Avery At The Miramar (Operations) Limited

Miramar Care Home

Inspection report

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05 December 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 04 and 05 December 2018, the first day of the inspection was unannounced.

Miramar Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. Miramar Care Home accommodates 122 older people and people living with dementia in one building. The service has 10 single bedrooms with en suite bathrooms and 69 apartments for one or two people. There were 58 people using the service at the time of our inspection. Three people did not receive any care or support. Two people moved in to the service on the second day of the inspection. Eight people lived in the Cypress suite which was a dementia unit within the service. Most people using the service were able to tell staff how they preferred their care provided.

At the last inspection on 05 June 2018 we rated the service Requires Improvement overall. We found continued breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a new breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider submitted an action plan dated 22 August 2018 to detail how they planned to meet the breaches of regulations.

We undertook an unannounced focused inspection of Miramar Care Home on 04 December 2018. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 05 June 2018 had been made and because information of concern had been received. The team inspected the service against two of the five questions we ask about services: is the service safe and is the service well led. This is because the service was not meeting some legal requirements. During our focused inspection we found that the provider had not met all of their actions detailed in their action plan.

No risks or concerns were identified in the remaining Key Questions through our ongoing monitoring or during our inspection activity so we did not inspect them. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

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

The provider did not follow safe recruitment practices. Gaps in employment histories had not been explored to check staff suitability for their role.

At the last inspection registered persons had failed to deploy sufficient numbers of staff to meet people's needs. Since our last inspection the registered manager had reviewed people's care needs and the layout of the building. To support more efficient staff deployment the building had been divided into individual units and people were being given the opportunity to move to new apartments in these units. Some people had taken up this offer and had moved and further moves were planned. Despite these changes, staff deployment remained a concern. People had mixed views on the response times to call bells. Meal times and first thing in the morning when people wanted to get up and ready were key times of the day where staff were busy providing care and support and responding to people's needs. Call bell records evidenced some people often had long delays to receiving an answer to their call. This is an area for improvement.

At the last inspection the registered provider had failed to ensure the proper and safe management of medicines. Although some improvements had been made, medicines continued to be an area of concern. People who were prescribed topical medicines such as creams and lotions had additional topical medicines administration records (TMAR) in place, these had been completed inconsistently. Most people who were prescribed 'as and when required' (PRN) medicines to manage different minor ailments as well as pain or constipation. Some people did not have PRN guidelines in place to advise staff the reasons the medicines could be given, when they should give the medicines, how many could be safely taken in a 24 hour period and what were the side effects to watch out for.

At the last inspection the registered provider had failed to do all that is reasonably practicable to mitigate risks to people. At this inspection some people continued to be at risk because identified risks were not monitored. People who relied on equipment such as hoists and slings to help them manoeuvre from one place to the next had not been suitably assessed. Mobility risk assessments had not always been updated in a timely manner following a fall.

People continued to be protected from abuse. Policies were in place and available to staff. Staff were confident that any concerns they raised would be addressed quickly.

The service looked and smelt clean. Housekeeping staff carried out cleaning around the service as well as communal areas. The service had been well maintained. Repairs and maintenance of the service had been carried out in a timely manner. Since we last inspected the service, some areas on the ground floor had been redecorated and restyled. Further works were planned for other areas of the service.

At the last inspection the registered provider had failed to effectively act on feedback from relevant persons on the services provided, for the purposes of continually evaluating and improving the service. The registered provider had failed to maintain an accurate, complete and contemporaneous record in respect of each person's care. At this inspection systems and processes were in place to monitor the service. These were not sufficient to get an oversight of what is happening in the service and whilst they had highlighted some areas of concern and action plans put in place, the systems were not robust enough to capture the breaches of regulations found during this inspection. Records relating to people's care and the management of the service were not well organised or complete.

An improvement plan was in place based on the outcome of the last inspection. A number of dates had lapsed on the improvement plan which meant that the action to improve the service was taking longer than first identified. The regional manager agreed to send CQC an updated improvement plan each month.

The staff morale was low, staff and people felt unsettled and anxious about changes to the management team. The provider had set up 'listening groups' provided by the regional manager. Staff had been invited to discuss any concerns or issues they had privately and confidentially. Six staff had taken up this opportunity.

People and staff had opportunities for sharing their views. People's views had been listened to and acted upon. The provider had implemented 'Resident of the day'. Resident of the day includes staff spending time with people to review care plans and asking people for their feedback about their experiences of the service. People shared with us their positive experiences of resident of the day, such as time spent at the beach and having a cup of coffee.

At the last inspection the registered provider had failed to show on every website maintained by them or on their behalf the Commission's most recent rating of Miramar Care Home. At this inspection the provider had displayed their rating in the entrance foyer and on their website.

The registered manager worked in partnership with other professionals including a clinical nurse specialist for older people.

Services that provide health and social care to people are required to inform the Care Quality Commission, (the CQC), of important events that happen in the service like a death, serious injury, abuse or deprivation of liberty safeguards authorisation. Notifications had been sent to CQC when required.

This is the third consecutive time the service has been rated Requires Improvement, which is the second consecutive time under the new provider name Avery At The Miramar (Operations) Limited. You can see what action we told the provider to take at the back of the full version of the report.

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

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 consistently safe.

The provider had not always followed safe recruitment practices. Staff deployment at key times of the day needed to be reviewed.

There were shortfalls in the arrangements used to manage risks and provide safe care and treatment.

The provider had not always taken action in relation to accidents and incidents and as a result had not learned lessons from accidents and incidents to prevent them from happening again.

Medicines were not always managed safely. Topical medicines practice was inconsistent across the service.

Staff understood the various types of abuse to look out for to ensure people were protected. Registered persons had reported safeguarding concerns to the local authority and CQC appropriately. Measures were in place to minimise the spread of any infection. Staff used personal protective equipment to safeguard themselves and people.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Improvements to the service had been made, however further improvements were required to systems to enable registered persons to effectively monitor the service. Records relating to people's care and the management of the service were not well organised or complete.

The provider had reported incidents to CQC. There was a registered manager in place. Staff felt well supported by the registered manager.

The staff morale was low, staff and people felt unsettled and anxious about changes to the management team.

People and staff had opportunities for sharing their views. People's views had been listened to and acted upon.

The provider had displayed their rating on their website and in the main foyer.	

Miramar Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 04 and 05 December 2018. The first day of the inspection was unannounced. The inspection was carried out by three inspectors and an assistant inspector. The assistant inspector spent time talking with people.

Before the inspection, we reviewed the information we held about the service including previous inspection reports. We looked at notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. We also reviewed information of concern that we had received from people, relatives and staff.

We did not ask the provider to send us a provider information return (PIR) as this was a focused inspection. A PIR is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spent time speaking with 15 people who lived at Miramar Care Home. Not everyone was able to verbally share with us their experiences of life at the service. This was because of they were living with dementia. We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We observed care and support in communal areas. We spoke with a visiting GP and a health and social care professional. We also spoke with two relatives one of whom contacted us after the inspection site visit.

We contacted health and social care professionals including the local authority commissioners and safeguarding coordinators and Healthwatch to obtain feedback about their experience of the service. There is a local Healthwatch in every area of England. They are independent organisations who listen to people's views and share them with those with the power to make local services better.

We spoke with 20 staff; including a chef, maintenance staff, administration staff, care staff, senior care staff, nursing staff, the residential care manager, the registered manager and the regional manager.

We looked at 11 people's personal records and care plans, medicines records, risk assessments, staff rotas, staff schedules, five staff recruitment records, meeting minutes, policies and procedures.

We asked the provider to send us additional information after the inspection. We asked for copies of policies and -procedures, hoist check records and staff training records. We received the information in a timely manner.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 05 June 2018 we found that registered persons had failed to ensure the proper and safe management of medicines. The provider had failed to deploy sufficient numbers of staff to meet people's needs and had failed to do all that is reasonably practicable to mitigate risks to people.

At this inspection, we found medicines were still managed in an unsafe manner. The provider had changed medicines supplier since we last inspected. The new supplier had been in place for six weeks. Staff who administered medicines told us the new supplier was more effective. Prescribed medicines and topical lotions and creams were printed onto medicines administration records (MAR). Those people who were prescribed topical medicines such as creams and lotions had additional topical medicines administration records (TMAR) in place. There was inconsistent practice in the service on how these were stored and completed. In one area of the service, TMARs were kept in the medicines room with the medicines and in other areas the TMARs were kept in people's own rooms.

The management team told us that it was nursing staff responsibility to check that TMAR's had been completed within the nursing unit and the responsibility of lead care staff to check that staff had administered topical creams on the residential units of the service. There was no evidence to show that topical charts were checked by nurses or lead care staff in the service, except in the Cypress unit for people living with dementia. On one residential unit we found that topical charts had not been completed since the 02 December 2018. Some TMAR charts showed that people required creams twice a day. Records evidenced that they had only received the creams once a day. For example, one person was prescribed Sorbaderm cream which should be applied to their groin twice a day. TMAR records showed it had only been given once on 26 and 30 of November and 01 and 02 December 2018. There were no entries at all to show if the cream had been applied on 03 and 04 December 2018. The MAR for one person showed they were prescribed a high number of creams including Hydrocortisone cream 1% apply thinly twice a day. We checked their TMAR and found there was no chart for Hydrocortisone cream 1%. Their TMAR for Aveno and Proshield had not been signed for since 2 December 2018.

Medicines management had been checked by the senior management team within their 31 October 2018 and 16 November 2018 audits of the service, these evidenced that further improvements were required. The registered manager had implemented changes to the processes of checking TMAR in one area of the service with a view to roll out this practice to all units within the service. The nurse within the Cypress unit showed us evidence that they were frequently checking TMARs and identifying errors or omissions in recording and had been meeting with staff to rectify this. There was no evidence of these checks in other areas.

Medicated transdermal patches were not well managed. Some people living at the service required transdermal pain relief patches applied to their skin. Patient information leaflets supplied with transdermal patches detail that patches should not be applied to the same area of skin for three to four weeks. The supplying pharmacy had supplied the service with transdermal patch application records so that staff could record where they had sited the transdermal patch. These had been completed in an inconsistent manner. Some records had not been completed fully to detail which area of the body the patch had been applied to.

One person's record did not list where they had their transdermal patch applied on 14, 17 and 26 November 2018. Some records showed that the patch had been re sited to the same area of the person's body as frequently as every two weeks which increased the likelihood of skin irritation. During the process of checking transdermal patch application records on 05 December 2018, nursing staff found that one person had missed a dose of their pain relief. They were due to have their transdermal patch changed on 03 December 2018. The patch was applied on 05 December 2018 and the MAR chart was amended to show when the next patches were now due.

One person was an insulin dependent diabetic. Nursing staff administered the person their insulin on a daily basis. A nurse told us this was administered after the nurses had checked the person's blood glucose levels. The MAR for the person showed that the insulin had not been signed for on 30 November 2018. The blood glucose monitoring record for the person had not been completed on this day either. The nurse showed us that there was an electronic record of the blood glucose reading on that day. We were unable to identify whether the person had received their insulin or not.

Medicines such as tablets, injections and eye drops were stored securely in a locked medicines room. This room was fitted with an air conditioning unit to ensure that the room stayed at a stable temperature. The temperature records evidenced that temperatures were with safe storage range (below 25 degrees Celsius). However, temperatures had not always been recorded consistently; No temperatures had been recorded for 02 and 03 December 2018.

Most people who were prescribed 'as and when required' (PRN) medicines to manage different minor ailments as well as pain or constipation. People living in the residential and nursing units within the service did not have PRN guidelines in place to advise staff the reasons the medicines could be given, when they should give the medicines, how many could be safely taken in a 24 hour period and what were the side effects to watch out for. People living in the Cypress unit had clear guidance in place, which meant that staff had good clear information about what medicines were required to meet their needs.

The failure to ensure the safe administration of prescribed medicines is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff administering medicines several times during the inspection. Staff wore red tabards over their uniform to ask not to be disturbed as they were administering medicines. Medicines records contained a photograph of each person, which helped staff administering medicines identify people. Staff checked the prescription label before dispensing the medicine for the person to take. People were asked if they were in pain and PRN medicines were administered accordingly. Those people unable to verbally communicate that they were in pain were assessed using a visual pain score tool. Staff we spoke with competently explained how this was used. Medicines were counted at the end of each day. When medicines were administered staff recorded this on each person's MAR. They also signed into the handheld electronic devices to record in each person's care notes that medicines had been given.

At this inspection some people continued to be at risk because identified risks were not monitored. Previously we found that staff did not always monitor ongoing risks effectively, leaving people at risk of harm. People who relied on equipment such as hoists and slings to help them manoeuvre from one place to the next had not been suitably assessed. One person's moving and handling risk assessment related to a one-off manoeuvre that had occurred. The assessment did not detail that the person required staff to use a hoist and sling to move them in their bed every four hours. Staff confirmed that were using the equipment and daily records evidenced that during meal times the person had been assisted to move to a sitting position. This meant that staff did not have clear guidance and information about the size and type of sling

to use and which loops on the sling were best for the manoeuvre. Staff told us there were generic slings in use within the service which they had been using for different people which increased the risks of infection control issues as well as the risk of injury from using a sling which was the wrong size. We reported this to the registered manager and the regional manager who denied this and confirmed that each person had their own sling which they had been assessed for. An investigation was carried out; this brought up issues that staff were using old slings which they felt better met people's needs rather than the sling the person had been assessed for.

Some people were at high risks of falls. Mobility risk assessments had not always been updated in a timely manner following a fall. For example, one person's mobility assessment showed the person last had a fall in August 2018. However, accident records showed that the person had also fallen three times in November and twice in October 2018. The person's care records evidenced that staff had taken action in relation to the falls and the person was currently being reassessed to live in a different area of the home to meet their needs.

People that were living with diabetes had not have risk assessments in place to detail what staff should do if the person suffered hypoglycaemia or hyperglycaemia (low or high blood sugar levels). There was nothing in people's care plans or risk assessments to detail what their normal blood sugar reading was and what the symptoms could be. This meant that staff did not have all the relevant information they needed to enable them to provide safe care and treatment to people living with diabetes. One person living with diabetes who required insulin injections had a care plan in place which detailed that their blood sugar levels should be checked twice a day. However, records showed that the person's blood sugar levels had only been checked twice a day on six days out of 11. This meant this person had not received care and support that they had been assessed as requiring.

One person had been seen by a dietician and advised to have a fortified, pureed diet and fluids in a particular type of cup. Their records indicated that they were at risk of choking, however there was no choking risk assessment in place to detail how staff should safely support the person to eat and drink. Whilst we observed staff safely supporting this person to eat and drink, staff who did not know the person well (such as new staff and agency staff) did not have all the information they needed to ensure they provided safe care and support. This put this person at risk of harm.

Another person was at risk of choking and had been seen by dieticians and SaLT (speech and language therapists) between May 2018 and August 2018. Advice from these healthcare professionals was to provide a soft diet, normal fluids, fortification (adding vitamins and minerals to prevent nutritional deficiencies) of soft foods and provide alternative protein sources. The person was offered a varied diet from a pictorial menu of items that they were able to eat. The person's care plan detailed that their food should be cut up by restaurant staff before it comes out and the person requires a normal healthy diet with chicken and three eggs a week. Records showed conflicting information as to whether this healthy diet had been met. Some information about what had been eaten was missing. The person and their relatives reported that food is not always cut up or prepared by the restaurant staff to a suitable size and texture. The person's relative said, "Her food has to be a bit thicker than puree, they should cut the meat up, with a machine or whatever. But when she gets it is often too thick and she takes it out and leaves it. We have spoken to staff about it. They said they would talk to the chef. But it happens again, but the chefs have all gone, it might be the agency chefs." We observed staff bringing a meal to the person's apartment. The staff member said the person's meat in the meal should be "Shredded a bit more. The chef diced the meat but it looks like it needs dicing a bit more." The staff member cut up the person's meal a bit more to ensure it was at the right consistency. The person's relative said, "The carers don't always cut it up more when they bring it. Some do." The registered manager told us that there were agency kitchen staff employed to cover some vacancies.

Further improvements were required to ensure that kitchen staff received adequate information on how to cater for and meet this person's nutritional needs as well as maintaining the person's safety.

Several people living in the cypress unit required transdermal patches. The nurse confirmed that these were consistently applied to certain areas of people's bodies as people were known to remove the patches or pick at them if they were within reach when they were applied to the upper arms or front of their shoulders. This meant that people were at higher risk of developing skin irritation. There were no risk assessments in place to detail safe ways of applying the transdermal patches to different areas of the skin on people's backs to reduce the likelihood of skin irritation.

Registered persons had failed to do all that is reasonably practicable to mitigate risks to people. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff maintaining people's safety around the service. Staff recognised when people were walking or standing without using their walking frames or sticks. Staff provided gentle reminders to people about how to keep safe and guided people when needed to places of safety. Some people struggled to identify which floor they were on and where their room was. Staff provided guidance to people who had lost their way around the service, some people just needed directions and way marking whilst others needed to be taken to their room to help them identify their rooms.

Since our last inspection the registered manager had reviewed people's care needs and the layout of the building. To support more efficient staff deployment the building had been divided into individual units and people were being given the opportunity to move to new apartments in these units. Some people had taken up this offer and had moved and further moves were planned. Other people had decided not to move and continued to be supported in their apartment. A few people were considering moves. Any new people deciding to move into the service would be offered apartments in the unit most appropriate to their needs and the need to move in the future if their needs changed would also be discussed. This was a change to the admissions process as previously people moved into an apartment of their choice and were not required to move if their needs changed. This had impacted on staff deployment and had caused delays in care delivery and the response to call bells previously. Some staff feedback was that the new units had improved the delivery of care at the times people wanted it and the changes had needed to be made.

Despite these changes, staff deployment remained a concern. People had mixed views on the response times to call bells. Two out of eight people had positive comments about response times. One person described how they had fallen and staff had responded very quickly to the bell. They said they, "Got pretty immediate attention". Other people reported, "Response time is quite bad, after twenty minutes of ringing the call bell I hit the alarm bell, waiting fifteen or twenty minutes is quite normal. Happens day and night but night staff are better than day staff"; "Staffing is very sparse at the moment. I don't think there is enough staff. They are using agency staff at the moment a lot more than they used to"; "We have a call bell. They are quite good at that. We both have an emergency call bell around our necks. We both have call bells on our bedroom. We normally wait about ten to fifteen minutes for staff to come, there are blind spots, such as when staff change over, then we can wait half an hour. Ten to fifteen minutes is a long time if you need to go to the toilet. They come straight away if you press the emergency bell"; "I have call bells in the living room, the bathroom and the bedroom. I did wait half an hour one day, but that's unusual. When I ring it they come, normally I wait about ten minutes. I don't use it often because I don't need much support. I try not to use it because I know staff on my wing are very busy"; "This is a recurrent problem. When people have finished eating they wait and they wait and they wait, there is not enough carers when people want to return to their accommodation" and "It takes a long time for staff to bring me back from the restaurant." During the

inspection we observed call bell response times and spoke with staff. Catering staff in the restaurant told us that there was often delays to staff supporting people to go back to their apartments after a meal. People carried their call bell device to the restaurant and this was pressed to alert staff to come to collect them. Meal times and first thing in the morning when people wanted to get up and ready were key times of the day where staff were busy providing care and support and responding to people's needs.

Call bell records showed that one person who complained to us during the inspection about the response time waited for approximately 30 minutes on four occasions in two weeks for their bell to be answered. A second person who raised concerns had waited approximately 20 minutes on two occasions, a third person rarely rang their bell and had had to wait approximately 25 minutes on one occasion. A fourth person had waited over 30 minutes on one occasion. Another said they often had to wait to be supported to return to their apartment after lunch. This delay had been identified by the registered manager and the regional manager and they were considering the placement of a second dining room in another area of the service to reduce the time and distance staff had to support people to travel for each meal.

We recommend that registered person's review staff deployment within the service.

We observed people were not rushed when supported by staff with their care, whether it was to meet personal care needs, support to mobilise to another part of the home or to have medicines.

The provider had not always followed safe recruitment processes to ensure that staff employed to work with people were suitable for their roles. Candidates had been asked for their full employment history but this had not always been provided. Registered persons had not identified gaps in employment and explored reasons for these. Most of the applications showed employment history in year only rather than months and years. This had not been recognised and action had not been taken to obtain more detailed information. For example, one staff member had gaps in their employment between January 2015 and January 2016, May 2003 and October 2014, November 1994 and June 2001. Another staff member had no employment history documented from leaving full time education in 1999 until 2007. Interview notes had been kept but any discussions that had taken place about gaps in employment had not been recorded.

The provider had failed to operate effective recruitment procedures. This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that staff were vetted through the Disclosure and Barring Service (DBS) before they started work and records were kept of these checks in staff files. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Nurses were registered with the Nursing and Midwifery Council and the registered manager had made checks on their PIN numbers to confirm their registration status. The provider was actively recruiting for a number of posts within the service which had become vacant due to two large organisations opening up in the local area which had attracted staff to leave the service. Staff vacancies were back filled by staff picking up additional shifts and through the use of agency staff. New staff shadowed experienced staff for a minimum of two weeks when they started to get to know people and the layout of the building. They also completed induction training. Agency staff, especially new agency staff were deployed to work alongside an experienced substantive staff member. All the staff and senior staff confirmed that this happened.

The registered manager and provider monitored accident and incident records to ensure that relevant actions had been taken. A monthly report was created which broke the accidents and incidents down in to categories, including what had been witnessed and unwitnessed. This enabled the registered manager to identify trends and look at ways in reducing the incidents happening again. One person had frequently

fallen, the registered manager had identified their health and mobility had deteriorated and they were supported to move to another area of the home. This had a positive impact on the person as the move had reduced the number of falls they had.

People told us they felt safe living at the service. Comments included, "Yes, I am safe here. It feels like my home"; "I think our belongings are safe, I leave our apartment door open"; "Yes, I have been here six and a half years now and I've always felt safe"; "I don't think you would find anywhere safer. Many of the young ladies [staff] here take a great interest in what they are doing and they make a great effort in doing it" and "Yes, yes, safety, there is no issue I think, not at all."

People continued to be protected from abuse. Policies were in place and available to staff. Staff told us about different types of abuse and were comfortable to report any concerns they had to the registered manager, department managers or provider. Staff were confident that any concerns they raised would be addressed quickly. The registered manager had raised any safeguarding concerns they had with the police, local authority safeguarding team and the Care Quality Commission. Training records evidenced that most staff had attended safeguarding training.

The service looked and smelt clean. Housekeeping staff carried out cleaning around the service as well as communal areas. The service had been well maintained. People told us, "The cleaning is good and the maintenance is quite good, there is no problem with that and you have free Wi-Fi in the rooms and all over the building, we use it for banking and shopping on line"; "They clean our apartment once a week"; "The overall standard of cleaning varies a bit, but it's not bad" and "This is a very upmarket home, and it will be even more upmarket, it is a nice place to live." Only 43 out of 115 staff had completed infection control training. There was plenty of personal protective equipment (PPE) in place to protect people and staff from cross infection. One member of staff reported that not all staff wear PPE when assisting people to use the toilet. We reported this the registered manager.

Repairs and maintenance of the service had been carried out in a timely manner. Where damage had occurred due to leaks, people were moved to another vacant room or suite so that the work could be completed in a safe and structured way. Since we last inspected the service, some areas on the ground floor had been redecorated and restyled. Further works were planned for other areas of the service. We observed people and their relatives using these areas to sit and chat, read newspapers and have coffee and tea.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 05 June 2018 we found that the registered provider had failed to show on every website maintained by them or on their behalf the Commission's most recent rating of Miramar Care Home. The registered provider had failed to effectively act on feedback from relevant persons on the services provided, for the purposes of continually evaluating and improving the service and had failed to maintain an accurate, complete and contemporaneous record in respect of each person's care.

At this inspection, we found continued concerns in relation to monitoring, evaluating and improving the service and issues with maintaining accurate records. At this inspection the provider had displayed their rating. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. We found the provider had displayed a copy of their rating in the entrance foyer and on their website.

Although there were systems and processes in place to monitor the service; these were not sufficient to get an oversight of what was happening in the service. The provider's audits had highlighted some areas of concern and action plans had been put in place. However, the systems were not robust enough to capture the breaches of regulations found during this inspection around medicines management, risk management and recruitment procedures.

An improvement plan was in place based on the outcome of the last inspection. The action plan had not robustly addressed shortfalls to topical medicines administration records (TMAR) and food and fluid charts. The action plan did not include information about how the provider will ensure that actions have been effective, such as checks and audits to make sure new processes are completed consistently by all staff. A number of dates had lapsed on the improvement plan which meant that the action to improve the service was taking longer than first identified. The improvement plan had not been reviewed and revised with new timescales. The regional manager agreed to send CQC an updated improvement plan each month.

We found inconsistent practice in relation to topical medicines recording, and food and fluid charts during the inspection. For example, one person's food chart records were inconsistent; some records detailed what the person had eaten. Some detailed how much the person had eaten and some records just stated the person had a balanced diet but did not say what they had eaten. We checked another person's electronic care planning records on 05 December 2018 and these showed that on 04 December 2018 the person had only drunk 5ml of fluid in a 24 hour period which was not sufficient to sustain good health. Another person's electronic record showed a red warning message to alert staff that the person had only been offered and had drunk 200ml of fluid in last 24 hours. Another person's care records showed the person had only drunk 30 ml of 600ml of fluid offered on 01 December 2018. The following day the person had only drunk and been 200ml of fluid. There were no records of how much fluid the person had been given on 04 December 2018, although their care notes mentioned that a few cups of tea and a glass of water had been offered. There was no evidence to show that the management team were checking the electronic system to check for concerns and issues.

Staff carried out audits called 'Well-being measures' on a monthly basis. This captured people's experiences as well as checks to ensure that care plans and risk assessments were up to date. Medicines for each person were counted as part of the wellbeing measure. However, only tablets and capsules were counted. No checks were undertaken of topical medicines. The wellbeing measures were submitted to the registered manager for checking and inputting. However, no audits and checks had been carried out to check the validity of the information. We looked at one person's completed wellbeing measure for November 2018 with the registered manager. The wellbeing measure had recorded that the person had a moving and handling risk assessment in place. There was not one. The wellbeing measure also recorded that the person's care plan addressed the person's religion culture and beliefs. Again, we checked and it did not. The registered manager agreed that random sampling of wellbeing measures were required in the future to help them monitor the service more closely.

We discussed embedding checks and audits with the registered manager. The registered manager told us they planned to implement senior care staff and nurse checks at the end of each shift to check that essential records had been completed and relevant action had been taken. This will include checking that TMARs, repositioning records, catheter records, fluid and food records have been completed and that care and support has been carried out in accordance with each person's care plan.

Call bell audits were carried out on a weekly basis. During the inspection we noted that each floor of the building had different times displayed on the call bell monitoring panels. For example, the first floor time was one hour behind the actual time. The ground floor panels were approximately half an hour behind the actual time. This meant that although the management team could identify the length of time call bells sounded for, the time of day could not be accurately identified.

The failure to establish and operated effective systems and processes to assess, monitor and improve the quality of the service. The registered persons had failed to maintain an accurate, complete and contemporaneous record in respect of each person's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was working their notice to leave the organisation. The provider had a plan in place to manage the service when the registered manager left. This included deploying an experienced manager who worked for the provider and had a proven track record of improving services to lead the service for at least a year and provide consistency for people and staff. A hand over period with the registered manager and the new manager working alongside each other was planned. We were told when the name of the new manager is known the provider will write to people and staff informing them. One staff member said, "[Registered manager] will be missed". Another staff member said that she had made "Positive changes". It was clear that people and their relatives knew the management team. The management team knew people's names and spent time engaging with them, answering queries and helping people if they needed it.

The role of deputy manager was vacant. The post had been advertised and applications had been received. The regional manager was clear that the deputy manager needed to have leadership skills and be able to work with and support the team. The provider was making changes to the management structure and some posts were being removed from the structure and new posts were being added. Staff were unsure what the new management structure would be and reported they found this "Very unsettling". People living at the service had also picked up on the staffing changes and were feeling unsettled. One person told us, "A lot of senior people have left. The chef, a senior carer, the head of maintenance and the registered manager is leaving and I am concerned what this will mean."

Staff morale was very low. Staff reported they were anxious about the future leadership of the service when

the registered manager leaves at the end of January 2019. All the staff we spoke with reported that the registered manager was approachable and supportive. The registered manager confirmed they checked with staff for their views every day. Staff said the registered manager was open to suggestions and acted on them. There were mixed views from staff about other members of the management team.

Some staff reported that they had not been paid correctly. The provider put this down to changes in the way staff signed in, to a short term paper system to a new electronic system. Some staff confirmed their pay had been corrected with support from the registered manager but there was often a delay in the payment being received. They all reported that this reduced their morale and did not make them feel appreciated by the provider.

Three staff reported that they had felt bullied by team members both current or past or had witnessed bullying. Staff had not reported this to the registered manager or provider so they could address it. One staff member raised a concern with the regional manager during our inspection, which they planned to investigate fully. Another staff member said that they have requested not to work with another staff member as they do not feel supported by them and this has been acted on the management team. One senior carer member of care staff said, "It's a nice place to work" and said they had never felt bullied.

Some staff reported that communication from the provider about changes was poor but they were informed by the management team. The provider had set up 'listening groups' provided by the regional manager. Staff had been invited to discuss any concerns or issues they had privately and confidentially. Six staff had taken up this opportunity. Three had raised concerns about not getting paid correctly and actions were being taken to address these concerns. Most staff were positive about the service and their role and enjoyed working at the service. No concerns about bullying were brought up.

Despite some staff reporting bullying and communication issues, staff reported that they worked as a team and described one senior care staff as "Amazing". They told us that most senior care staff lead the shift consistently. One senior care staff said, "I have a good team" and that staff worked well together. Another senior carer said, "We all try to support each other and work well as a team".

The provider had recognised following our last inspection and by attending meetings that many people were not joining the 'residents' meetings and sharing their views. The provider has arranged for three monthly 'residents' meetings for each of the three floors. We were told that people, their relatives and representatives and staff will be invited to share their views to ensure everyone has the opportunity to make their views known. One person said, "Each month there is a residents' forum. In the past there was a forum for catering and activities but Avery have modified that now." A second person said, "They have residents' meetings, I have been sometimes. There's certain residents that talk more than others and they seem to cover everything." Another person told us, "The people here are performing very well. I have thought the supply staff from the agency, one or two weren't very good and they didn't reappear. I only mentioned it very, very casually." Another person said, "I think the managers should come round more. I think it would nice if the managers sat with us at lunch times sometimes and saw what food we are getting."

The provider had implemented 'Resident of the day'. This was now in place for everyone. The people who were 'residents on the day' were recorded on the staffing allocations sheet so staff know who they are. Resident of the day includes staff spending time with people to review care plans and asking people for their feedback about their experiences of the service. This process had only started recently and had not always been completed correctly by staff. When this is identified staff were required to complete the process fully. One person told us they had requested to go for a paddle in the sea and had been supported to do this by staff with a couple of friends. They said it was "Amazing" and their face lit up with a huge smile as they told

us all about it. Another person had requested their favourite meal which was prepared for them. Another person told us they had been taken out on the bus to visit the bandstand on the promenade and had gone for a coffee. They explained that although they lived near the sea, they did not get to see it that often and therefore they like their residents' days and being taken out. They said, "I liked going to the bandstand." Another person told us, "My residents' day is on the 20th of every month. On 20th of every month I can get staff to come into my apartment and doing anything I want."

Staff, and other stakeholders had not been asked for the views of the service in the form of a survey since the last inspection, the provider planned to do this in 2019.

Staff were clear about their roles and responsibilities. Some staff were completing training to develop them for a new role and were very enthusiastic about his. The provider had emailed staff reminding them of their roles in the new residential and nursing units. Staff meeting minutes show that any concerns raised by staff were responded to with explanations about why changes were needed. Staff were thanked by the registered manager for their work. One read 'Thank you all, not been easy but you're doing well'. Staff were encouraged to speak with the registered manager about any concerns they had.

The provider had noted that there was a culture of communication by rumour at the service and many of the concerns people, their relatives and staff had was based on incorrect information. This had unsettled people. Emails had been sent to staff to address the rumours and concerns and verify why changes had been made. Staff were requested to discuss any concerns with the registered manager. One person told us, "It's a nice home, I like the home, I want it to be a happy home. I don't want you to think that things are going downhill, it is because things have happened and things are going in the right direction."

A staff recognition scheme was in place and people and staff could nominate staff who provided a good service.

A regional support manager had been supporting the registered manager to make improvements at the service. Improvements have been made to the Wi-Fi system at the service to ensure that electronic care recording devices are always connected to the server and all records are captured in the system. The provider has recognised that the electronic care planning system used at the service did not support staff to easily evidence the care provided to people and any actions taken. They have considered going over to a paper based system but have decided not to at this time as this will be further change and work for staff. A new electronic system is planned in the future, following trials in other of the provider's services.

There was now a food comments book in the dining room. This showed that on the whole negative comments were being made by one person. There were some compliments for the food as well, from people and their representatives. Work was currently being done to revise and review the range of food that was available on a day to day basis. Under the previous provider people could have whatever they wanted whenever they wanted. This was not manageable for kitchen staff. New menus were in place and records showed that people were offered a range of foods. One person said, "They do ask people's opinions. The chef comes to the meeting or one of the kitchen staff. There'll be one of the managers there. People express their dissatisfaction and the chef responds. Not really sure they put things into action." The management team had received compliments from a relative praising the service for providing excellent end of life care to their loved one. Another relative thanked the management team for improved communication.

The regional support manager planned to continue to visit the service regular, attend meetings and meet with people, their relatives and staff.

The registered manager worked in partnership with other professionals including a clinical nurse specialist for older people. A meeting was planned for 06 December 2018. We received feedback to evidence that this had taken place and that support to the registered manager and the service had been discussed. Since the last inspection the service had joined the red bag scheme. The red bag scheme is scheme put in place to improve transfer pathways between care homes and hospitals. Care staff pack a dedicated red bag that includes the person's paperwork, medicines, discharge clothes and other personal items. The registered manager was due to collect the red bags before the 09 December 2018.

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

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Registered Persons had failed to operate effective recruitment procedures. Regulation 19 (1)(2)(3)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons had failed to do all that is reasonably practicable to mitigate risks to people. The registered persons had failed to ensure the proper and safe management of medicines. Regulation 12 (1)(2)

The enforcement action we took:

We served the registered provider a warning notice and asked them to meet Regulation 12 by 31 January 2019.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Registered persons had failed to establish and operated effective systems and processes to assess, monitor and improve the quality of the service. The registered persons had failed to maintain an accurate, complete and contemporaneous record in respect of each service user's care. Regulation 17 (1)(2)

The enforcement action we took:

We served the registered provider a warning notice and asked them to meet Regulation 17 by 31 January 2019.