Caring Homes Healthcare Group Limited

Miranda House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service
Miranda House is a nursing home for up to 68 older people. Most of the people living at Miranda House live with dementia. Accommodation is on two floors which are accessed by a lift. There were communal areas on each floor including lounges and kitchen areas. The home has a garden which people can access on the ground floor. At the time of our inspection there were 55 people living at the service.

People's experience of using this service and what we found
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests. The policies and systems in the service supported this practice, however, the documentation for recording assessments of mental capacity were not always clear. We discussed this with staff who told us the provider was reviewing documentation. We have made a recommendation about recording best interest processes.

The provider's pre-admission assessment tool had not always been completed in full when an assessment had been carried out. This meant we could not be sure all of people's needs had been assessed. However, there was supporting documentation from other agencies collected as part of the pre-admission assessment.

People were cared for by staff who had been trained and were supported in their roles. Mealtimes had improved since our last inspection, but further work was needed to support people with meals in their own rooms. People were supported to choose their meal when sat at the table which was effective for people with dementia. Kitchen staff had a good overview of people's dietary needs and met regularly with care staff to monitor people's weights.

Where a referral was needed to a healthcare professional, staff did this in a timely way. Local GP's visited weekly or sooner if needed and staff communicated people's needs effectively. Staff had handovers with each other and daily meetings to make sure all staff were up to date with people's needs.

All relatives we spoke with at Miranda House were very positive about the care and support provided. They thought the service was safe and there were sufficient staff available to help. We observed there were enough staff on duty and reviews of staffing rotas confirmed this was consistent. People were supported by staff who had been recruited safely with required checks carried out by the provider. Risks had been assessed and there were management plans in place to give staff guidance on action to take. Medicines were managed safely with nursing staff taking responsibility for administration.

People had been involved in their care and were cared for by staff who were kind and caring. We observed many positive interactions with people and staff that demonstrated staff knew people well. Information on people's background had been collected and shared with staff so they knew who people were. Relatives were welcome at any time and many brought their dogs in for people to interact with.

People had their own personalised care plan which recorded all their needs. Care reviews were held regularly, and care plans updated when needed. Where people required additional monitoring, this was carried out and care delivered was recorded in people's files. Activities were provided and planned with people and relative's involvement. The home had a mini-bus which was used to take people out into the local community. People's end of life care needs were recorded and many people had chosen to stay at Miranda House until the end of their life.

There was a new registered manager who had made many improvements. People, relatives and staff all told us the registered manager was approachable, visible and listened to everyone. There were meetings for people, relatives and staff which were held regularly. People's views were sought, and surveys carried out. The registered manager took action to improve the service in response. Quality monitoring was in place and the provider had a good oversight of this service. Complaints were logged and monitored. The service had received many compliments about the care provided at Miranda House.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 10 December 2018) and there were three breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations. We have made one recommendation in the key question Effective.

Why we inspected
This was a planned inspection based on the previous rating.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Miranda House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two 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.

Service and service type
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.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who use the service and seven relatives about their experiences of the care

provided. We spoke with 13 members of staff, the registered manager and the regional manager. We 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 reviewed a range of records. This included 10 care plans, 18 medicines administration records and six staff files in relation to recruitment. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at activity information and the complaints procedure. We contacted 11 healthcare professionals for their views and feedback about care and support at Miranda House.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people were safe and protected from avoidable harm.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People's medicines were managed safely. Since the last inspection the deputy manager had made improvements to make sure systems to manage medicines were safe. The medicines administration records (MAR) had no gaps in recording. All handwritten entries had been signed by two members of staff which reduces the risk of transcribing errors.
- People who had their medicines covertly had guidance for staff to know how to administer medicines. Staff had consulted with a pharmacist to make sure medicines could be safely administered when mixed with food or drink.
- Where people were prescribed 'as required' medicines there was guidance in place to help staff to understand when to administer this type of medicine. Where people were prescribed a medicine to be given using a patch staff recorded where on the body the patch had been applied.
- Staff recorded on a topical medicine administration record (TMAR) when they applied a cream or lotion. All those seen had no gaps in the recording and a body map to guide staff on where to apply all creams. Staff had recorded on creams and lotions the date they were opened which follows best practice guidelines.
- We observed nursing staff administering medicines on both days of our inspection and saw their practice was safe. They had knowledge of people's needs and knew how they liked to take their medicines. People had an identification sheet which held key information such as allergies and a current photograph. On the reverse were details of how people wanted to take their medicine. For example, if they wanted it with their meal, on a spoon and what drink they would like.

Assessing risk, safety monitoring and management; Preventing and controlling infection

At our last inspection the provider had failed to make sure people felt safe in their environment and keep the home clean and well maintained. There was also limited information in people's personal evacuation plans (PEEP). This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People had a PEEP in place which contained up to date information to help staff evacuate people in the

event of an emergency.
● At our last inspection we saw people did not routinely have a call bell in reach. At this inspection we saw this had improved.
● Risks had been identified and assessed. Staff had good guidance in place to guide them on how to support people safely. Assessment of risks included areas such as pressure ulcer prevention, malnutrition and falls.
● The provider had generic risk assessments in place to make sure staff worked following safe systems. Fire systems were tested, and fire equipment was serviced regularly. Safety checks of the environment and equipment were carried out regularly. For example, bed rails, window restrictors, toilet frames and shower chairs were all regularly checked for safety and signs of wear and tear.
● At our last inspection the environment was not always clean, and we observed staff using unhygienic practice. At this inspection staff were following good infection prevention and control practice. There was personal protective equipment available and staff used it appropriately. Staff were assessed on their practice such as handwashing techniques.
● The home was clean and whilst there were some odours we observed staff taking remedial timely action. One relative told us, "The service is very clean, they [staff] are always cleaning the place to a high standard; they are very good and clean very well, there is no scrimping."
● Infection prevention and control training was provided to staff and regular audits were carried out every other month. We observed results in audits had improved over the months.

Systems and processes to safeguard people from the risk of abuse
● People and relatives told us the service was safe. Comments from them included, "The quality of care here is second to none, the staff do an absolutely wonderful job and I know they [relative] are safe" and "Staff are able to resolve any tensions, or individuals that maybe experiencing distress in a very nice tactful way. Nothing ever gets to a difficult point."
● Staff had been trained on safeguarding people and were knowledgeable about the different types of abuse. Staff knew how to report concerns and were confident the appropriate action would be taken.
● The registered manager and regional manager understood their responsibilities to report incidents of safeguarding to the local authority and CQC.

Staffing and recruitment
● People were being cared for by staff who had been recruited safely. The provider carried out the necessary pre-employment checks. This included a check with the disclosure and barring service (DBS). A DBS check helps employers make safer recruiting decisions.
● The provider checked all nurses had a current registration with the nursing and midwifery council.
● There were sufficient staff on duty. Staff rotas demonstrated staffing was consistent. The service rarely used agency which made sure people had a consistency with staff caring for them. The registered manager audited call bell data to make sure staff responded to people's requests for help in good time. Data we reviewed demonstrated call bells were being answered in two minutes or less.

Learning lessons when things go wrong
● Accidents and incidents were recorded and investigated to look at causes. Management reviewed all incidents and where needed took measures to reduce the risk of re-occurrence.
● Staff were able to discuss incidents at handovers and daily meetings. This enabled any learning to be discussed.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.
At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has improved to good. People's outcomes were consistently good, and people's feedback confirmed this.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
● At our last inspection we saw that mental capacity assessments had not been completed to a consistent standard. There was also not enough information in the best interest decision making process to identify the decisions being made. At this inspection we saw whilst some improvements had been made, further improvement was needed.
● Where people lacked capacity, the provider used their own MCA document to record the assessment and the best interest decision making process. Whilst we saw staff had completed the assessments of capacity it was not always clear what the outcome of the assessment was. Staff told us that where a best interest section had been completed this would mean the person lacked capacity. We discussed this with the providers dementia lead for the region who told us the documentation was currently under review.
● Best interest decisions had been made for some people with the involvement of family members. This part of the process required improvement. We were not always clear what options had been considered so the service could not demonstrate they were adopting the least restrictive. In addition, staff had not always clearly recorded who had been involved in this process. For example, for one person we saw staff had recorded that 'family' had been involved. We were not clear who this was.

We recommend the provider seeks advice and guidance to review the documentation used to record best interests decision making.

● The service had applied to the local authority for DoLS authorisations. Some had been assessed and granted. Where there were conditions on authorisations the service was meeting them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● Prior to admission people were assessed by management or senior staff. We saw that some pre-admission assessments were not completed in full. Whilst staff had obtained some additional information from other agencies this did not provide information for all of people's needs. For example, one person we saw had no information recorded in their nutritional needs section. For another person we saw the sections for mobility and hobbies was blank. This meant we could not be sure people had all their needs assessed prior to admission. We raised this with the regional manager during our inspection who told us they would address this shortfall.
● People's needs were continually assessed by the nursing team. They used nationally recognised assessment tools to assess people's needs in areas such as pressure area development.
● The provider had an oral health assessment which we saw had been completed for people. We did see one assessment that had not been completed which we shared with the regional manager. They assured us they would ask staff to complete this immediately.

Adapting service, design, decoration to meet people's needs
● People were living in a purpose-built environment that needed updating in some areas. Some flooring required replacing and we saw there was one room which could be confusing to people. It had been identified as a sensory room which is an area which can provide sensory stimulation to people. However, it had become filled with furniture and objects that prevented it from being used appropriately. The registered manager had identified this, and we saw it was part of the service environment action plan to re-develop this room.
● The provider had a plan to develop the environment and make improvements. However, there had been a property emergency which had paused re-development work. The regional manager told us once this issue had been dealt with planned works would resume.
● Following our last inspection, the provider had taken action to improve some areas. For example, there was new signage up to help people find their way around the building. Some areas had been re-painted and new artwork had been bought.

Supporting people to eat and drink enough to maintain a balanced diet
● At our last inspection we saw that staff were not recording people's food monitoring charts accurately. At this inspection this had improved. Monitoring charts we saw were completed in full. Charts were stored in people's rooms so staff could record food and fluids at the time of delivery.
● Some people who were eating their meal in their rooms had to wait for assistance. In addition, some of the support they had was not as effective as support offered in the dining room. For example, people in rooms did not have a visual choice of meal or the social experience people in the dining room experienced. The regional manager told us that due to the amount of people needing support service of meals had to be staggered slightly. The registered manager told us they had worked to improve mealtimes and were planning further developments. They were aiming for a whole home approach to mealtime support. This meant that all staff regardless of their role would help people at mealtimes. This would provide more staff to enhance mealtimes further.
● People eating in the dining areas were supported to eat and drink by staff who were knowledgeable about people's needs. Mealtimes we saw in dining rooms were relaxed with staff offering people choices of meal when sat at the table. For people with dementia this was more effective than having to choose the day before or earlier in the day. Food looked and smelt appetising and people could have as much as they wanted to eat.
● Staff sat down with people to eat their meal and provided support in an unhurried way. Staff used this opportunity to engage with people and make the mealtime a social event.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live

healthier lives, access healthcare services and support

● At our last inspection transfer booklets which recorded key information for people to take with them to hospital were in use, but they lacked detail about how to support people. At this inspection improvement had been carried out. Booklets were completed with enough detail to give emergency medical staff information to meet people's needs. The registered manager had reviewed the procedure for transferring people to hospital and added some effective systems to give staff guidance.

● People were referred to appropriate medical professionals when needed. A local GP visited the home weekly and reviewed people's health needs where needed. We observed evidence in people's care plans that referrals had been made to speech and language therapists, opticians and occupational therapists. People were also referred to the dentist when needed. One healthcare professional told us, "I often see examples of great care, where nurses and carers really know their residents and understand their needs."

● Staff used handovers and daily head of department meetings to share information about people's needs and events that had happened.

● People's relatives were informed where appropriate about any health matters. Staff recorded communication with relatives in people's care plan. One relative told us, "The service always calls me to let me know if anything has happened, I am confident that they would always call me if they needed to."

● Care staff worked with the kitchen staff to make sure people's dietary needs were kept up to date in the kitchen. The chef had up to date information on people's diets, weights and allergies as well as people's likes and dislikes.

Staff support: induction, training, skills and experience

● People were being supported by staff who had received training. The provider had a range of training which staff completed during their induction. Once this had been completed there were updates as needed.

● The provider made sure staff received training in areas such as first aid, moving and handling, dementia and mental capacity act. Training was a mix of e-learning and face to face. One member of staff told us, "They [registered manager] ask if we need training, if we say we need it we get extra training."

● Staff had opportunity for supervision with their supervisor. This process enabled them to talk about any concerns they had and any further training needs. Staff told us they felt supported by the provider and management. Comments from staff included, "Supervision is useful because whatever we express, [registered manager] will make sure concerns are solved" and "[Registered manager] did my last supervision, you give your input and they give you theirs. It is always nice to hear you are doing a good job and we get asked about training."

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good.
This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
● At our last inspection we observed incidents where staff were not providing care that was person-centred and respectful of people's wishes. At this inspection we observed the staff approach had improved and people were treated with respect.
● People and relatives told us the staff were caring. Comments about the staff included, "This is a very unique home and the circumstances they [staff] are working. There are adequate staff here to meet the need for the home, it is just enough to keep people engaged. Staff work hard to make people happy and engaged here. The quality of staff they employ are the best", "The atmosphere is alright, it is very good and [relative] seems happy" and "They [staff] are such a lovely bunch of people, they are so family orientated here. The staff are first rate, absolutely no question of it. They are not here for the salary, they are here because they are genuinely good people."
● We observed staff were kind and caring towards people. Staff took their time with people and helped them to communicate their wishes. Where people had specific communication needs staff followed guidance in people's care plans. For example, one person who did not have English as their first language used a board to communicate. The board had translations on to help the person communicate with staff more effectively.
● People's backgrounds and life history information was recorded and available for staff to read in people's rooms. Staff used this information to talk to people and understand their needs. One member of staff told us, "I treat everyone how I would like my mum or my grandma to be treated."
● The service had received many compliments and thank you cards from relatives that were on display in the reception area. One relative told us, "It is a very settled existence here, it is very good and brings me lots of comfort to know how my loved one is being cared for properly."

Supporting people to express their views and be involved in making decisions about their care
● People were offered choices such as where to spend their time, what to eat and drink, what to wear and what they wanted to do. People were also involved in care reviews which were held regularly to review the care and support provided.
● People had a keyworker. This was a member of staff identified to work with them more closely. This system helps people build relationships with a particular staff member who got to know people and their families well.
● People were encouraged to attend 'resident's meetings' to discuss with the registered manager views about their care and support. The chef told us they attended these meetings to plan menus based on what people wanted. Minutes were kept and shared with the staff.

Respecting and promoting people's privacy, dignity and independence

● People's personal information was treated with respect and held securely. Staff understood the need to respect privacy, we observed them knocking on people's doors before going into their rooms. We also observed staff were respectful when needing to communicate with each other about people. This type of conversation was held in the care office or discreetly, so it could not be overheard.

● Staff told us how the promoted dignity when providing personal care. They told us they made sure doors were shut, they always made sure people were covered with a towel and always told people what they were going to do and asked if it was ok to do this. One person told us, "'I feel respected living in here, I don't look for complaints." People were asked what gender of care worker they preferred. Their preferences were recorded in people's care plans. Privacy and dignity were woven through people's care plans to act as a prompt for staff.

● People were encouraged to do as much as they could for themselves to promote independence. For example, people being supported to eat at a mealtime were given verbal encouragement by staff, gentle prompting to try and eat their meal themselves. One member of staff told us, "We encourage people to do what they can, choose their own clothes, have their own breakfast. If they are able to walk, we encourage them to walk, just standing behind them just in case."

● People's relatives and friends were able to visit at any time and were welcomed by staff. One relative told us, "I can come in any time to have something to eat with my loved one. I regularly come in on a weekend, we are offered soup and rolls. The food is excellent, it always looks nice."

● The provider's dementia lead told us they were working with families in the home to help them gain a better understanding of dementia and how to support their family members. They planned regular talks with families and the provider was going to make dementia training available for families to do if they wished.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

At our last inspection the provider had failed to make sure information in care plans was consistent to promote person-centred care. This was a breach of regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

- At our last inspection we observed care that was not person-centred. Staff were not responding to people's needs and some mealtimes were chaotic. At this inspection improvements had been made and our observations demonstrated that staff approach had improved.
- People were being supported by staff who were responsive and worked as a team to provide care and support. The registered manager told us as they were fully recruited in nurses at the home. They had organised rotas, so nurses worked alongside carers in a caring role. This had provided staff with mentoring and a nurse we spoke with told us this had enabled them to learn more about people's needs. New information had been used to develop the care plans. One member of staff told us, "You get to know people well working with care staff, this helps with the care plan."
- At our last inspection we saw care plans lacked details about people's needs and preferences. At this inspection there had been significant improvement to care planning with good details being recorded. Care plans had been reviewed regularly and updated when needs had changed.
- The regional manager told us staff had worked hard over the past year to improve care plans. The registered manager had carried out person-centred workshops to help staff identify dignified words to use and person-centred information to record in plans. They said their approach was that staff would "write it, talk about it and believe in person-centred care". Staff had recorded a one-page summary which outlined people's needs. This was kept in people's rooms so newer staff would know at a glance what people's needs were and what was important to the person.
- At our last inspection daily notes were task focussed and generic in places. At this inspection this had improved but still needed further development. Some people's daily notes captured basic information mostly around how staff had provided personal care. There was little additional information around supporting people's social and emotional needs. The regional manager and registered manager told us this was part of the improvement plan for the home and the next step to take. Staff had made improvements to recording but now needed to "take it up a level". The registered manager planned some further workshops to support staff to develop their recording.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● People's communication needs had been identified and recorded in their care plans. Where people required help to communicate this had been sought. Guidance in people's care plans encouraged staff to think about their body language and facial expressions when communicating with people.

● The provider could provide information in a range of formats. This included a larger font and pictorial information. We saw menus were provided in a picture format as was the complaints procedure.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● People were supported by a team of activities staff who planned a programme of social events and activities. Plans were available around the home to inform people what was happening daily. Activities staff told us they met with people monthly to ask people what they wanted to do. One relative told us, "We have seen the school being involved and some of the residents visit the secondary school, so there is a lot going on really. The Activities Co-ordinator does a lot of work, she has a lot of energy and is very attentive. She has worked with us to work out what our family members would like to be engaged in activities wise, so there is always a good range of things on offer."

● The service had access to a mini-bus which could be used to transfer people to the local community or on a planned trip to a place of interest. During our inspection we saw some people going out on the bus for a planned trip out.

● Activity plans demonstrated there was a variety of activities available including baking, music sessions, arts and crafts and pamper sessions. Activity staff told us they organised for local schoolchildren to visit, which the "residents love". They also told us a therapy dog visited to enable people to interact with it. Family members were encouraged to bring their dogs in if they were suitable. One relative said, "They [staff] are very good, they let me bring my dog in to visit which I think is lovely. It really helps bring a sense of family and homeliness."

● Miranda House is positioned in the same grounds as a church. People were able to visit the church easily and clergy regularly visited the home. One relative said, "My [relative] has a church visitor every Sunday, from the Catholic Church. The home is very well thought of in the community."

● People who did not want to leave their rooms or could not leave their rooms were visited by activity staff to provide one to one activity. One member of staff told us, "I try and focus on people in their rooms, or people who won't leave their room. That is my goal, to make them feel wanted and loved whilst they are here."

Improving care quality in response to complaints or concerns

● People and their relatives were given the providers complaints policy in a 'service user guide' when they came to the service. The complaints procedure was also available in the home if people needed further information.

● The registered manager kept a log of complaints and investigations carried out. Since they had started in their post complaints had reduced. They told us they hoped this was because they were visible working with staff, so people and relatives could approach them before issues escalated. One relative said, "There isn't very much to complain about. [Registered manager] is very good, he sorts things out straight away." Another relative told us, "We would be happy to raise concerns openly and objectively, which is refreshing."

● The provider had an overview of compliments and complaints. They monitored complaints for any patterns or trends.

End of life care and support

● People could be supported at the end of their life at Miranda House. The staff team worked with local healthcare professionals to make sure people were comfortable and pain was managed.

● People had the opportunity to record their wishes for the end of their life and share what they wanted to happen. We saw many people had stated they wished to stay at Miranda House for end of life care rather than be transferred to hospital.

● There was nobody receiving end of life care during our inspection, however staff and the GP had prepared some medicines for some people to be ready 'just in case'. This enabled staff to act responsively should those people's health deteriorate.

Good

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now improved to Good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to have effective quality monitoring in place which assessed risks to people's safety, identified areas for improvement and produced timely action plans. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

- Since the last inspection there had been changes to the senior management. There was a new regional manager and a new registered manager. These changes had improved provider and management oversight of this service.
- Accidents and incidents had been monitored monthly by the registered manager. Reviews and analysis had made sure action needed had been taken and we saw outcomes for people had improved. For example, in April 2019 there were 25 falls, in September 2019 falls had reduced to three for the month.
- The provider had a programme of quality monitoring in place. Staff completed regular audits according to the provider's timescales. For example, the deputy manager carried out monthly medicines' audits. Any actions were shared with staff and monitored until completed. The regional manager monitored quality monitoring to make sure action taken was completed in a timely way. This system had improved quality monitoring which had led to improvements in care delivery and support.
- The provider supported staff to develop their skills and knowledge which created a culture of learning and improving care. The deputy manager told us they had the opportunity to complete an additional nursing qualification which they were doing at the time of our inspection. Another nurse told us they were becoming the tissue viability link nurse which involved additional training. Staff told us about opportunities they had to complete work-based qualifications which they were pleased to do.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had a duty of candour policy which it implemented following any incident or accident. Where appropriate the service apologised to people or their relatives. During our inspection we found the regional manager and registered manager to be open and honest about areas for improvement. They recognised there were still some improvement to be made and were working as a team to take the action required.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● People were being supported by staff who enjoyed working at the service and strived to provide person-centred care. Comments from staff included, "I am very passionate about the dementia side of things and 'Living in their world' training", "It is nice to work here, we provide good care to people with dementia" and "I love it here, I love the residents. It is a very rewarding job, I would like someone to look after me the way I look after them,"

● People, relatives and staff we spoke with told us the service was well-led. The new manager had made a difference and made improvements which were appreciated. Management were visible and supportive. Comments from people, relatives and staff about the registered manager included, "Since [registered manager] has taken over he has been good, if you have any concerns he will invite you to the office to talk about it", "The manager we have at the moment is fantastic, he has changed a lot and there is more of a positive vibe. He is very easy to talk to, you just tap on his door at anytime and he will chat with you" and "[Registered manager] is very polite, very approachable, he is trying to bring the home up and improving things."

● The providers dementia lead had carried out observations at the home to help develop the dementia care and support. They visited the service regularly. We saw their observations were available for staff to see and discussed at team meetings. This enabled staff to reflect on their practice.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives had been asked for their feedback. The provider carried out surveys which people and relatives had been invited to complete. There was also a suggestions box in the reception area of the home where people and relatives could leave their comments. One relative told us, "We have received surveys to give feedback on the service, we can feedback at any time we feel we need to, we are not restricted to this. We have attended a relatives forum to give feedback."

● The registered manager took action on feedback received from people and relatives. For example, people and relatives had raised concerns about staffing. In response the provider had increased recruitment so that agency use was down to 0 hours.

● Team meetings were held monthly for staff with minutes kept of discussion. There were meetings for different roles and general staff meetings for any staff to attend. 'Relatives and residents' meetings had been held so the service could keep people up to date with events and developments.

● Staff told us they thought there was good team work at Miranda House. Comments from staff included, "The team works well, everyone tries to support each other" and "It is a lot better now than it used to be, we are more of a team now, we are much more united."

Working in partnership with others

● Staff worked in partnership with a range of professionals which helped to make sure people had the support they needed. One healthcare professional told us, "When I've visited I found the home in pretty good order, staff seemed to be busy and engaging with residents and there was a nice atmosphere."

● Miranda House had links with the local community. People used local services in the home such as a hairdresser, visiting clergy and local healthcare teams. People also accessed local services in the surrounding areas. One relative told us, "There are some very good community links, the home is represented in the local carnival, so they always have a presence."