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
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Miranda House provides accommodation and nursing care for up to 65 people with complex dementia needs and at the time of the inspection there were 63 people accommodated. At the previous inspection the home was found to meet the standards inspected.

This inspection was unannounced and took place on 13, 16 and 21 October 2015 and 17 November 2015

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People did not receive their care and treatment in a safe way. Risk assessments were devised for people at risk of falls, for people at risk of developing pressure ulcers (sometimes known as bed sores)and for people at risk of

Summary of findings

malnutrition. Action plans to mitigate the risk were not followed by the staff. For example, pressure ulcer dressings were not assessed according to the tissue viability wound management plan.

People were not protected from safe medicine management. Medicine Administration Records (MAR) were not signed by staff when medicines were administered. Accurate records of the stocks held were not maintained and the temperature of the room where medicines were kept was above the acceptable range. People were prescribed a combination of anti-psychotic and medicines for agitation and to induce sleep. For some people these medicines could cause people to fall over causing harm and injury.

People were at risk from the spread of infection. Bins with lids were not provided in bathrooms, food was taken from the kitchen and from dining rooms to people's bedrooms uncovered. Staff were not using appropriate boards to prepare breakfast and were using the same utensils to spread butter and jam on people's toast. On our return visits we found some improvements in where staff prepared meals and we saw staff using lids on meals being taken to people's bedrooms.

People did not benefit from consistent staff supervision. Some staff did not always interact with people in a positive manner. We saw staff speak to people without eye contact or not giving the support to reduce people's levels of anxiety. We saw people entering and leaving other people's rooms and consistently walking the corridors. Interest points were not provided and memory boxes that helped people find their rooms were empty.

Staff did not show a clear understanding of the principles of the Mental Capacity Act (MCA) 2005. For example, there was family involvement for best interest decisions when they did not have the authority to make these decisions. Consent was gained from a relative to deliver personal care to one person who refused personal care. Guidance was not provided to staff on how to manage situations when people became aggressive or violent towards staff attempting to deliver personal care.

Best interest decisions were made by staff without first assessing people's capacity to make these decisions.

Some people were placed at higher risk of falls by best interest decisions that were made. For example, taking walking aids away from a person in bed to maintain clear pathways in the event the person got out of bed.

The care plans in place were not up to date and did not reflect people's current needs. For example, we saw people with injuries but care plans had not been developed to manage the wound. We found intervention charts which should be used to monitor the effectiveness of the care plans were not completed as required. Daily reports were not consistent with the intervention charts. Staff had documented for some people a good intake of fluid but the intervention charts showed the fluid intake was below the recommended fluid intake.

Records were not completed accurately and in a timely manner. We saw staff recording that they had checked people at 30 minutes intervals. However the record was completed three hours later. Medicine Administration Records (MAR) were signed to show fortified drinks were administered twice daily although the stocks in place showed they had not been administered.

Quality assurance arrangements were place to assess people's safety and wellbeing. However, medicine audits had not identified poor stock control systems and the poorly ventilated medicine room.

New staff received an induction and attended training needed to meet people's specific needs. For example dementia awareness. Staff were supported with their roles and responsibilities. Staff with lead roles such as nutrition and End of Life had the training needed to undertake additional roles. One to one meetings where staff discussed concerns, personal development and performance took place with their line manager.

Safeguarding adult's procedures were in place and staff attended the training which helped them identify the signs of abuse. Members of staff knew the signs of abuse and the responsibilities placed on them to report suspected abuse. Some relatives said their family member was safe living at the home.

People had a choice of meals at mealtimes and snacks were provided between meals. Fortified meals were provided to people at risk of poor nutrition. The chef consulted with people on their likes and preferences.

Summary of findings

People were supported with their ongoing health. GP visits were arranged and people had regular optician check-ups. People were referred to healthcare professionals for specialist input. For example social workers, tissue viability nurse specialist and psychiatrists.

Activities coordinators organised activities, entertainment and outings. However, a limited number of people were benefitting from outings and activities. The activities coordinator interacted well with people and showed they had a good understanding of people's background. We also saw some staff interacting well with people and showed they had insight in the causes of some behaviour. For example, how previous employment impacted on behaviours.

Relatives knew a complaints procedure was in place and felt confident to approach staff with complaints. The registered manager investigated complaints and responded in writing to the complainant on the outcome of complaints investigations.

The views of relatives on the standards of care at the home were sought by the home through surveys. Three responses were received and they gave positive feedback on the care and treatment their family member received. The action plan from the surveys was to improve the questionnaires used to seek feedback on the delivery of care and treatment.

We conducted another visit on the 17 November 2015 and the staff we spoke with said there had been improvements since our previous visits.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service is in 'Special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

Summary of findings

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

The service was not safe.

Where risks were identified the actions to mitigate the risk were not followed by the staff.

People were at risk from unsafe medicine systems and from the spread of infection.

People were not supervised and staff's interaction was not always positive.

Relatives said their family member was safe living in the home. Members of staff knew the signs of abuse and the actions needed to report alleged abuse.

Is the service effective?

Inadequate

The service was not effective.

Mental Capacity Act (MCA) assessments were not in place for best interest decisions made by the staff.

Staff were not provided with the guidance needed to gain consent from people who refuse personal care and became aggressive towards staff.

Members of staff were supported to develop the skills needed to deliver care and treatment. Training and one to one meetings were used to support staff with their roles and responsibilities.

Is the service caring?

Requires improvement

The service was not always caring.

The staff used a calm approach towards people but they did not always support people when individuals were feeling frustrated.

We observed instances of care delivered with respect and dignity. We saw some staff sitting with people and giving assistance without rushing or urgency.

Is the service responsive?

Requires improvement

The service was not always responsive.

Activities were limited and activities coordinators were not able to provide meaningful activities to a wide range of people.

People's needs were assessed but care plans were not developed to meet the assessed needs. Records of interventions such as positional changes and food and fluid charts were not always being kept or were incomplete. People at risk of malnutrition may not be receiving appropriate nutrition or hydration.

Summary of findings

Relatives knew a complaints procedure was in place and their concerns were investigated by the registered manager.

Is the service well-led?

Requires improvement

The service was not always well led.

People were not always protected from inappropriate care and treatment as records were not up to date or accurate. For example, care plans, risk assessments and medicine administration charts.

Quality assurance arrangements were in place to monitor the standards of care. Action plans were developed where standards were not being fully met. However, the audit formats did not identify where standards of care and treatment needed improving. For example poorly ventilated medicine rooms.

The views of family and friends about the quality of care were gathered through surveys.

Working relationships between staff were good and the registered manager was approachable.

Miranda House

Detailed findings

Background to this inspection

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

This inspection was unannounced and took place on 13, 16 and 21 October and 17 November 2015.

The inspection was completed by three inspectors, a specialist advisor and 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.

Before the inspection, we reviewed information we hold about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us.

During the visit we spoke with three people living at the home, 10 relatives, the registered manager, area manager, three registered nurses and six members of staff and activities coordinators.

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 spent time observing the way staff interacted with people who use the service and looked at the records relating to support and decision making for two people. We also looked at records about the management of the service.

Inadequate

Is the service safe?

Our findings

Systems were in place to assess and monitor risk. However, people were placed at risk of harm.

Some relatives raised concerns about the number of falls their family member was experiencing. One relative said their family member had been found in another person's room with "a few knocks and bruises' but staff did not seem to be able to explain why". Another relative said their family member had fallen on the 9 October 2015 and needed emergency medical attention from hospital staff. They said "most of his falls were at night and there seemed real problems. It was easier to manage him in bed, and so they didn't always get him up, but I think this benefits staff and not my relative". The relative went on to tell us that a discussion with the staff had happened and "it was a bit better now".

The third visitor talked to us about their relative " her mobility is less now and she has been having falls, one of which last year was bad and I phoned the council. They do the best they can but it is not really enough and if they use agency staff they do not always recognise the triggers to her falling. She was on 15 minute observations. But either it wasn't enough or it wasn't being done as she still has falls. I'd raised it with the manager and she listened sympathetically"

The duty rotas and staff confirmed that agency staff were being used at the home.

Staff said risk assessments were completed where risks were identified. A member of staff gave us an example of risk management. They said the staff regularly checked on one person prone to falls and that a sensor mat was used in their bedroom to alert the staff the person was standing. A registered nurse said they completed risk assessments then consulted the manager about equipment to lower the level of risk. For example, using beds that could be lowered for people at risk of falls.

Risk assessments were in place for people at risk of falls, pressure sores and for people at risk of malnutrition. However the risk assessments did not always give appropriate guidance to staff.

We looked at a risk assessment developed for one person at high risk of falls. The risk assessment dated 6 March 2013 stated "when XX is in bed to take the wheelchair and zimmer frame out of his room away from him, encourage him to ring the call bell if he needs help and assistance".

On the 10 November 2015 this risk assessment was signed as reviewed and staff had drawn a line across "and zimmer frame." On the 6 October staff had documented "gets angry when wheelchair and zimmer frame are removed. When he is in bed then remove, to ensure safety and free from clutter should he attempt to walk around the room."

Staff had failed to recognise that the individual would continue to attempt to move around his room with or without his zimmer frame. and that the removal of the zimmer frame may increase the risk of falls. The documentation did not demonstrate that staff had considered other strategies to keep the individual safe such as a sensor mat.

People were placed at risk because action was not taken to mitigate the risk of not receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was assessed at high risk of pressure ulcers (sometimes known as bed sores). This person had developed pressure ulcers whilst being at the home and had lost a significant amount of weight. Compromised nutritional status such as weight loss, under nutrition and dehydration are known risk factors for the development of pressure ulceration. The staff had referred this person to the tissue viability nurse.

Tissue viability booklets were developed by the provider in conjunction from input from a range of clinical specialists. Staff at the home were responsible for the completion of the booklets. The booklets gave guidance to staff on how to treat and manage the wounds.

The entries made by staff were difficult to follow as they were not made in chronological order. Information on the progression and treatment of wounds were recorded in several places and so there was no central point where the information could easily be found.

For one of the wounds the guidance stated that staff should assess the wound on a daily basis. We looked at the person's care plan file. The details relating to the management of the person's skin integrity were difficult to

follow as records were not all in chronological order, or had been recorded in sections other than the one relating to skin integrity. Also, some information had not been recorded.

A risk assessment form found in the person's file under the section relating to 'safe and enabling environment' in fact related to skin integrity. The risk assessment proposed that the person had their position changed every two hours whilst in bed and that an air mattress and pressure relief cushion was provided. The risk assessment was dated 11th May 2015. The monthly evaluation sheet for this risk assessment had not been signed for July and October 2015. Records of positional changes indicated that the person did have their position changed during the night, although this was not always every two hours as stated on the risk assessment.

The care plan dated 26/10/2015 recorded for another person that a blister had developed on their right heel and that a pressure relieving bootee had been provided. A further entry dated 8/11/2015 recorded that the blister had 'burst' and that it had been cleaned and a dressing applied.

A tissue viability monitoring record had been commenced on the 26/10/2015. No photograph had been taken. The second entry dated 08/11/2015 recorded a wound measuring 1.5 by 1.5cm. The entry described the dressing used and stated that the wound should be reassessed in five days. No further entries had been made by the time of our visit on the 17/11/2015. A period of 9 days. This was 4 days over than that described in the care records.

We spoke to the nurse in charge for the first floor and showed her the dressing record. The nurse was unaware the person's wound had not been reassessed. We found there had been some confusion about the wound management of the dressing. The nurse in charge of the first floor thought another nurse had redressed the wound but when we spoke with this nurse they told us the covering bandage was replaced and had not reassessed the person's wound. Staff had put the person at risk of developing further tissue damage, by not reassessing the persons wound in a timely manner.

We visited the person's room and found that they had a pressure relief mattress on their bed. This had been set to the maximum inflation setting of 'hard' despite the persons weight being recorded as 54.1kgs. This is a potential risk to the person's skin integrity.

We looked at records of the person's positional changes from the 6th to the 16th November 2015, which was the day before our visit. We found that records were incomplete on ten of the eleven days we looked at. For example; nil recorded from 12 mid-day to 12 midnight on the 15/11/2015. Nil recorded from 08:00 to 20:00hrs on 13/11/2015 and nil recorded from 07:00 to midnight on the 06/11/2015. Records indicated the person was having their position changed whilst they were in bed at night, and that this was generally carried out every three hours, although there were some omissions. This meant people were not supported to improve the healing of pressure sores because there was a lack of monitoring. People were at greater risk of pressures sores deterioration.

The registered manager was made aware of our findings regarding this person at the end of our visit.

People were placed at risk because action was not taken to mitigate the risk of not receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A Malnutrition Universal Screening Tool was used to assess the potential risk of people developing malnutrition. People at high risk of malnutrition were weighed weekly and for some people the GP had prescribed supplements such as fortified drinks. We saw that for two people supplements were prescribed to be taken twice daily. Members of staff recorded on the medication administration records (MAR) that supplements were given. The stocks found in bedrooms show supplements were not given. For example, one person received 112 fortified drinks on 16 September 2015 and on the 16 October 2015 we found 106 in this person's bedroom, although the MAR chart had been signed as administered.

Some people had been assessed as being at risk of dehydration. Members of staff said food and fluid charts were used to monitor the fluids people were having. They said each morning during handovers they were told about people who had not had the recommended daily fluid intake. For these individuals staff were told to encourage people to have more fluids. A relative said 'the food and fluid charts in the rooms were not always up to date".

On the whiteboard in the nurses station it was stated "Any resident identified as taking less than 1500 mls in 24 hours

by night staff need monitoring. Seniors will assign a carer to monitor and prompt these individuals throughout the day. Any fluid intake concerns to be reported to the nurse immediately".

The food and fluid charts for one person also at risk of malnutrition dated 14, 15 and 16 October showed the fluid intake for this person was below 1000 mls on each day. However, staff recorded on the 14 October "food and fluid intake fair," on the 15 October it was recorded "good food and fluid intake" and on the 16 October staff recorded "good diet. Fluid well."

On 17 November 2015 at 2:30 pm we looked at the care records and fluid intake charts for a person at risk of malnutrition. We noted their weight on the 8 November 2015 was 42Kg. The fluid intake records for the 17 November stated this person had drunk 100mls of fluid at 1:00am, 200mls at 6:00am and at 9:00 am100mls of tea. When we visited this person we saw an empty jug, uneaten sandwiches from lunch and a mug of orange juice. At 2:33 pm a member of staff entered the room and gave this person a supplement drink. We returned at 5:00pm and found no further entries in the food and fluid chart and beside this person was the supplement drink and the orange juice both partially full.

On 17 November 2015 we spoke to a member of staff who said it was the senior carer's responsibility to check food and fluid charts to ensure people received enough to eat and drink. This member of staff said "monitoring is improving" and added that, following our last visit, a checking system was introduced to ensure people received any nutritional supplements they had been prescribed.

People were placed at risk because action was not taken to mitigate the risk of not receiving safe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were administered by the registered nurses. We found instances where medication administration records (MAR) charts were not signed to indicate the medicines administered. Stock control records of medicines carried forward from the previous prescription cycles were not maintained. A registered nurse said the night registered nurses were better able to audit medicines when the monthly repeat prescriptions were received. This meant a complete record of medicines received and medicines administered was not maintained

The temperature of the room where medicines were kept was over the acceptable temperature of 25 degrees. The records of room temperature showed the room was often above 25 degrees. This meant people were at potential risk of harm because extreme temperatures may cause the medicine to deteriorate and reduce their effectiveness .

Some people were prescribed with anti-psychotic medicines as well as medicines to induce sleep and to reduce levels of agitation. For example, one person was prescribed with Risperidone twice daily, Nitrazepam at night and Lorazepam one twice daily and when required (PRN) three times daily. The registered nurse said a medicine review from the GP was to be requested on the day of our visit because this person had become "sleepy" and was at risk of falls. The well-being care plan dated 18 September 2015 for another person stated "not sleeping well at night. Trazadone re-started by GP to help at night" to be administered as well as lorazepam when required in the evening.

Staff did not consider whether all the medication the person was on was contributing to the person experiencing more falls as a result. Staff were administering medication for agitation and sleep. There was no guidance in place as to what to consider when PRN medication was given. This meant people were prescribed with medicines that placed them at higher risk of falls.

At times staff were using medicines for agitation to control behaviours. For example, we saw recorded in the Cognitive assessment review care plan dated 18 September 2015 "episodes of aggression behaviour towards staff and others. Should he become physically aggressive try and calm him, remove from escalating situation, guide him to his room and give him PRN (medicines administered when required)". Other strategies such as diversion were not recorded nor considered before the use of the medication.

Medicine systems did not protect people from the risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staffing arrangements did not ensure there were sufficient staff deployed to properly supervise people. A relative said "they do the best they can but it is not really enough and if they use agency staff they do not always recognise the triggers to her [relative] falling". Another relative said that particularly at weekends the "younger

Inadequate

Is the service safe?

staff tend to group and sit chatting about personal things and neglect the people who may be needing assistance". A third relative said her relative "likes to go out and is much better when she goes out, but there are not enough staff to take her out when the family are not there to do it".

The staffing rota showed during the day there were seven caring staff on duty with a registered nurse on both floors, housekeeping and catering staff on duty. Staff said overall the staffing levels were good however one member of staff said "staffing levels were not good for the high demand of people's needs."

During the inspection we observed people walking the corridors, sitting in lounges and dining room without any staff presence and little interaction. We saw people entering other people's rooms. For example, the response from a member of staff at 7 pm when we drew their attention to one person entering another person's room was "I know that I will have to get him out". We also observed a very distressed person moving dirty dishes on the trolley, two members of staff intervened, and pointed to the person to go for a walk down the corridor. Staff did not recognise that there was another person who was in the same distressed state further down the same corridor. This could have potentially led to conflict between the two people. Staff were busy with other tasks however, this person continued to call out in the corridor five minutes later . There was no additional staff intervention during this time.

The staffing arrangements did not ensure there were sufficient staff deployed to properly supervise people. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were at risk from the spread of infection. We saw foot operated bins in toilets did not have a lid. The general manager told us following our feedback at the end of the inspection visit that foot operated bins with lids had been ordered. They said staff were reminded of best practice when they were seen not following infection control guidance. For example, leaving bedrooms wearing gloves.

We saw poor food and hygiene practices. We saw members of staff taking meals from the dining room to bedrooms not covered and at lunchtime cakes placed on top of the food trolley were not covered this trolley came from the downstairs kitchen to the upstairs dining room. On the 17 November 2015 we saw staff were covering meals they were taking to people's bedrooms.

At lunchtime on the first day of our inspection visit we saw a member of staff take the food waste container from the trolley and place it on the floor, another member of staff took the container from the floor and placed it back on the trolley. A member of staff then came along and placed glasses rim side down on the trolley where the food waste container had been.

On the second day we saw three members of staff preparing toast for breakfast. We saw there was limited space on the dining table where staff were preparing breakfast. We saw staff handling the food without first washing their hands. The staff were using a tray instead of a plate or board to spread butter and jam on the toast and on the same table there was also a radio. Good food hygiene guidelines state that different coloured boards for different food groups should be used to prevent cross contamination. The use of the tray for the preparation of the toast would not meet food hygiene guidelines. We saw the same three knives were used to spread butter and jam for the people having toast. On the third day of the inspection we saw a larger table was provided to help staff prepare breakfast.

People were not protected from the spread of infection and poor food hygiene systems. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff attended safeguarding adults training. Members of staff knew the signs of abuse and the actions needed when they suspected abuse. A member of staff explained some people at times became aggressive and violent towards others. They said these incidents of aggression were reported to their line manager. A relative said generally their family member was safe with the staff.

Inadequate

Is the service effective?

Our findings

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Deprivation of Liberty Safeguards (DoLS) application were in progress for people who lacked capacity and were under continuous supervision.

Miranda House supports people who have dementia. We observed that throughout various points, key pads on doors were in place. Staff, relatives and people confirmed that no people who resided at the home had the access codes to get through the doors. Staff told us that if people left the building they would bring them back or go with them. This did not consider peoples capacity nor an individual's right to take appropriate risks. Due to this it could be considered that people were under constant supervision and that DoLS should be applied. However, applications for deprivation of liberty safeguards (DoLS) were not made to the supervisory body for all the people at the home who could not safely leave the building. The registered manager said 16 applications had been made.

We looked at DoLS application for two people where we identified some inconsistencies within the records. For example, the DolS application for people stated a lasting power of attorney was appointed for health and welfare but the registered manager did not have a copy of the power of attorney. The section of the DoLS application which states: 'there is someone whom it is appropriate to consult about what is in the person's best interests who is neither a professional nor is being paid to provide care or treatment' was not completed. The DoLS application did not contain any record that a discussion had taken place with the person who holds power of attorney regarding the application for a DoLS. The registered manager said a discussion had taken place but was unable to find any record relating to this taking place in respect of the best interest decision to deprive the person of their liberty. The capacity assessment attached to the DoLS application was not completed correctly. The section which confirmed the person had an impairment of, or a disturbance in the functioning of the mind or brain had not been completed, neither had the section relating to the decision required.

Best interest decisions were made without assessments of capacity which showed a lack of understanding of the MCA principles. The framework needed before best interest decisions could be made were not in place. For example, we saw a best interest document dated 22 September 2014 for one person which stated "due to risk to self, pull cords were removed from bedroom". We saw a diary entry for 12 October 2015 where one person was to have plastic plates because "the plate smashed and she fell on top of the plate".

There was a lack of clarity from a registered nurse regarding the involvement people had in their assessments of capacity. The registered nurse said capacity assessments were done over a period of time. We looked at an MCA dated 14 October 2015 and the section of the form for "where the required decision" was blank and the assessment conducted to establish lack of capacity was not detailed.

People's capacity to make specific decisions was not assessed. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Staff told us that there were people who resisted personal care and became aggressive towards staff. A member of staff told us how they managed this in a positive way. They told us that for some people they used distraction techniques to gain consent for personal care. For example, discussing the consequences of not having personal care, giving people time and other staff approaching the person. This however was not always seen in practise.

Members of staff involved families without them having authority to make best interest decision. A member of staff said there were other people who were not able to communicate verbally, who had continence problems and refused personal care. This member of staff said "people who can't communicate, it's done (personal care) in their best interest. For example, one person will not consent to personal care. We ring the daughter for consent to personal

care." The daughter had given her consent in writing for personal care. We saw documented in the daily record of care on 27 September 2015 where a relative had recorded and "I have given XX permission to carry out all personal care on XX if XX refuses all care" which the relative signed. The registered manager confirmed there was no power of attorney for this person. Documentation evidenced that family members did not have lasting power of attorney for this decision. An action plan which directed staff on how to manage situations where people refuse personal care and become aggressive towards staff was not in place.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Referrals for support to manage difficult behaviours were sought from the specialists such as psychologist. However, advice was not always followed. For example, staff were recommended to develop charts that describe the Antecedent (behaviours before an incident), Behaviour (what the challenging behaviour was) and Consequence (how it was resolved) (ABC). ABC creates insight into the behaviour which helps staff develop strategies to divert and diffuse difficult challenging incidents. However, staff were not consistently completing forms when challenging incidents occurred.

ABC charts were not used to develop action plans on how staff were to manage difficult behaviours. Care plans developed directed staff to use a calm approach when people presented with difficult behaviours. For example, the behaviour that challenges care plan for one person states “based on the person preference for quiet areas, the staff were given guidance to direct the person to a quiet area and offer drink”. The personal care plan dated 18 September 2015 for another person stated “no longer aggressive both verbal and physical. He co-operates as long as staff explain to him what they are doing”. The ABC chart describes an incident which occurred on 3 October which shows this person was aggressive and violent when personal care was provided. Staff recorded “the staff had to call for help and continue with it. After finish left in the room to calm down but he was punching the walls.” The care plan and guidance to staff had not been updated following this incident.

Staff had continued to deliver the personal care while the person was distressed and potentially without their consent. This could be considered as restraint and as such should be considered under DoL’s and the principles of the MCA.

On the 17 November 2015 the registered manager told us there was a plan in place to submit DoLS application.

A registered nurse said they explained to people the tasks they were about to undertake. A member of staff said some people were aggressive and explained how this was addressed. For example, “we don’t grab people, we don’t restrain, we put people’s hands down when they are raised to hit. This is in line with training to manage difficult behaviours”. Another member of staff said when people became aggressive they gently distracted people and diverted their attention. This demonstrates that some staff may have understood the principles of dealing with “aggressive behaviour” but that this was not being put in to practise in all cases such as the use of medication and the continuing with personal care when individuals were clearly not consenting.

Guidance was not provided on how staff were to manage the challenging difficultbehaviours of some people. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014..

Staff said people were helped to make choices such as meals. A member of staff said to help people make choices they were shown the plates of food with the options available. We observed staff speaking to people at eye level when they asked them to select their preferred meal from the available options given. We saw staff encourage people to eat their meals at all mealtimes observed. For example, we saw another meal provided when the staff discovered it was cold. A dessert was then offered when the person declined to eat the replacement meal. This was accepted and eaten without support. However one relative, who visited the home every day told us that this was unusual and that “they never had staff in the dining room or lounge like today.”

A member of staff who had a lead role in nutrition told us on the ground floor there were 13 people at risk of low weights. They said where there are concerns about people’s weight, nutritional care plans were developed.

The chef told us people’s dietary requirements were catered for. For example, diabetic and fortified meals. They

Inadequate

Is the service effective?

said during the admission process they consulted with people on their likes and dislikes. We saw a care plan developed by the chef for a person with poor nutrition and the action plan included fortified meals, snacks between meals and homemade milk shakes. For example, meals were prepared with additional cream and butter to provide additional calories to help people maintain their weight. The chef confirmed snacks were provided between meals which happened at 11am and 3pm when cakes were offered with refreshments.

People were registered with a local GP and regular check-ups were arranged with the optician and chiropodist. Staff documented the visits from social and healthcare professionals which included the advice given. For example, to reduce medicines following a medicine review. Referrals for specialist support was sought for example, tissue viability specialists, dieticians and psychologist. We spoke with a social worker who said the people living at the home had complex dementia and the staff were good at managing complex behaviours.

New staff received an induction to prepare them for the role they were employed to perform. A member of staff said the induction was good, they shadowed more experienced staff and they attended dementia awareness training. They said there were opportunities to develop their skills and to undertake vocational qualifications.

Systems were in place for staff to discuss issues of concern, performance and training needs. A member of staff said one to one meetings with the line manager were held regularly where their performance was discussed. Another member of staff said “everything is discussed” at one to one meetings. A registered nurse said one to one meetings were three monthly with the deputy manager.

Requires improvement

Is the service caring?

Our findings

People's property was not respected and staff did not provide adequate supervision of people who enter bedrooms. People were not restricted in movement but problems resulting from this were not being addressed. Some people went into others bedrooms and some people's behaviour was inappropriate when they were in other people's bedrooms.

Memory boxes which help people to identify their bedroom were empty. We saw people consistently walking up and down corridors but interest points at the end of corridors or "fiddle boxes" were not available. Staff told us that the reason these were not available was that people removed the items from the memory boxes on doors and also took items from the "fiddle boxes" into their rooms. The home manager told us that she was awaiting information from families to complete the boxes.

We observed six people sitting in the dining room at 12:17 pm on the second day of our visit. People were not supervised by staff, one person was singing but there was little interaction with the other five people in the dining room. At 12:24 pm we saw two staff arrive and addressed two people by name and said "alright". One person said "girls will you take me to my room" and a member of staff without looking at the person said "of course". There was no interaction from the staff to the other 4 people in the room.

Staff explained how they promoted relationships with people. They said when time was available they sat and consulted with people about their likes and preferences. A member of staff said "we sit and chat to people in bed and to help people eat we put music on."

We also observed another member of staff having good interaction with a person in the lounge. This member of staff was sitting on the arm of the sofa with her hand gently placed on one person's shoulder. We observed them having a conversation about the person's past employment and the member of staff clearly had good insight into the reasons for certain behaviours exhibited.

A registered nurse said "I practice what I preach. I engage with people while I undertake tasks for example, while medicines were being administered".

The members of staff received a number of Thank You cards from relatives for the care and treatment delivered to their family member.

The relative said "they were happy that their family member was treated with dignity and respect and that the staff look after then as best they could".

We observed an agency worker outside in the garden with a person on one to one support from staff. They said they had returned from the bookies and said "their normal day was to go to the pub then the bookies then back for lunch before going to the bookies and the pub and coming home again late afternoon." We observed the person was treated with respect and dignity. We saw lively banter which was matched by the person's attitude and language and for this particular person was exactly what was needed for their care to work well.

Requires improvement

Is the service responsive?

Our findings

Staff said people at the home had high levels of care needs. A member of staff said the carers benefited from having registered nurses on duty. Where there were concerns for people, the registered nurses gave staff guidance on meeting people's needs. They also said care plans were followed and amended when there were changes to people's needs. Any changes to the care plans were passed onto other staff and the registered nurse during handovers. A member of staff said they had access to care plans, they read the care plans and wrote reports on daily events.

3 relatives told us they were not aware of review meetings taking place. A relative said their family member had been living in the home over two years but there had been no review in that time. Another relative told us their family member's continence needs were not met by the staff and that they often provided personal care during their visits. They said "this is a regular occurrence almost daily".

Care plans were developed on how staff were to support people. The action plans for some people were inconsistent for example, the frequency of when staff had to observe people. For example, on the 18 August 2015 the daily living skills care plans was reviewed for one person and the staff recorded "15 minutes obs. (observations) enters other people's room will put himself on the floor". The moving and handling risk assessment for the same person was reviewed on the same day and states "likes to walk, staff to offer him a chair to rest. Sits on the floor when tired, 30 minute obs (observations)". For another person we saw a hypertension (high blood pressure) care plan which stated the person was to have low salt and low fat diet. This person was also at risk of malnutrition but there was no reference to a low fat low salt diet in their nutritional care plan. The chef was not aware of the dietary requirement for this person.

We noted two people had injuries or health conditions. For example, a facial injury and a swelling on the hand. A member of staff said the person with the facial injury had caused the injury to themselves. We saw recorded in the diary where the wound was to be checked for contagious infection and a GP visit was arranged because injury was not improving. We saw on the 12 October 2015 the person was referred to dermatology and the GP prescribed antibiotics on the 23 October 2015. The evaluation of skin integrity stated "skin of XX intact except for the right side and on treatment." A care plan was not developed on managing the wound.

For the person with a large swelling on his hand, staff said it was related to a medical condition known as purpura (internal bleeding from small blood vessels which had an appearance of small spots). A record of the swelling was not made for this person. This meant staff were not always informed about people's injuries and enduring health conditions and how they were to be managed.

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

The activities coordinator said they "worked two days a week, Tuesdays and Fridays and tended to focus on crafts as that was their strength." They said trips were organised for example, "weekly bus trips with residents but owing to staffing levels could only take three residents each time and while this was great for the three residents. It meant that the other 60 odd residents had no activities during this period." They explained "they also visited coffee shops and garden centres and that they had an outside singer come in once a month. The activities on the Tuesday were well supported by relatives"

The activities coordinator had spent some time decorating the summerhouse in the garden as a beach hut and the intention was to use this as a coffee shop. The coffee shop was to be used to increase the number of people who would be able to "go out" as more people were able to use the facility.

We observed an activity and we saw good interaction between people and the activities coordinator. The activities coordinator reminisced with people about their past and showed an extensive knowledge of each person. People and their relatives said the activities coordinator was very caring and totally committed to providing people with meaningful activities that many people enjoyed.

Relatives were aware a complaints procedure was in place. A relative said they did know about making a complaint and they would be happy to raise a concern or raise a complaint but the deputy rather than the manager would be approached. They said "the manager was OK but felt she was less approachable at the moment".

Requires improvement

Is the service responsive?

The registered manager investigated a complaint received in September 2015. We saw the complainant received a written response on the outcome of the investigation.

Requires improvement

Is the service well-led?

Our findings

The registered manager had not ensured that staff always maintained accurate, completed and contemporaneous records. For example, a falls risk assessment was part of one person's admission on the 23/9/15, which assessed the person at low risk of falls. A review of the incident forms for the home identified they had subsequently had two falls, one on the 17/10/15 resulting in bruising to their right knee and one dated 6/11/15 resulting in a swollen black left eye and grazed left knee. The care plan and risk assessment had not been updated to reflect the fact that this person had suffered two falls. The registered manager informed us a falls analysis had been completed and us a copy of a falls report she had completed for another person.

We found that documentation was not up to date and did not clearly identify which bedrooms people resided in. Given that the home used a number of agency staff this could increase the risk that inappropriate care and support was provided by staff. We asked the location of one person bedroom admitted to the home on 23/09/2015. The registered nurse showed us copies of the handover forms dated 14/11/15 - 15/11/15 and 15/11/15 – 16/11/15 used by staff to share up to date information in respect of each service user during the handover. We saw on the handover form dated 14/11/15 - 15/11/15 a different name for the person we were discussing with the registered nurse. When we pointed this out to the registered nurse they said the staff must have used an old form.

On the first day of the inspection we saw staff at the end of their shift completing records on the day's events. At 12:40 pm on the second day of our visit we saw a member of staff signing a monitoring chart to indicate they had observed one person every 30 minutes from 8am until 11am. We asked why this chart was not been done at the time. They said the charts were not available. This meant there was an increased risk of errors and not in line with best practise. The registered manager was to seek advice from human resources as recording half day's information was not acceptable.

Care plans and risk assessments were not always up to date and people's current needs were not reflected in the care plans. Intervention charts used to monitor the delivery of care were not completed by the staff according to the care plans. Poor recording of unexplained bruising was found and evidence of a body map not completed. We saw gaps in the recording of intervention such as food and fluid intake. It was also noted that for two people the same staff had signed the record to say they had provided personal care at 12 noon.

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

Audits and systems were in place to assess the standard of care in place. For example, an infection control audits dated 8 September 2015 assessed all areas of the home. Where standards were not fully met action was taken by the registered manager. For example staff were not following good practice hand hygiene and staff were reminded about hand hygiene practices at a recent staff meeting.

Visits from the regional manager took place and where improvements were needed an action plan was developed. The report for September 2015 showed a sample check of records were reviewed to assess all required information was held. For example, a risk assessment for bed rails was in place and fluid and food charts were in place for people assessed at risk of poor nutrition. We saw an action plan was in place for Deprivation of Liberty Safeguards (DoLS) applications to be made by the end of October 2015 for people subject to continuous supervision.

Medicine audits were undertaken by the area manager. The medicine audit for October 2015 had identified staff were not signing the medicine administration records (MAR) when medicines were administered. We saw the document required the area manager to confirm a record of temperature was maintained. The temperature range of the room was not part of the assessment completed by the area manager. This meant the audit had not identified the room was above the acceptable temperature of 25 degrees.

Accidents and incidents were assessed to identify trends and patterns. For example the management of falls and behaviours that challenge. We saw one care plan was updated from the analysis of falls. However the action taken as a result of this analysis was not always effective as detailed throughout this report and that there had been significant number of people at risk of falls. For example, between 15 and 17 October 2015 five people fell.

A registered manager was in post. A registered nurse said the manager was approachable and will take action. They said the manager was contactable at all times.

Requires improvement

Is the service well-led?

The registered manager said the "service provided the best care and people were enabled to be as independent for as long as they can". They said a supportive style of management was used and the challenges included improvements of the environment.

Staff meetings were organised to discuss issues, the running of the home and to share information. A member of staff said staff meetings were organised but the times were not always convenient for staff off duty to attend.

A number of staff had recently resigned. A registered nurse said five registered nurses included the deputy and five care staff were leaving. The registered manager said staff were "empowered to develop their skills" and some staff were leaving for promotional posts. Retention was recognised by the registered manager as a challenge and exit interview with staff were to take place to explore the reasons for them leaving. Training for staff was being developed which recognised staff's potential and clinical leads on both floors were to be assigned.

Staff said the team worked well together. A member of staff said there had been changes in staff and some staff were leaving but there was a stable core of staff. They said the manager "would try and find a solution". Another member of staff said "the home has come a long way. We have been though rough times. I am proud, we were nominated for an award. There is room for improvements".

The views of relatives on the standards of care at the home were sought by the home through surveys. Three responses were received and they gave positive feedback on the care and treatment their family member received. The action plan from the surveys was to improve the questionnaires used to seek feedback on the delivery of care and treatment. The registered manager said house meetings where relatives attended took place. They said support was also provided at these forums to "achieve a deeper understanding of where people were on the dementia journey."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicine systems did not protect people from the risk of harm.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People were not protected from the spread of infection and poor food hygiene systems.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient staff were not deployed to meet people's needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Care plans were not up to date and did not reflect people's current needs.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People were not protected from robust management of records.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's capacity to make specific decisions was not assessed. Best interest decisions were made by staff without first assessing people's their capacity to make decisions. Guidance was not provided on how staff were to manage the challenging difficult behaviours of some people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were placed at risk because action was not taken to mitigate the risk of not receiving safe care and treatment