. Another member of staff told us they had recognised the person's agitation and had given them some pain relief. However, they had not ensured further observation to ensure the person had settled. On further discussion, a member of staff told us the person was flushed, as they were in full sun, from their window. This had not been previously identified. Staff drew the curtains and sat with the person, holding their hand. The person touched and pulled at the staff member's hand but then became settled and began to sleep comfortably. Whilst staff had identified the person's initial agitation, they had not ensured further interventions to ensure the person's well-being.

At lunchtime, staff showed each person a choice of two meals. This enabled people to visually decide what they wanted to eat. However, after they had chosen, the member of staff continued to show other people the meals, so they could choose. This meant there was a delay in people receiving their food, which increased some people's anxiety. The delay also increased the risk of people forgetting what they had ordered. Whilst people were waiting, other staff verbally asked them for their meal choice. One person was asked what they wanted for their meal by three different members of staff. This increased the risk of confusion. The meal time was at times chaotic, with lots of noise and staff moving around. A peripatetic manager told us they had recognised this and were considering the development of the meal time experience. This formed part of the home's action plan. Another meal was much quieter. Staff were attentive and gave appropriate support where needed. One person had finger foods as this was easier for them to manage.

One person told us they were unhappy with their situation and wanted to get up rather than staying in bed all the time. This was brought to the attention of the registered manager, who confirmed they would speak to the person and review their care. A relative told us they did not feel staff always understood their family member's needs. They said staff approached their family member from behind, which frightened them. The relative said their family member also spent long periods of time alone in a lounge where the television was on. They said their family member found this distressing, as they were unable to distinguish between what was on the television and reality. The registered manager told us they would look into this, but did not feel people were left alone in communal areas.

Not all care plans contained sufficient detail about people's needs, preferences and the support they required. For example, information to guide staff on managing certain challenging behaviours were variable in content. One plan did not clearly show the signs of the person's agitation or how the behaviours were presented. A monitoring chart showed other behaviours the person had displayed, but these were not identified in the person's care plan. This did not ensure the person would be appropriately and consistently supported, at these times. A record for another person showed they displayed challenging behaviour when

receiving personal care. The information did not explain at what point of the support, this behaviour was displayed. This did not enable the person's care to be accurately reviewed, to ensure a more positive experience. There was a section within the monitoring record, which required staff to record details of how the behaviour was managed. One monitoring record stated, "Explained that it is not acceptable". Another record showed staff had told the person to stop what they were doing, but they had "refused to do this". This did not show a clear understanding of the person's needs or their health condition.

One care plan stated the person sometimes made sexual comments towards staff. The guidance for staff to manage this stated, "distract [their] attention and talk about other topics." This was insufficiently detailed to enable staff to manage the situation effectively. Another person found support with their personal care difficult, so often declined. Their care plan showed how best to approach and engage them with personal care, but it was also written, "try to establish any problems in her past that may be causing anxiety". There was no further detail to clarify this. Another plan stated a person could only speak "one or two words". Information to enable effective communication was not identified. Records showed the person had declined a shower every day for the last ten days. When asked how the person had communicated this, the staff member told us the bathroom floor was being re-laid.

People's health care plans were not always clear or accurate. One plan stated the person should avoid sweets due to their health condition. Due to this, the person's family had been asked not to bring in "sugary things" like cakes, sweets and chocolate. However, in another section of the plan, it was written the person had these items in their room and they were to be offered during personal care interventions. This was conflicting and did not promote the successful management of the person's health. It was stated the person was "overweight" and a low-calorie diet was to be offered. Their documented weight did not reflect this view. Another plan identified the person's epilepsy. The guidance stated, "give tablets, fill in epilepsy chart if [they] have a fit." This was insufficient and did not ensure staff had the information required, to ensure the person's safety. One plan stated, "to have only snacks and drinks on bedside table to reduce risk of choking on some food items." This lack of detail did not ensure staff knew of the high-risk foods, the person should avoid. Staff told us another person was having low calorie food to promote weight loss. This was not documented in the person's care plan. Another record showed a person needed oral care twice a day. There was no further detail to inform staff what assistance they required with this.

One person did not have English as their first language. Their plan recognised this but there was limited information about how to communicate with the person effectively. For example, it was documented that staff should approach the person, "in an open and friendly manner, being careful about body language". There was no further detail to inform staff what this meant in practice. There was also no information about how the person expressed pain. This did not ensure staff would recognise or take steps to rectify any discomfort the person was experiencing.

People's care plans had been regularly reviewed. However, the information was not always appropriately evaluated. For example, within the evaluation section of the plans, staff had recorded statements such as, "Care staff always make sure that [person's] needs are met at the home" and, "Does not always respond appropriately." The evaluation of a communication plan stated, "Unable to communicate properly". Another person had lost weight. Whilst this had been recognised, the evaluation section of the plan did not show any amendments, which needed to be made to promote weight gain.

Advanced care plans, which detailed the person's choices and preferences regarding their end of life care, were not always in place. Those which had been completed, lacked detailed. For example, one plan stated, "[Person] would like to stay at the home". Another stated, "Contact son when passed away". There were other generic phrases such as "Would like to be kept comfortable and pain free." A senior manager told us

they were aware of this, but were piloting new documentation within the organisation. They said if successful, the documentation would be implemented at Miranda House. 'End of life' care plans and their implementation were identified within the home's action plan.

Daily records were task focussed and generic in places, which did not promote people's dignity or individuality. There were entries which stated, "Pad changed". The recordings for one person included, "Personal care given as required. He had good food and fluid intake. Had supplement as prescribed. Active wandering around the home. Checked regularly. No new concerns." Also, "He had a good day, found him looking around on and off. Spent most of his day in lounge, sat calm and comfy watching television. Good eating and drinking in the dining room. Settled day. Checked regularly." Within the records, it was regularly stated, "Had a good day" but there was no further information to show what contributed to the "good day". In addition, it was not clear whether this was the staff's perspective, or the person's. The records did not show the time of any care support. This did not ensure people received support on a regular, on-going basis. Staff told us they generally made entries in people's care records at the end of their shift, rather than at the time of care delivery. This increased the risk of inaccurate recording.

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

An internal audit had identified people's care plans were vague and not person centred. As a result, improvements were being made to make the plans more personalised. In addition, a new format was being introduced. Those which had been reviewed, generally contained detailed information about areas such as individual choices and preferences. This included whether a person preferred a light on at night and how many pillows they liked to sleep with. There were some details to enable topics of conversation, such as "[Person's name] enjoys football, sport and talking about his previous career, and about his family."

Some care plans provided staff with guidance on how they should communicate with a person, who had difficulties in this area. One person was deaf and staff had recorded "speak loudly and clearly". There was also information about the person enjoying "banter" with staff. Another record showed triggers for a person's anxiety and how they preferred to be supported if they became anxious. This included guiding the person to a quiet place, what kind of things staff should say and how to provide reassurance. One record stated the person preferred to be supported to bed between 18.00 to 19.00. Whilst this was the person's choice, there was no detail about why they liked to retire so early. Another record showed a person was at risk of falling from their chair. A best interest decision had been made for the person to use a lap-belt to enhance their safety.

There were members of the staff team, who spoke the same language as a person whose first language was not English. Staff told us these staff were called upon, if the person was unable to express their needs. Staff told us this worked well and minimised the person's agitation. The staff's names were documented in the person's support plan.

A range of social activities were arranged. The registered manager told us social activity provision within the home, was "excellent". They said, "It's something we pride ourselves on". The registered manager told us there were designated activity staff and activities were arranged, seven days a week. In the evenings between 5 and 9pm, they said care staff arranged activity provision for people. The registered manager told us, "Staff don't always realise that some of the care they provide is an activity, speaking with people and having a chat is an activity." Whilst acknowledging this, one staff had documented that "giving a person a beer" was an activity, rather than a task. The registered manager told us a gardening group and committee with people and their relatives, had been developed and a greenhouse was on order. Staff told us key events

were celebrated. This included having strawberries and cream whilst watching tennis on the television and themed events such as, Indian and Hawaiian parties. One member of staff told us they often read to people in their rooms or looked at photographs. They said they had "signed up" to a reminiscence newspaper, which covered nostalgia topics for older people and those living with dementia. A peripatetic manager told us they were in the process of arranging a link with the local school so the children could visit on a regular basis. They said in addition, there was a new initiative to rename the different units within the home.

There were variable comments about the opportunities for social activity provision. One person told us, "I enjoy some of the activities. It depends what's on". Another person said "They leave me alone. I like being on my own, I don't do the activities". Feedback from relatives included, "[Family member] enjoys the music sessions and I've also seen keep fit" and, "There is bingo and other local events. They are very good and encourage people to take part." Other relatives had concerns about the amount of stimulation their family member received. One relative told us, "There's no stimulation. She just sits in the same place all the time, she needs more company. I get fed up with seeing my [family member] doing nothing, seeing them not talking to her". Another relative raised similar concern. They told us, "The worst thing is there's not enough to stimulate them, not enough 1:1s". One relative described a variety of activities but felt they were of limited interest to their family member. One relative was more positive. They told us their family member had settled better into the home than their previous setting and there was more interaction and stimulus than before.

During the inspection, staff engaged with some people well. However, those people in the lounge who were quieter and more withdrawn, received less attention. One person was 'fiddling' with their clothes and running their fingers over the table in front of them. A peripatetic manager asked staff if there was anything the person could have to enhance stimulation. They returned with a brightly coloured pink, inflatable guitar. The person was not interested in this. Another member of staff later told us the person, and some others, did not have anything to hold to occupy them, as they would put things in their mouth. Staff often sat with people, whilst writing their care records but interaction during this time was limited.

The registered manager and staff told us there was a strong focus on people going out and being part of the community. This included going to places of interest, local shops and parks, and for lunch at a pub. A barbeque event, where people could invite their relatives, was being arranged for the following weekend. A plan of activities for the week was displayed on A4 paper, on the wall outside of the lounge. This showed activities such as breakfast club, a 'families' morning and a trip to the local steam museum. During the inspection, some people went to a coastal town. One person told us they were looking forward to having fish and chips 'on the front'.  Other people enjoyed a visiting singer. Some people joined in with the singing whilst others were watching and listening. Some people were dancing with staff and there was a lot laughter. Staff told us they had access to a minibus every other week, as it was shared with another service within the organisation.

People told us they knew how to make a complaint if they were unhappy about the service. One person said, "If I had a problem, I'd take it to the carers and they'd sort it out." Another person said, "If I had a problem I would talk to someone, depends how serious it was. The manager or the nursing manager." Relatives told us they would readily voice any concerns they had. Specific comments were, "If I don't like something I say so, but I haven't had to do that", "If I had a concern I would see the manager" and "Complaints are well handled. I see them in the office [if I need to] and it's sorted quickly." One relative however, said they would raise a concern but it was not always resolved quickly. They told us, "You have to keep on and on." Another relative told us they were wary of discussing their concerns in case there were repercussions for their relative.

A complaint procedure was in place and a record of complaints was maintained. However, the investigation

into the complaint was not always clearly evidenced. For example, concerns had been raised about the level of noise coming from the home. The registered manager had responded by saying an individual's "dementia journey could be vocal", so understanding was requested. There was no information to show an investigation into the possible reasons for the noise had been undertaken, or that it had been minimised as a result.

The complaint procedure was not displayed around the home in an 'easy to read' format. A senior manager told us this was because people and their relatives were given the opportunity to raise any concerns by using the iPad provided. They said this had worked well.

Requires Improvement

# Is the service well-led?

## Our findings

This service has had a poor history of compliance with regulation. In September 2016, there were shortfalls in the safe management of people's medicines. There remained shortfalls in July 2017 and at this inspection, medicines were still not safely managed. This meant there had been three consecutive inspections, in which shortfalls had been identified.

At this inspection, in addition to medicines, there were shortfalls in areas such as the management of risk, infection control, the environment, people's care and care planning. As a result, there were two repeated breaches and a third breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These failings demonstrated ineffective governance and leadership.

The provider had identified the service required improvement and there were a range of action plans in place, However, the improvement required was not recognised in a timely manner. Some of the information, within the action plans, showed timescales for the work as being "ongoing" or "as soon as possible". This did not ensure improvements were "kept on track" and could be effectively monitored. The action plans showed some work had been completed but there was also a large amount that was "work in progress".

Incidents and accidents were reported. The registered manager analysed information relating to falls. However, some of the analysis was limited. For example, most falls from February 2018 onwards had taken place over a weekend. The timings of the falls had been monitored but there was no written investigation into why this was so. This did not enable measures to be put in place to minimise further occurrences.

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

The registered manager told us, to aid improvement, there had been added support from senior managers and other departments within the organisation. This included HR (Human Resources) and the Estates Department. They said a second maintenance person had been recruited, to ensure any works were undertaken in a timely manner. A senior manager told us in addition to these areas, a peripatetic manager specialising in dementia care had been seconded to the home. They were working with staff, undertaking training, completing audits and developing care plans, in line with best practice in dementia care.

The peripatetic manager told us they were working with staff and encouraging things such as, "Living in people's reality, and focussing on the word 'yes' and not the word 'no'. Also, explaining to staff that instead of asking people to sit down, they should ask them to "go for a walk with you". The peripatetic manager told us they wanted staff to challenge each other. They said for example, "If you see staff walk past somebody without saying hello, challenge them and remind them." Within the inspection, not all staff had adopted these practices. One person was in the dining room, feeling the surrounds of the windows, but the majority of staff did not speak to them, as they walked by. Some staff said, "Hello [person's name]" but did not stop long enough for the person to see who was talking to them.

There was an initiative whereby staff were being able to work with the registered manager. This was so they understood how the home functioned and what was expected of the business. The peripatetic manager told us, "Staff shadowing the registered manager, empowers them. They take them on assessments, sit in on interviews, look at the DoLS and capacity assessments and give them coaching. Sometimes staff can come out with some good ideas or inspirations. Their strengths can come out more when shadowing." The peripatetic manager told us they were also promoting an awareness of every aspect of care. They said, "Everything is about care, the kitchen is about care, the activities are about care."

The registered manager told us the ethos of the home was to provide good quality care, which was forever evolving and making a difference to people's lives. They said staff were "brilliant" and it was a "very calm and happy home". The registered manager told us they were passionate about their job. They felt their strengths were engaging with people and developing staff. They said they enjoyed nurturing and coaching and thrived on openness and honesty. The registered manager told us they hoped they were approachable and had an "open door" policy. Staff confirmed this. They told us the registered manager was good at giving them time, listening and responding appropriately to any concerns or questions they had. One member of staff said, "She will always come and find you to give an answer to a query or to make sure you're ok." Another staff member told us, "She's very fair. I can't fault her. She treats you with respect. If she doesn't know, she'll always find out and get back to you."

The registered manager was complimentary about the staff team. They said they were knowledgeable and worked well together. The registered manager told us there were initiatives to help staff feel valued. This included, "Employee of the month – recognising excellence", whereby any staff member could be nominated and awarded for their work. The registered manager told us they gave staff regular feedback, including any given by people's relatives, and always thanked them for their work. Another manager told us there was a culture of recognising staff's strengths. They said they would move staff to work in different departments, dependent on where their skills were.

A daily meeting was held with the heads of each department. This enabled the day and any key events to be discussed, which enhanced communication. For example, the maintenance team spoke of the work they would be doing on the home's lighting and the nursing staff discussed if anyone was unwell and if any prescriptions, were expected. Records showed the chef was regularly informed of any dietary needs such as allergies or weight loss.

The registered manager told us they kept up to date with current practice from a variety of sources. These included the Internet, training courses, meetings and networking. They said they had good support from senior managers and attended manager's meetings on a regular basis.

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 9 HSCA RA Regulations 2014 Person-centred care |
| Treatment of disease, disorder or injury | Information within care plans was not to a consistent standard and did not always promote person centred care. Regulation 9(1)(a)(b)(c)(3)(b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | Medicines were not safely managed. Regulation 12(1)(2)(g). The environment compromised good infection control. Regulation 12(1)(2)(h). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | Governance was ineffective, as it had failed to identify potential risks to people's safety or address other shortfalls in the service. Regulation 17(1)(2)(a)(b). |