Camelot Care Homes Limited

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Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Camelot Care Homes Ltd provides accommodation and nursing care for 57 older people in two adapted buildings. People have their own rooms and share communal areas such as lounges, dining rooms and bathrooms. Outdoor space is an enclosed courtyard area. At the time of our inspection there were 51 people living at the service.

People's experience of using this service and what we found
People's safety was not ensured. This was because there were shortfalls in fire safety and risk management. We observed inadequate fire safety systems in place which were not dealt with in a timely way. Whilst we shared our concerns with the registered manager, they could not confirm or provide assurance the work had been completed.

There were other risks within the environment. This included blocked fire escapes, trip hazards, unprotected hot water pipes, excessive hot water from hand wash basins, and unrestricted access to scalding water and hazardous substances. These hazards had not been identified by the registered manager or provider.

Inadequate systems were in place to prevent and control infection. Not all areas of the home were clean, as there were cobwebs in people's bedrooms, stained carpets and brown marks on furniture and bed rail covers. Some areas were difficult to keep clean and needed repair. For example, there were peeling surfaces on the kitchen cupboards and missing tiles on some walls. There was carpet in the laundry room, which was not hygienic.

Not all accidents and incidents had been appropriately reported to CQC or the local safeguarding team. Adequate action had not always been taken to minimise a reoccurrence of an accident or incident. This included ensuring all external doors were secured, after a person went outside unsupported at nearly midnight and fell.

The provider had made some improvements regarding the safe administration of medicines since the last inspection. However, medicines were still not always being managed safely at the home.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. This was because people's capacity had only been assessed in terms of them living at the home. There were no decision specific capacity assessments in place.

Staff supported people to eat and drink, and some people had their intake monitored. However, the monitoring records lacked detail or had not been fully completed. This showed people were not having enough food or fluid, so the monitoring process was not effective. The shortfalls had not been identified or escalated as a concern.

The information within people's care plans lacked detail and did not always reflect individual needs and choices. There was limited information about health conditions, and wound care plans were not consistently in place. The terminology staff used within care records, was not always respectful and did not show an understanding of people's needs.

People's privacy and dignity was not always promoted. There were limited interactions between staff and people who used the service unless interventions were taking place. Not all showed a caring approach and there was mixed feedback about the staff. Staff were positive about their role, and said they enjoyed working with people.

There were auditing systems in place but these were not effective, as shortfalls found during this inspection had not been identified. The registered manager was not able to answer some questions about the management of the service, and some requested information could not be located. The registered manager did not have clear oversight of the service.

There were enough staff to support people, and call bells were answered in a timely manner. Staff covered any sickness or annual leave as necessary, and agency staff were also used. There were approximately 180 vacant care hours. Recruitment was ongoing with an aim to fill these vacancies. Robust recruitment procedures were being followed.

Staff received a range of training, which was deemed mandatory by the provider. This included health and safety, moving people safely and food safety. Some staff however were waiting for safeguarding training, and positive behavioural management training had not been undertaken. The registered nurses completed training for their professional development. Staff felt well supported and had one to one meetings with their line manager. They also had annual appraisals, to discuss achievements and areas to work on.

People and their relatives knew how to raise a concern. Records showed formal complaints which had been raised, but investigations or any correspondence to the complainant was not evidenced. People had been asked for feedback about the quality of the service they received.

Staff gave very positive feedback about the registered manager.

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

Rating at last inspection
At the last focused inspection, the rating for this service was Good (published 04/12/21).

Why we inspected
The inspection was prompted in part due to concerns received about people's support and alleged restraint of a person and them being forced to eat. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

The overall rating for the service has changed from Good to Inadequate. This is based on the findings at this inspection. We have found evidence that the provider needs to make improvement. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Camelot Care Homes Ltd on our website at www.cqc.org.uk

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches in relation to risk management, the safe management of medicines, ensuring consent, person centred care, reporting incidents and accidents, and good governance.

We made on recommendation for the provider to improve documentation to evidence compliance with their complaint procedure.

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

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures:.
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

Camelot Care Homes Ltd

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors, an assistant inspector and a member of the medicines team.

Service and service type
Camelot Care Homes Ltd is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was a registered manager in post.

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. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made judgements in this report. We used all of this information to plan our inspection.

During the inspection
During the inspection, we spoke to six people, three relatives and 15 members of staff including the registered manager, nursing and care staff, catering and housekeeping staff, activities and maintenance staff and the administrator. We spoke with one visiting health professional. We reviewed 11 care plans, and 11 medicine administration records. We toured the environment and considered documentation related to the management of the home. This included accidents and incidents, staff recruitment and training, complaints and quality auditing.

After the inspection
We gained feedback about the service from four health and social care professionals, currently involved with the home.

Due to the concerns identified during the inspection regarding fire safety and excessive hot water temperatures, we issued a Letter of Intent under Section 31 of the Health and Social Care Act 2008. This informed the Nominated Individual of Possible Urgent Enforcement Action, if a satisfactory action plan to address all safety concerns, was not received within the stated timescale. This information was sent to CQC as required.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last focused inspection in October 2021, we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
- Risks to people's safety had not been appropriately identified and acted upon.
- Risks in relation to fire were not managed safely leaving people at significant risk. For example, two people's bedrooms did not have a fire/smoke detector, and records showed some fire safety equipment was in need of replacement.
- The hot water in 11 bedrooms and in a toilet just off a corridor, was very hot. These excessive temperatures had not been identified.
- Doors which should have been kept closed and locked to protect people from hazards, were left open and unsecured, leaving people exposed to risks from falling, scalding or hazardous substances.
- A hoist was blocking a fire escape, and a ladder, clothes airer and other items were blocking a fire exit escape route from the building outside. The path was overgrown with weeds, which could cause injury and inhibit a timely escape in an emergency.
- There were records regarding the passenger lifts, which stated there were defects that required corrective action. The registered manager was not able to provide evidence that all of these defects had been completed.
- One person was in bed, and had bedrails in situ. The bedrails were metal and did not have any covers on them. This meant there was a risk of injury through entrapment.
- Risks people faced with their health had been assessed and formed part of their care plan. This included areas such as skin integrity and malnutrition. However, some assessments contained conflicting information. For example, records showed one person was at high risk of pressure sores, but another record showed a low risk. An assessment to accurately calculate the risk had not been completed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Systems and processes to safeguard people from the risk of abuse
- Systems were not effective in safeguarding people from the risk of abuse.
- Not all accidents and incidents had been reported to the local safeguarding team. This included one person who had been left alone, despite having one to one staff support in place. They then fell in the garden. Another person had bruising to their hand, and said they had more up their arm. There was not an investigation to determine the cause of the bruising, and it had not been reported to the safeguarding team.
- Just before the inspection, a safeguarding alert was raised, as it was alleged staff were placing their hands on top of a person's hands, to stop them hitting out whilst they were being assisting to eat. The daily records showed restraint was taking place as it was written, 'Sometimes needs two staff to hold hands gently and

other staff to wash [them]' and, "Two staff to hold [person's] hands gently to avoid hitting the staff.' The person's care plan in relation to restraint was unclear. This did not give staff clear guidance to ensure the safe management of the person's behaviour.
● The registered manager told us only agency staff with experience and training supported this person on a one to one basis. However, the care plan stated at least two staff were needed for personal care. The agency worker confirmed permanent staff helped with personal care and during meals. They also took over when the agency staff member was on a break, and overnight when no one to one cover was in place. These staff had not had the training needed, to provide them with skills required, to work safely in these situations.
● Records showed 15 members of staff had safeguarding training that was 'pending'. The registered manager told us safeguarding had been discussed with those staff during their induction. They said the staff were now waiting to do the safeguarding training course, which the provider deemed mandatory.

Failing to have systems in place to make sure people were protected from abuse and improper treatment placed them at risk of harm. This was a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us they had completed safeguarding training. They said they would raise, document and report any concerns they had regarding abuse or poor care. Comments included, "I would report it to [clinical lead] and [registered manager]. I would keep saying why things weren't right" and, "[Registered manager] is always telling us to report concerns. We can go to head office if we needed to. She even says if we have any issues about her, we should speak to her. She's a very transparent person."
● The registered manager confirmed safeguarding was promoted as a culture within the service. They said staff were always told to keep their eyes open for any signs of abuse. They were also encouraged to make a safeguarding referral themselves at any time, including at weekends, when the registered manager was not on duty.
● People told us they felt safe at the service. One person said, "I do feel safe here." This person's relative said, "I know my [relative] is safe. The staff keep an eye on the residents. They're really on the ball here." Another relative told us, "I do have confidence in [family member's] safety. Whilst I'm here I watch, and would say if I wasn't happy even with the slightest thing."

Preventing and controlling infection
● Inadequate systems were in place to prevent and control infection.
● Not all areas of the home were clean. There was dust and cobwebs in people's bedrooms, staining on carpets, debris along the beading of small tables, and brown marks on an armchair and bed rail cover.
● Some areas of the home were worn and damaged. This included broken or missing wall tiles in bathrooms and the laundry room, and peeling paint on radiator covers. In the smaller kitchen, the flooring was lifting, the edges of the cupboards were peeling off and the windowsills had peeling paint. There was carpet in the laundry room, which was not hygienic.

Failing to have systems in place to make sure people are protected from the risk of infection from their environment placed them at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff completed COVID-19 testing as per government guidance and reported the results on the government website. In the event of an outbreak of COVID-19, staff knew how to isolate and cohort people if needed.
● Records showed, and staff told us they had completed training in infection prevention and control. They had received additional training in good hand hygiene, and the safe use of their personal protective

equipment (PPE).
● Throughout the inspection, visitors and staff were wearing face masks. Staff told us they wore additional PPE when supporting people with their personal care.

Using medicines safely
● Medicines were not always managed safely.
● There was adequate stock of prescribed medicines. However, there were expired items such as plasters and dressings in the first aid box. Also, the staff did not always record the opening date of liquid medicines. This meant these medicines and dressings might not be effective or have the desired effect.
● Staff did not record administration of time sensitive medicines accurately. This meant it could not be verified from the medication administration records (MARs) if time sensitive medicines, prescribed to given at specific times, were administered appropriately as prescribed.
● Some people were prescribed medicines, such as pain killers and laxatives, to be given on a when required basis. However, staff did not always record information in the person's care plan or have a protocol in place to give these medicines consistently as prescribed. This was also highlighted during the previous inspection and within an audit undertaken by the provider on 30/05/22.
● Care plans regarding medicines were not always in place or person centred. For one person who experienced seizures, there was no care plan in place to provide guidance to staff on how to monitor or manage if they had a seizure. Similarly, there were no care plans in place for people who were prescribed high risk medicines such as insulin or anticoagulants. This meant there was a risk staff members may not be able to monitor or manage the side effects of these medicines effectively.
● Medicines related allergies were not always accurately recorded on the MARs. For example, the staff had handwritten a MAR for one person, but not recorded their allergies.

Failing to ensure the proper and safe management of medicines, placed people at risk of harm. This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staffing and recruitment
● There were enough staff to support people safely.
● The registered manager told us they had a dependency tool, which helped them determine the numbers of staff required on each shift. They said they also took other factors into consideration such as the geography of the building.
● There was a staff presence in the communal areas, which was part of the home's house rules.
● During the inspection, people were not rushed and call bells were answered in a timely manner.
● People and their relatives told us there were enough staff. One person told us, "They do come when you call them." A relative said, "Yes, I would say they have enough. You can always find someone if you need to speak to them. There's always someone around."
● Staff personnel files demonstrated a formal recruitment process was followed. This included checks of the applicant's identity, their right to work in the UK, past work performance, and if they were suitable to work with vulnerable people. In two applications however, any gaps in employment were not explained.

Visiting in care homes
People's relatives and friends were encouraged to visit in line with government guidance. One relative told us, "It was difficult at times but that was the guidance, not the home's rules." Another relative said they were able to visit whenever they wanted.

Requires Improvement

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 our last comprehensive inspection in November 2018, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

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 MCA 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, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- Consent to care had not been sought in line with guidance.
- People's capacity had only been assessed in terms of them living at the home. There were no decision specific capacity assessments in place. This was not in line with guidance and did not ensure people were being supported appropriately.
- Many people had bed rails in use. None of these people had their capacity to consent to the use of bed rails assessed. There was no documentation in place to evidence how best interest decisions had been reached or if any less restrictive options had been considered.
- Risk assessments for bed rails had been completed, but the documentation was conflicting. For example, in one person's assessment, it was documented staff had discussed the bed rails with them and they had consented to them. However, their care plan stated they lived with advanced dementia, were unable to communicate their needs and did not have capacity to make any decision.
- Care records contained misleading statements, which did not show staff had a good understanding of consent. For example, some care plans stated, "Staff to consent before any intervention", rather than informing staff to gain the person's consent.
- At lunch time, staff did not always gain consent from people regarding wearing a clothes protector. Two staff asked people, but did not wait for the answer. One person declined, but they were encouraged to wear one, to save their clothes. A relative had also identified this lack of consent. They told us, "At lunchtime, the staff just come and put the 'bib' on. They don't ask first."

Failing to act in accordance with the Mental Capacity Act 2005 did not ensure appropriate consent to care and treatment. This was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Adapting service, design, decoration to meet people's needs

● There were many aspects of the environment, which needed repair or decoration.

● Whilst one unit was light, with wide corridors and space for people to move around in, the environment was bland and in need of a refresh. There was peeling paint, and holes in the wall on the staircase where the handrail had come off, but it had not been replaced.

● In the other unit, the décor was of a poor standard. Some walls had different colours of paint on them, the edging was rough, and several ceilings had patches on them where there had been a leak.

● The small lounge known as the Parlour was hot, with the thermometer showing 27 degrees. There were three radiators in the relatively small room. Staff told us they usually put something in the window to prop it open, as it would not stay open on its own.

● There was limited signage, to enable people to find their way around more easily. This was particularly so in one unit. There were some sloping floors which had not been highlighted with hazard tape. A curved staircase, leading to two staff rooms, was not easy to manoeuvre and had a low ceiling. This was accessible to people, which increased the risk of them falling.

Supporting people to eat and drink enough to maintain a balanced diet

● During the inspection, staff gave people assistance to eat and drink as needed. They gave encouragement, and asked people if they needed help to cut up their food. However, care records did not demonstrate people were having enough food and fluid.

● Everyone living at the service was having their food and fluid intake monitored yet this was not effective. Records showed poor fluid intake, but there was no information to show staff had escalated any concerns about this. Registered nurses had not documented anything to show they had checked the records or were aware of people's poor fluid intake.

● Records showed people's daily fluid intake was regularly under one litre per day. Although staff documented when they offered people drinks and they declined, this still did not show that people had been offered a sufficient volume to drink each day.

● We showed the fluid intake records to the nurses on duty, the clinical lead and the registered manager. None of them said they were aware of low fluid intake.

● Records for people with catheters, did not always show they had been given enough to drink. This was despite it written in their care plan that staff should encourage a good fluid intake to prevent the risk of urinary tract infection (UTI).

● Food intake records lacked detail. Staff had not always written what people had eaten. Instead they had written statements such as, "Had dairy dish, had a standard portion, ate most of the food." This meant it was difficult to assess whether people were eating a nutritionally balanced diet and exactly how much they had eaten. Another record at 13.33, stated the person had a standard portion and ate most of their food and dessert. However, nothing was recorded for teatime and the next entry was at 09.21 the next day.

Failing to ensure accurate monitoring records, did not mitigate the risk of malnutrition or hydration which put people at risk of harm. This was a breach of Regulation 17(Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● The tables in the dining room were laid and there were condiments and napkins available. All meals were served plated, but staff did not explain what the meal consisted of. Plate guards were used, once it was identified some people were struggling to pick their food up.

● People gave variable feedback about the food. Some people said the food was good, they had a choice and sufficient amounts, but two others said their portion sizes were too big. One person said the food wasn't warm. We asked the kitchen staff if the temperature of the food was checked before it was served. They replied by saying the inside of the hot trolley was warm so the food should be warm too.
● People's relatives also gave variable feedback about the food. One relative said, "[Family member] says they don't mind the food, but it always seems to be tins of stewing steak or mince. Quite often the food is cold and dry." Another relative said there was no choice at breakfast. In the kitchen there was a list of what people ate for breakfast, which did not promote individual choice.
● Records showed people's weight was monitored. Staff discussed any weight loss with the GP. A relative confirmed this. They told us, "They [staff] monitor [relative's] food and drink intake and they weigh them every week."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The home had intermediate care beds. This was an initiative which helped avoid unnecessary hospital admissions, and delayed discharges once people were medically fit for discharge. People were assessed and generally referred by the local authority.
● The registered manager told us they assessed people's needs prior to offering a permanent placement at the home. They said they were proud of the work the team had done with some people following their admission. This particularly applied to those people who presented with very complex needs.
● One health and social care professional told us, "When it comes to admissions, Camelot are very accommodating. We have a lot of urgent cases especially from hospital and found that Camelot are generally very prompt and are keen to help us out as much as possible." Another health and social care professional told us, "There has been a patient in the care home recently [with specific needs] that the staff have found difficult to manage. This was an inappropriate placement but was done in an emergency during COVID and the patient was not moved on. I think the staff did their best in the circumstances."

Staff support: induction, training, skills and experience
● There was a staff training plan, which was deemed mandatory by the provider.
● Records showed staff had completed training in areas such as fire safety, food safety, moving people safely, health and safety and equality and diversity. However, staff had not undertaken training in positive behavioural support or health conditions such as dementia or autism.
● Staff told us they had enough training to enable them to do their job effectively. They said the majority of training was online and they could do it at their leisure.
● The registered nurses told us they completed mandatory training but also did additional learning for their professional development. One registered nurse told us, "We get recommended for courses and we get updated training every six months or year. We do a five-day skin integrity course, syringe driver training and catheter training for example." They told us they were all tissue viability link nurses. This ensured a greater understanding, and updated knowledge of skin care.
● Records showed staff had received formal one to one meetings with their line manager every six months and had an annual appraisal. Staff told us these systems were helpful, but they could also speak to the registered manager for support and advice at any time.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People had access to a range of services to meet their healthcare needs.
● The registered manager told us they had good relationships with the local GP surgeries. They said GPs visited routinely each week and would give advice or visit when called. They said they also had links with other specialists such as the care liaison team, speech and language therapists and tissue viability

specialists.

- Care records showed the appointments and interventions people had received regarding their health. This included those services as described above, by the registered manager.
- One person however, had teeth which looked like they were decaying. On the first day of the inspection, they did not have a toothbrush in their en-suite facility, and a staff member was unable to locate one. A disposable toothbrush for sensitive teeth was in the cupboard on the second day of the inspection. The registered manager told us the person was waiting to see the local dentist, as their previous appointment had been cancelled due to COVID-19. The registered manager was not aware of specialised dentists, who could visit people at the home. They told us they would look into this.

Requires Improvement

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 our last comprehensive inspection in November 2018, we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- People rights to privacy, dignity and independence were not always promoted.
- People told us staff knocked on their bedroom doors before entering, but this was not always seen in practice. One staff member entered the person's bedroom, without knocking, when we were talking to them. The registered manager also walked into a bedroom, not expecting anyone to be there. The person was in their en-suite, using the toilet.
- There was a copy of the house rules, within staff's personnel files. This stated people should be 'brought down to the lounge (unless requested otherwise) once washed and dressed.' This did not promote individual choice or independence.
- There were signs on walls and furniture in people's bedrooms which did not promote dignity. The signs informed staff how to remove laundry and gave pointers for bed rail safety. The signs did not promote a homely approach or respect people's personal space.
- Some of the language used in care plans lacked dignity and was unprofessional. For example, we saw comments such as, "fussy", and "can be moody and grumpy."

Ensuring people are well treated and supported; respecting equality and diversity
- People were not always well supported or treated with respect.
- There were very little interactions with people, unless a task was being undertaken. This included offering a drink, or assistance with a meal, rather than general conversation and engagement.
- One staff member stayed in the lounge with people to ensure safety, but there was very little interaction. Discussion or social activity was not promoted. Similarly, staff who were supporting people on a one to one basis, did not fully engage or maximise opportunities. They walked with a person, but there was little communication or engaging the person in their surroundings.
- Some interactions did not show a caring approach or enhance the person's sense of wellbeing. For example, staff placed a drink in front of one person and said, "Drink that." Another staff member said, "Have a drink please." One staff woke a person by lightly flicking their cheek. They said the person liked it that way, but another staff member was not aware of this preference. They said calling the person's name loudly was usually successful to wake them.
- People and their relatives gave us variable feedback about the staff. One relative told us, "I'm not overawed. General warmth and communication from staff is lacking. Maybe I expect too much, but I think it's the little touches. Just a little bit of kindness would be nice." Another relative said, "The nurses are all very good. They go above and beyond." A person said, "I do like them. They are very good at what they do. They have to put up with a lot."

● Staff were very positive about their role, and said they enjoyed working with people. One staff member said, "I like it here very much. The care is good and we have a good team." Another staff member told us they would recommend the home. They said, "It's very friendly here. We consider this as people's homes. We try to keep it homely."

Supporting people to express their views and be involved in making decisions about their care
● During the inspection, people were not always offered choice or encouraged to make their own decisions.
● At lunchtime, a member of staff gave some people orange squash to drink. Another staff member then came into the dining room and offered blackcurrant as an alternative. Whilst this was taking place, a further member of staff pointed to each person and said, "She's likes orange", "He likes orange", "She's likes orange." This informed staff of what people liked, but was disrespectful, and also took away people's choice.
● Some people used wheelchairs, with staff assistance, to move around. Staff helped some of these people to the dining room, but did not ask them where they wanted to sit. They made the decision for the person, and there were no pleasantries, or asking the person if they were happy with their positioning.
● Within people's care plans, it was written the person should be supported to have a strip wash daily, and a weekly shower. The information did not evidence people's personal choices. A registered nurse told us, "We try to do at least weekly [showers] but if they want more they can ask." It was not clear how those people who were unable to verbally communicate could ask for more than one shower per week.

Failing to ensure interactions were respectful, choice was offered and privacy was respected was a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff told us they always encouraged people to make decisions, such as what to wear. One staff member told us, "I ask people questions all the time. It's their home, their life, so it's not up to me to decide what they do."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

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

- People had an up to date, electronic care plans in place. However, the information lacked detail and did not always reflect the person's individual needs and choices.
- Information about people's key health care conditions such as epilepsy and diabetes was limited. In one person's diabetes plan, one of the actions was, "Nursing staff to educate [person] on the possible signs of hypo/hyperglycaemia". This did not provide any guidance for staff. There was a list of the signs of hypo and hyperglycaemia, but the information only guided care staff to inform the nurse if these were seen.
- Wound care plans were not consistently in place. There was no plan for one person who had been identified as having a wound for two days. Photographs of wounds were taken, but staff had not used a measuring tool to assist them to monitor the size of the wound and any improvement or deterioration.
- It was documented in people's care plans about having a daily strip wash and weekly shower. However, care records did not demonstrate this had always taken place. There was also no record of people declining this support, if this was the case. In one person's daily records there were eleven days in May when there was no record of the person having a wash or a shower, and 21 days when there was no record of oral care being given.
- The plans contained minimal detail about people's preferences. This included the preferred times for going to bed and getting up, whether men preferred a wet or dry shave, or the type of clothes people preferred to wear.
- Staff had used language within people's daily records that was not professional and showed a lack of understanding of people's needs. For example, one record stated, "Keeps coming out of the bed unaided. Shouting and screaming at times", and, "Has the inappropriate behaviour of smearing faeces everywhere in bed three times."

Failing to have effective care planning in place did not ensure people received care that met their needs or preferences. This was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- The registered manager told us documentation could be written in a way to meet people's

communication needs if needed. This included large font. A staff member also told us they would read any written text to the person, if their eyesight was poor.
● People's communication needs were detailed in their care plan. For example, it was stated one person was hard of hearing and needed staff to speak into one ear only because they could hear better that way. However, staff did not always follow this guidance and spoke directly at the person, rather than into their ear.
● One member of staff told us people had varying communication needs. They said these often became clearer, as staff got to know the person.

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
● There were two activities organisers who were responsible for organising social opportunities for people. The registered manager told us another member of staff supported these staff.
● During the inspection, there were various activities taking place in the dining room, at the same time. Two people were looking at an electronic pad, one person was colouring, another was doing a jigsaw and others were playing bingo. On another day, people were doing flower arranging. Care staff had accompanied some people in the garden.
● Activity staff said the majority of their time was spent in the lounge or dining room with people. One of the staff said they tried to spend time with each person during the week. This might include doing a hand massage, painting someone's nails or reading to them. They said they were planning external events for the summer, with some taking place over the Queen's Jubilee weekend.
● One member of staff told us there was no formal activity plan. They said activities were based on people's preferences on the day. The member of staff told us, "I leave books around and they get picked up. People spend time just flicking through them or take them to their room. I find it works well. It's all about them and what they want to do. Flower arranging is popular. They don't put the flowers where I would, but it doesn't matter. It's theirs, not mine."
● There was mixed feedback about the activities on offer. One person told us, "They keep us busy. There's always something to do." Another person said, "No, I don't join in. It's not for me."

Improving care quality in response to complaints or concerns
● People and their relatives knew how to raise a concern.
● The registered manager told us they always wanted to know if a person was unhappy, so they could take action to address the problem. They said they spoke to people and their relatives regularly, so hoped any concerns would be raised at an early stage.
● One relative told us if there was anything they were concerned about, they would always speak to staff or the registered manager, at the time, They told us, "If it's not good enough, they need to know. It's my [family member] so I will say and make sure it gets sorted." They told us anything they have raised in the past, has always been addressed and satisfactorily resolved.
● The registered manager maintained a record of any complaints they received. A recent complaint raised concerns about inadequate staff support with their relative's personal hygiene. The record showed a 'return to basics' induction for carers would be introduced. However, there were no timescales or who would be responsible for this. The records did not show any correspondence to the person who had raised the concerns, or an investigation. There was no evaluation to show the concerns had been satisfactorily addressed.

We recommend the provider improves their documentation to evidence compliance with their complaint procedure.

End of life care and support

● The home was able to provide care at the very end of a person's life. At the time of the inspection, no one was receiving this type of care.

● Registered nurses told us they were trained to provide end of life care and could access training and support from the local hospice if they needed to.

Inadequate

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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- There was a quality assurance system in place, but this was not effective in identifying shortfalls within the service.
- Shortfalls raised at this inspection, such as those related to fire safety, risk management and the environment had not been identified. This included two people's bedroom's which did not have a fire/smoke detector, unprotected hot pipes and excessively hot water temperatures. All presented risks to people's safety.
- The registered manager told us they regularly walked around the building, yet had not noticed such hazards or areas in need of improvement. We showed the registered manager our concerns, including a ladder in a corridor, blocked fire exits, bare wires in a door frame, and easy access to a boiling kettle. The registered manager told us it was good to have fresh eyes to see these things.
- Certain questions within an environmental audit, had not been answered. This included whether the fire doors met current fire regulations or when the portable electrical appliances had last been tested. This did not give assurances regarding safety, and also gave a misleading outcome to the audit which was not accurate.
- The registered manager often found it difficult to locate documentation or answer questions asked of them relating to the management of the home. They were heavily reliant on the home's administrator for this. Some information could not be found. For example, there was a record of what had failed the last portable electrical tests, but not what other appliances had been tested.
- The registered manager had not taken responsibility to address or follow up matters of priority such as the replacement of the fire/smoke detectors in two people's bedrooms.
- There were printed 'keep shut' signs on internal doors in the corridors, but the doors were open. The registered manager told us the signs were there to ensure safety when the home was planning to become a dementia care unit. This was years ago, but the signs had not been taken down. The registered manager had failed to identify this. This gave confusion, as to which notices staff needed to take notice of, thus creating the risk of error.
- Some audits covering areas such as infection control, food and dining, nutrition and falls had taken place. These had identified good practice. However, a recent oral care audit had identified 35% of people had not received their oral care in March. The action to address this was group supervision and oral care training for all staff, and to improve record keeping. The record did not show who would be responsible for this or when it would be completed by.

● The registered manager had not identified the monitoring system of people's fluid intake was not effective. This increased the risk of people becoming dehydrated, especially during the hot weather.
● There was an improvement plan in place. The registered manager said this was ongoing as things were added to it on a daily basis. The last entries were those shortfalls we had identified during the inspection. However, some shortfalls had 'ongoing' written against them. This did not ensure they would be satisfactorily addressed or evaluated. The testing of the portable electrical appliance testing was deemed high risk, with a completion date of 9 May 2022. On 27 May 2022, the last day of the inspection, this had not been completed.
● The provider visited and undertook their own audits. One of the things identified was to check staff were using footplates on people's wheelchairs when supporting them. During the inspection, we saw staff trying to fit the footplates on the chairs. However, the strap on one of the footplates to hold the person's foot in place was broken, and the tyres were flat on another.
● At 14.15 on the last day of the inspection, there were three plated meals in the kitchen, which people had not wanted at lunchtime. A member of staff told us they would be offered at teatime. Once raised with the staff member, they were placed in the fridge. Leaving food out, particularly in warm weather and the risks associated with this, had not been identified.

Failing to have systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people, placed them at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Records showed there were eight incidents, which had not been notified to CQC as required. Six of these were also not sent to the safeguarding team.
● Some incidents that CQC had been notified about, were not included in the service's incident and accident records. This meant analysis for incident and accidents did not contain all the correct data to analyse. Patterns and risk could therefore be inaccurate or missed, which could put people at risk of harm.
● The registered manager had a separate 'Safeguarding log for 2022'. This listed when incidents and accidents had been referred to the local authority. The information on this log differed from the information on incident reports.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009: Notification of other incidents

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Feedback about the registered manager was complimentary. Specific comments were, "She's good to us and really listens," "She has a lot of compassion" and, "[Registered manager] will help with anything. She's not a manager who sits in her office, she will come and join us. She helps if we're short of staff. She's everywhere."
● All staff were friendly, helpful and accommodating to the inspection team. They told us they enjoyed their role, and enjoyed supporting people.
● The registered manager told us they spent the majority of their time 'on the floor' with people and staff. They said they did not manage the home from the office. They wanted to be approachable, but also monitor the care which was being delivered. The registered manager told us staff often did not know they were behind them.

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

● The registered person told us they aimed to develop relationships so people and staff could feel free to say if they had any concerns or suggestions.
● Staff had one to one meetings with the registered manager to ensure their wellbeing and to discuss their work.
● People and their relatives were sent questionnaires to give feedback about the service they received. Feedback from the most recent survey was positive in all areas.

Continuous learning and improving care; Working in partnership with others
● The registered manager told us they liked teaching and mentoring and worked closely with the registered nurses. They told us "You have to train staff and keep them under your wing. It's important to invest in staff."
● The registered manager told us they encouraged group supervision with staff. This enabled shared learning and discussion about good practice or any challenges being faced.
● The registered manager and registered nurses worked closely with a range of health and social care professionals. This included GPs, speech and language therapists and occupational therapists.
● The service was part of an initiative for care home providers. The registered manager told us they built relationships as part of this, and often worked with other managers in the area.
● After the inspection, one health and social care professional told us, "I have a good working relationship with Camelot Care Home. The main member of the team I've normally spoken to is [name of staff member], along with some other very good nurses. The staff are happy to provide me with feedback [and/or] answer questions I have about their residents. They seem to know their residents well." Another health and social care professional told us, "We have developed a very good relationship with Camelot."

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Incidents and accidents were not always reported to the Care Commission as required. Regulation 18(1)(2)(1)(5) of the Care Quality Commission (Registration) Regulations 2009

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care planning did not fully demonstrate people's needs, treatment or preferences. Care records did not demonstrate the care people had received. Regulation 9(1)(2)(3)(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect, and their independence was not promoted. Regulation 10(1)(2)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Systems were not in place to ensure people consented to all aspects of their care in line with the Mental Capacity Act 2005. Regulation 11(1)(3)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of service users associated with the environment had not been assessed. Action had not been taken to mitigate such risks. Regulation 12(1)(a)(b) Not areas of the home were clean and effective systems were not in place to prevent and control infection. Regulation 12(1)(2)(8) Medicines, including time specific medicines and those taken as required, were not being safely managed. Regulation 12(1)(2)(7)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems were not in place or fully effective to safeguard people from abuse or minimise the reoccurrence of an accident or incident. Regulation 13(2)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There were inadequate systems to improve the quality of the service or to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. An accurate and complete record was not maintained to ensure adequate monitoring of the risk of dehydration or malnutrition. Regulation 17(1)(2)(1)(2)(3)

The enforcement action we took:

We issued a warning notice.