Caring Homes Healthcare Group Limited

Miranda House

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**

Summary of findings

Overall summary

At the comprehensive inspection of this service in October and November 2015 we identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the registered manager and provider with two warning notices and five requirements stating they must take action. We shared our concerns with the local authority safeguarding and commissioning teams.

This unannounced inspection was carried out to assess whether the provider had taken action to meet the warning notices we issued. We will carry out a further unannounced comprehensive inspection to assess whether the actions taken in relation to the warning notices have been sustained, to assess whether action has been taken in relation to the five requirements made at the last inspection and provide an overall quality rating for the service.

This report only covers our findings in relation to the warning notices we issued and we have not changed the ratings since the inspection in October and November 2015. The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Miranda House on our website at www.cqc.org.uk.

At this inspection we found that the provider had taken action to address the issues highlighted in the warning notices. Risks people faced were being effectively assessed and managed. Staff had clear information about the support people needed. They demonstrated a good understanding of people's needs and the support that was required to keep people safe. Staff were following the actions listed in the risk assessments and kept clear records of the care and support they provided.

The service was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had taken appropriate action when they assessed that people did not have capacity to make a decision. Staff had completed additional training in the MCA and DoLS and demonstrated a good understanding of the principles of the Act. People's care records contained detailed and decision specific mental capacity assessments and the provider had made DoLS applications to the local authority where appropriate.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

We found that action had been taken to improve safety for people who use the service.

Improvements had been made to the systems to assess and manage the risks people faced. Risks were being assessed and there were effective action plans, which were followed in practice to keep people safe.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

Is the service effective?

Inadequate

We found that action had been taken to improve the effectiveness of the service.

The service had taken action to ensure they were meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

We have not changed the rating for this key question from inadequate because to do so requires a full assessment of all the key lines of enquiry for this question. We will complete this assessment during our next planned comprehensive inspection.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We undertook a focused inspection of Miranda House on 8 June 2016. This inspection was completed to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection of October and November 2015 had been made. We inspected the service against part of two of the five questions we ask about services: is the service safe and is the service effective. This was because the service was not meeting legal requirements in relation to those questions and we issued warning notices following the comprehensive inspection. The inspection was undertaken by one inspector. Before our inspection we reviewed the information we held about the home. This included the provider's action plan, which set out the action they would take to meet legal requirements.

At the visit to the home we spoke with the registered manager, a peripatetic manager who was working at the service to help implement the action plan, the deputy manager, three health care assistants and two nurses. We spent time observing interactions between people who use the service and staff. At the visit we looked at four people's care planning records. We also looked at records of care provided for all people using the service, including food and fluid monitoring charts, wound management records and pressure care records. Before the inspection we received feedback from health and social care professionals who had been working with the service.

Inadequate

Is the service safe?

Our findings

At our comprehensive inspection of Miranda House in October and November 2015 we found the service had not taken effective action to manage the risks people faced. This was a breach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of the concerns, we served a warning notice on the registered manager. The registered manager wrote to us with the action they were going to take to address the issues. At this inspection we found that the registered manager had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 12 described above.

We assessed the care files of four people who use the service and records of the care provided for everyone using the service. Each person had a set of assessments covering risks they faced and the action staff should take to manage those risks. These documents had been reviewed since the last inspection. We saw that risks in relation to physical and verbal aggression, pressure damage, unintended weight loss and mobility / falls had been assessed and there were clear plans about action staff should take to provide care safely.

Where people were assessed as being at increased risk of falls, there was clear information about the equipment they needed to help keep them safe, such as walking frames and wheelchairs. The plans included information about how to use equipment people had been assessed as needing. Referrals had been made to the occupational therapist and they had been involved in designing people's plans where necessary.

There were clear plans in place for people who could become aggressive as a result of their dementia. The plans contained details of the behaviours people could demonstrate and the actions staff should take to support the person and keep them and others safe. These plans were specific to the person and were reviewed following incidents to assess whether any other measures should be used to support the person.

People had assessments of their risk of developing pressure ulcers and there was clear information on the actions needed to manage those risks. Where assessed as necessary pressure relieving equipment, such as mattresses and cushions were in use. Where people were identified as needing assistance to regularly re-position to minimise the risk of pressure damage, there was clear information about how frequently the re-positioning should occur. Records of care provided indicated people were supported to change their position in line with the care plans.

People had assessments of their risk of malnutrition and dehydration and there was clear information on the actions needed to manage those risks. Food and fluid charts were in place for people assessed to be at risk and had been fully completed. The amount people had to drink was totalled each day and action taken where people were not drinking enough to keep them hydrated. Staff were trying different ways to support people to drink more, including offering ice lollies in hot weather, a range of different drinks and regular support from staff reminding people to drink and assisting people where necessary. Food supplements people had been prescribed were being well managed. Staff kept a record of the support people received to

take supplements on the medicines administration record. This gave a record of the supplements people had received and there was a record of how many supplements they were holding for people.

There were clear care plans in place to manage any wounds people had. The plans included photographs, that were regularly retaken to record the healing process or any deterioration in the wound. Records indicated dressings had been changed and wounds re-assessed within the time-scales specified on the care plan.

Staff demonstrated a good understanding of people's needs in relation to risk management and said they now received much clearer information about how to keep people safe. Staff told us prompt action was taken when they reported a concern, for example if someone was not eating or drinking or if there had been a change in their mobility. Comments from staff included, "Changes are picked up quickly. Things are tighter, there's a better oversight of the risks", "Things have improved. We are involved in developing people's care plans and I'm confident people are safe. Action is taken on the back of the risk assessments" and "Things have improved greatly. We're on the right path now. (The peripatetic manager) is brilliant, a very good manager. I'm confident people are safe and risks are being managed. (The registered manager) will come in to provide support if needed".

The management team held a heads of department meeting each day. This brought together senior staff across the home to review the service being provided and plan a response to any issues they were experiencing. Records of these meetings included a review of people who were not eating and drinking enough to check suitable plans were in place to support them, a review of any incidents and plans in place to manage them and a review of anyone identified to be loosing weight and the plans in place. This helped to ensure there was clear communication about any emerging issues and there were clear plans to manage risks that were being identified.

Inadequate

Is the service effective?

Our findings

At our comprehensive inspection of Miranda House in October and November 2015 we found the service was not meeting the requirements of the Mental Capacity Act 2005 or the Deprivation of Liberty Safeguards. This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As a result of the concerns, we served a warning notice on the provider. The provider wrote to us with the action they were going to take to address this issue. At this inspection we found that the provider had followed the action plan they had written to meet shortfalls in relation to the requirements of Regulation 11 described above.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection we found staff had taken appropriate action when they assessed that people did not have capacity to make a decision. Staff had completed additional training in the MCA and DoLS and those we spoke with demonstrated a good understanding of the principles of the Act. People's care records contained detailed and decision specific mental capacity assessments and the provider had made DoLS applications to the local authority where appropriate. At the time of the inspection 48 applications had been made to the local authority, 19 of which had been authorised. The other applications were still being assessed by the local authority.

The registered manager had a log of decisions that had been made which involved a deprivation to the person following assessments that they did not have capacity to consent to a decision. These were reviewed regularly to ensure the actions that were being taken followed the principle of the least restrictive option to provide the care and support that people needed.

The registered manager reported she had obtained copies of any power of attorney documents that people using the service had in place. A power of attorney has legal authority to act on a person's behalf in some circumstances and can relate to decisions about finance or the person's health and welfare. Details of these powers were included in people's care plans. Where there was no power of attorney in place, staff had made decisions in people's best interest, following consultation with a range of people, including families and professionals. Staff were clear that a family member without power of attorney for health and welfare decisions could not consent on behalf of the person.