Camelot Care (Somerset) Limited

Camelot House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 18 and 19 January 2016 and was unannounced. We carried out our last comprehensive inspection on 29 April 2014, followed by a focussed inspection on 16 December 2014. We found the service was compliant with the standards inspected and no breaches of regulations were found.

Camelot House is a nursing home which is able to accommodate up to 90 people in two buildings. Camelot House can accommodate up to 62 people and Camelot Lodge can accommodate up to 28 people. The home specialises in providing nursing care to people who have dementia and other mental health needs.

At the time of the inspection there were 52 people living at Camelot House and 26 people living at Camelot Lodge.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Risk assessments, care plans and reviews were not always up to date, which meant risks related to issues such as nutrition were not being monitored or appropriate action taken to manage them. Care plans did not always tell staff how to recognise when people were becoming agitated or how to support them if they became aggressive. This lack of detail in care plans increased the risks for others and staff, particularly at night time, and for staff less familiar with the person. In addition a member of staff told us they were not trained to deal with the level of aggression shown by some people. The registered manager was aware that staff would benefit from enhanced training and was looking for training that would provide this.

People said they felt safe living at the home, and this view was shared by relatives. One person told us, "I feel safe here, rules and regulations are strictly adhered to and staff watch over us". Risks of abuse were minimised through the provision of policies, procedures and staff training. The registered manager had initiated a campaign to encourage staff to report concerns. This had led to an increase in safeguarding referrals which had been managed effectively.

There were sufficient staff to meet people's needs. A dependency tool was used to ensure the right staffing levels across the home, and several people received one to one support. Staff responded effectively when people required assistance. They demonstrated a good knowledge of people's individual needs. They were patient and caring in their approach, promoting people's independence and treating them with dignity and respect. People were supported to make choices about their day to day lives, such as what to wear and how they wanted to spend their time.

People were supported to receive ongoing health care support. Staff were knowledgeable about people's care and treatment needs, and people were referred appropriately to external health professionals. The

home worked closely with the community mental health team to assess people's needs and develop care plans to ensure they were met. We received positive feedback from them about the skills and responsiveness of staff when caring for people with very complex needs.

The home was accredited to the 'Gold Standards Framework' (GSF) and had been awarded 'Beacon' status. This award is recognition at the highest level for the quality of care provided to people at the end of their lives.

People's relatives said they were made welcome and encouraged to visit the home as often as they wished. They said the service was good at keeping them informed and involving them in decisions about their relatives care.

A daily activities programme took into account the needs of people living with dementia. Activities staff worked to involve everybody according to their individual needs and ability to participate.

The registered manager provided strong leadership and there were clear lines of accountability and responsibility. They had been proactive in developing a culture of transparency and openness at the home. Concerns and complaints were fully investigated and outcomes shared with interested parties, including the staff team. Details of actions taken as a result of quality surveys, suggestions and complaints were displayed on notice boards in reception. Staff learning and development was encouraged and supported by a dedicated training manager.
The provider had a range of quality monitoring systems in place which were used to continually review and improve the service. People's views were actively sought and suggestions acted on.
The registered manager and provider kept themselves well informed with regard to good practice initiatives and developments in care provision. Their learning was used for the benefit of people living at the home to keep staff up to date with practice, encourage high standards of care and improve to the environment.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Risk assessments, care plans and reviews were not always up to date.

There were sufficient numbers of staff to keep people safe and meet each person's individual needs.

People were protected from the risk of abuse through the provision of policies, procedures and staff training.

Systems were in place to ensure people received their medicines safely.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to manage risks in relation to behaviour that was challenging.

People's rights were protected, because the service acted in line with current legislation and guidance where people lacked the mental capacity to consent to aspects of their care or treatment.

People were supported with nutrition and hydration.

The environment promoted people's independence and quality of life.

Is the service caring?

Good

The service was caring.

People were treated with kindness, dignity and respect.

Staff were committed to promoting people's independence and supporting them to make choices.

People and their relatives were supported to maintain strong

family relationships.

People received high quality care at the end of their lives.

Is the service responsive?

Good

The service was responsive.

There was a comprehensive assessment of people's needs before they moved to the home and on admission.

Care plans were person centred, and supported people to make choices.

Staff had a good knowledge of people's individual needs. People were offered choices about their daily lives and staff worked flexibly around their wishes.

Complaints were dealt with effectively.

Is the service well-led?

Good

The service was well led.

There was a registered manager and the culture was open and transparent.

People, relatives and staff views were sought and taken into account in how the service was run, and suggestions for improvement were implemented.

The provider had a variety of systems in place to monitor the quality of care provided and made changes and improvements in response to findings.

Camelot 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 checked 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.

The inspection took place on 18 and 19 January 2016 and was unannounced. The inspection team comprised of two inspectors and an expert by experience with expertise in the care of people with physical and mental health needs. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We reviewed information about the service from the Provider Information Return (PIR), and other information we held about the service such as from notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We met with twelve people using the service, spoke with five relatives and visitors and looked in detail at eight people's care records. As most people were unable to comment directly on their experience of the service we spent time observing care in the communal areas and 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 spoke with 18 staff, which included the provider, registered manager, nursing and care staff and a range of ancillary staff. We looked at six staff records, at training and quality monitoring records such as audits and survey findings. We sought feedback from health and social care
professionals who regularly visited the home, including community psychiatric nurses and social workers, and received three responses.

Requires Improvement

Is the service safe?

Our findings

There was a risk that people may not receive safe care, because risk assessments and care plans were not always reviewed regularly. People's care records included assessments relating to their risk of pressure damage, malnutrition and falls. These were not always up to date however, which meant that risks were not always being monitored or appropriate action taken to manage them. For example, one person was assessed as being at very high risk of pressure damage with a monthly review indicated, but this had not been done for two months. A Malnutrition Universal Screening Tool (MUST) for one person had been completed five months earlier with a monthly review indicated, but no further review was recorded, even though their appetite had since become poor and they had lost weight.

Records showed some people sometimes became upset or agitated which led to them becoming angry or aggressive. Care plans did not always explain how staff could recognise signs of distress or agitation, or tell them how to support the person to distract or calm them. A member of staff told us they were not trained to deal with the level of aggression shown by some people. They had raised concerns about the skill mix and the type of people who were being admitted, especially in relation to the needs of current residents. These concerns were subsequently addressed by the management team. The registered manager later told us they recognised that some staff would benefit from enhanced dementia training to build on their skills in looking after residents with more complex needs. They were mindful to strike a balance in the home when admitting people with more complex needs.

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

People said they felt safe living at the home. One person told us, "I feel safe here, rules and regulations are strictly adhered to and staff watch over us". Another person said, "I am safe and happy here, people are so kind, I feel secure". This view was shared by relatives, who told us, "My loved one is very safe; there is always someone with them". People and their relatives told us they would raise any concerns with the manager or other staff and were confident they would be dealt with appropriately. One person said, "I would tell somebody if I was not happy about something, I speak plainly and I speak my mind, but so far have not had to do this".

People were protected from the risk of abuse through the provision of policies, procedures and staff training. Safeguarding training was mandatory for all staff and always discussed in supervision. Staff were knowledgeable about signs of abuse and encouraged to raise any concerns by the "See something. Say something" campaign introduced by the registered manager. A senior member of staff told us," Staff are not so worried about reporting…Relatives appreciate the fact that concerns are being acted on".

Since the last inspection the registered manager had made several safeguarding referrals to the local authority safeguarding team and Care Quality Commission. Many of these related to incidents where people were physically or verbally aggressive towards others living at the home. The registered manager had acted decisively to reduce risks. They had involved other agencies such as the community mental health team or

GP, in order to review people's mental health needs, carry out risk assessments and determine what action was needed to keep people safe. Allegations concerning staff being abusive towards people living in the home had been fully investigated and appropriate action taken, as prescribed in the home's disciplinary policy.

Risks of abuse to people were minimised because the provider ensured all new staff were thoroughly checked to make sure they were suitable to work at the home. Staff recruitment records showed appropriate checks were undertaken before staff began work. Disclosure and Barring Service checks (DBS) had been requested and were present in all records. The DBS checks people's criminal history and their suitability to work with vulnerable people.

There were sufficient numbers of staff within the service to keep people safe and meet their needs. We observed there were staff with people in communal areas at all times. Some people were receiving one to one care and staff providing this were identified by a red arm band. This meant they could focus fully on supporting the person, as staff and visitors knew not to distract them. Staff appeared to be very vigilant and aware of residents' movements. One person told us," "I am alright here, plenty of staff, they are here if I need them". Relatives commented, "There's always someone around", and, "There are plenty of staff, always in and out". In the provider Information return (PIR), the registered manager stated," To keep consistent and sufficient numbers of staff all residents are assessed using our dependency tool... The system is designed to allocate staff to a specific area of the home so that they can get to know the residents well and to build up good relationships with family and friends. Having a large workforce gives us the capacity to deliver flexible staffing across the home".

Systems were in place to ensure people received their medicines safely. People and their relatives told us they were satisfied with the administration of medication. One relative commented, "My loved one gets difficult at times and refuses to take their tablets, but I have seen staff have a joke and use a bit of gentle persuasion. This usually works. If not, they walk away and come back a little later when my loved one takes it without any trouble". We observed a resident being given their medication at lunchtime by a member of staff who addressed them by name, and told them they had their tablet. This was offered on a spoon directly into the resident's mouth, followed by a drink.

Staff who administered medicines completed medicine management training, and a group of care assistants were being trained about medicines, so they could support nurses on medicine rounds. We saw staff had correctly signed medication administration records (MAR) to show administration of medicines, with two staff signatures on the MAR sheet for controlled drugs. Where a person who lacked capacity was receiving their medicine covertly, there was evidence this had been agreed with their GP in their 'best interest'.

There was guidance with the medication administration records for the administration of medicines prescribed to some individuals for use as required (known as PRN), such as for pain-relief or certain behaviour. We saw that PRN medicines prescribed for calming people when agitated or aggressive were administered infrequently, avoiding a risk of restraint by sedation. Daily care records showed staff had tried other strategies to calm people, using the PRN medicines if these were not successful and a risk to the person or others was identified.

Medicines were audited regularly and action taken to follow up any discrepancies or gaps in documentation. All medicines were stored securely, including those needing refrigeration, and controlled drugs. Records were kept of room and fridge temperatures and showed that over recent weeks facilities remained within the recommended range for maintaining the effectiveness and safety of medicines.

Staff had a good understanding of the policy and procedures related to accident and incident reporting. Records were clear and showed appropriate actions had been taken. The registered manager analysed these records every month, which allowed them to understand any causes and identify any trends and preventative actions that might be needed to keep people safe.

There were systems in place to make sure the premises and equipment were safe for people. Maintenance checks of all equipment and regular services were completed monthly and any repairs addressed quickly by dedicated maintenance staff.

There were environmental adaptations and equipment to reduce risk. For example beds were being provided that could be lowered almost to floor level if people were at risk of falling from their bed, to reduce injuries. Windows we checked were restricted. We saw however that there were some risks to people because chemicals and detergents were not always securely stored, for example, toiletries in an unlocked bathroom, and a dispenser bottle of hand-disinfecting gel in the dining room. It was quickly removed by staff who told us it shouldn't have been left there.

Staff had received training in fire safety, and fire checks and drills were carried out in accordance with fire regulations. Individual fire risks assessments were in place and each person had a personal emergency evacuation plan (PEEP) showing what support they needed to evacuate the building in the event of a fire. PEEPs in people's care records appeared to reflect their current mental and physical needs. We saw for example one had been updated to show a person now required the use of a hoist to transfer them. PEEPs were also kept centrally for quick access by those managing an emergency requiring evacuation.

People were cared for in a clean, hygienic environment. The team of cleaning staff was managed by a housekeeper, who monitored the quality of the domestic and laundry services. Daily, weekly and monthly cleaning schedules were maintained. There were effective infection control measures in place. Staff had access to hand washing facilities and carried hand gel. Personal protective equipment (PPE) was provided for all staff, with different coloured aprons for dealing with food and drink, personal care and clean or dirty laundry. Systems were in place for ensuring nursing equipment such as hoists, suction machines and pressure-relieving mattresses were kept clean. Staff described systems for handling soiled laundry, such as using specialist bags for transporting it, and washing these separately, at higher temperatures than other laundry.

Good

Is the service effective?

Our findings

The service was effective. It was apparent staff knew the residents well. For example, a member of staff told us they knew which people become restless and agitated around teatime and ensured there were enough staff to manage any behaviour that become challenging. Staff anticipated incidents when people approached others who did not wish to be disturbed. We saw they reacted quickly to separate them, offering quiet and calm reassurance. A relative told us, "Staff know what to do when my loved one gets agitated". Three members of the community mental health team gave us positive feedback about staff skills and knowledge in managing people's challenging behaviours. They told us, "There are some people with quite severe mental health problems, and they have always managed really well". Although the care records were not always up to date, they told us staff had the information they needed to care for people, 'in their heads', and the "hands on care was very good".

Staff had a good understanding of people's likes and dislikes. For example, one person liked to spend most of their time outside in the enclosed garden. It was very cold on the day of our visit, and staff made sure this person was well wrapped up before going outside. Later, a member of staff escorted them back inside for a warm drink before going out again. We saw from this person's care records that they chose to be outside at every opportunity, so a risk assessment, best interest process and care plan had been completed, in consultation with relatives. There was detailed guidance for staff, for example, "Ensure [the person] is suitably dressed with a hat and sun cream in summer". This meant staff were able to support the person in their wish to be outside, while minimising any risks to their well-being and safety.
New staff completed a comprehensive induction programme. This covered a range of essential areas like manual handling, fire safety, infection control and dementia. During this period they worked alongside more experienced staff to get to know people and about their care and support needs. After this they were assessed to ensure they were competent before working unsupervised. New staff also completed the new Care Certificate. This is a more detailed national training programme and qualification for newly recruited staff.

The home had a dedicated training manager with responsibility for ensuring staff skills and knowledge were monitored and updated as required. The mandatory training programme included topics such as 'privacy and dignity', 'the mental capacity act and deprivation of liberty safeguards' and 'safeguarding', with the incentive of an additional payment once the programme had been completed. The registered manager told us safeguarding information was being translated into different languages to enable all staff to understand it fully. Staff were encouraged to continue their professional development and identify any additional training needs they may have. External speakers covered a range of subjects to help staff become more effective in their work. Senior nurses had clinical lead roles in key areas of practice, and accessed external training to support them in this, for example in leadership and management, or 'train the trainer' courses. This meant they could share their knowledge and expertise across the staff team. We saw senior staff observing more junior staff and giving praise or guidance as appropriate. We also saw staff seeking advice from the senior staff, who took the time to address their query fully. For example, how to support one person living with dementia who was distressed.

Each member of staff had an allocated supervisor, with supervision being provided at least every eight weeks, and an annual appraisal. Staff told us, "We talk about our qualities, what we're doing well, and areas for improvement". Regular agendas items included equality and diversity, safeguarding, and mandatory training. Discussions were documented to ensure accountability. We saw that staff were supported to learn from any mistakes. For example, a member of staff who had made an error when dispensing medicines wrote a reflective account of what had happened, and was then assessed undertaking a medicines round to ensure competence.

Staff had undertaken training in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS), and demonstrated a good understanding of how these applied to their practice. The 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. Where a person was thought to lack capacity, mental capacity assessments had been undertaken. Relatives and professionals were consulted and involved in 'best interest' decision making, for example in relation to the use of covert medication, alarm mats and the use of photographs. However one person's record did not indicate that a best interest process had been followed in relation to bed rails. The registered manager assured us this would be followed up immediately. Staff demonstrated to us how they supported people with day to day decisions and choices, and sought consent before acting. We saw them ask people if they could remove their tabards or assist them to a different seat. They repeated the request politely if people didn't understand, sometimes rephrasing the question. They waited while people thought and voiced their decision. Staff sometimes checked they had understood the person correctly before acting.

People's rights were being protected in relation to the Deprivation of Liberty Safeguards. (DoLS), and we saw 'easy read' leaflets explaining DoLS were available for people. 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 Mental Capacity Act 2005 (MCA). The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). A senior nurse had responsibility for identifying people who were potentially deprived of their liberty and several applications for assessment had been made. The registered manager confirmed the authorising body were updated about any changes in risk to ensure they gave priority to the most urgent applications.

People's nutritional needs were assessed to make sure they received a diet in line with their needs and wishes. Nursing staff kept the chef informed about people's dietary needs and preferences. Care staff told us they learnt about people's nutritional needs and any swallowing difficulties from their care plan initially and were informed of any changes during daily handovers. They reported any issues, such as if an individual was coughing, which could be a sign of swallowing problems. Food and fluid charts were kept to monitor any concerns, and the information shared with the GP if necessary, who could refer to the community dietician and speech and language therapist (SALT) for further assessment. The chef showed us information displayed in the kitchen from the SALT, about different types of diets that might be advised for people at risk of choking, for example a soft or puree diet. We saw such meals were served as the different components of the meal, to retain an appetising appearance, rather than being mixed together.

Most people enjoyed their meals and agreed they had enough to eat and plenty of choice. Comments included, "The food is not what I am used to and I do not like it, but we get tea and biscuits all the time so I am alright", and, "All the food is well cooked, we get a fair choice and there is plenty of it". People were offered a choice at meal times. Menus were also in picture form to help them choose. Staff told us they got

to know people's preferences from working with them and talking with them about what they liked or used to like. The main meal of the day was served in the evening, with a lighter meal at lunch. The registered manager explained this was based on research with the aim of reducing sleep disturbance due to hunger overnight. People could choose additional foods from a 'light bite' menu if they felt hungry outside of a meal time, and additional snack boxes were available for people who were not maintaining an adequate weight. Fresh fruit and drinks were seen in all communal areas throughout the day and we saw staff offering people drinks regularly.

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The dining room was calm during the lunchtime, with most staff giving their full attention when they provided support to individuals. People appeared to be enjoying their meal, eating at a steady pace. Staff did not rush people they were assisting with their food, drinks or when they assisted them from the tables.

People had access to healthcare services for ongoing healthcare support. They were seen regularly by their local GP, and had regular health appointments such as with the dentist, optician, and chiropodist. Where any health concerns were identified, visiting health care professionals confirmed staff at the home sought advice appropriately and followed that advice.

A programme of environmental refurbishment was underway. In the provider information return (PIR), the registered manager advised," Following the opening of Camelot Lodge in 2014 and the acknowledgment of how a purpose built dementia environment benefits the residents that live there we have upgraded Camelot House to include the features that were proving to work so well in the Lodge". Camelot House had been redecorated, with non-reflective, non-slip flooring, and grab rails and door frames painted in a bright contrasting colour so that people could see them and find their way around more easily. There was clear signage throughout. The environment encouraged people to be sociable with each other by having small areas of seating, and people could have quieter one to one time away from the busy activity area. Other improvements included movement activated lighting in some areas and the provision of two seater sofas, so that couples could sit together. The registered manager told us people and regular visitors had been involved in choosing colour schemes and styles of furniture. Further improvement plans included the creation of a second enclosed garden and the development of circular walking routes that enabled people to walk from the buildings through the garden areas with a 'sense of journeying'. Health professionals commented on how much lighter and brighter the home was, and how relatives had told them, "Camelot is looking really lovely".

Good

Is the service caring?

Our findings

People were supported by kind and caring staff who treated them with warmth and compassion. They told us, "Staff are wonderful, they do more than they have to do", "I am very happy here, I cannot speak too highly of the girls (staff), the way they look after us is kindness itself", and, "Staff are all lovely, some are from different parts of the world and that is nice, I love to hear the different accents". A relative said their loved one had not been at Camelot very long and they could see a marked improvement in their general demeanour. They told us they had found the staff to be very pleasant and caring.

In the provider information return (PIR), the registered manager described how the service assessed the values and compassion of potential staff when recruiting. "During interviews a question is asked to candidates about their understanding of care and compassion. This is followed up by asking the candidate how they demonstrate care and compassion in their everyday life. Candidates are selected when they are able to demonstrate an understanding of empathy and show emotional intelligence".

Staff were respectful, understanding and patient when assisting people. They addressed people by name, responded promptly to requests, such as for a cup of tea, and stooped to speak with people who were seated, giving them time to respond to any questions. One person being assisted was expressing distress about their parents, as though they were still alive. Staff acknowledged this concern then guided the conversation to talking positively about the person's children, which settled the person's distress and showed staff knew about matters important to the person. A senior carer told us they were supernumerary at times so they could help other staff to better understand and meet people's needs. For example, they might prompt them to sit down with people when assisting them at meal times, or show them how to engage meaningfully with people.

Care plans guided staff to treat people with dignity and respect. For example, "[The person] is very particular about getting certain things right. Do not shorten their name". We saw staff knock on people' doors and open them slowly when no response was heard, calling out as they entered the room. People could choose whether they wanted their bedroom doors open or closed as all bedroom doors had a holding device, which was linked to the fire safety system. A relative commented, "Privacy and dignity is always maintained, staff are very discreet when my loved one has an 'accident' and needs changing". Staff told us they always ensured curtains and doors were closed before supporting someone with personal care, and obtained consent before assisting them. They understood people living with dementia may need additional reassurance, and support to make choices, "I tell them who I am and why I am there. I always ask permission and offer choice". Clear glass windows in drawers and wardrobes allowed people to see what was inside, helping them to find specific items. Staff told us they supported people to choose what to wear by showing them two items of clothing.

A programme had recently been introduced where everybody living at the home was 'resident of the day' once a month. On this day people wore their best clothes and could request something special to eat. Every aspect of their care was checked, including a review of their needs and care plan, all items of clothing in wardrobes and drawers and any electrical equipment. This was an opportunity for a regular 'whole service'

review of people's well-being and environment, as well as allowing them to enjoy their own 'special day'.

People's religious beliefs were supported, and there was a regular service at the home which incorporated all faiths and non-religious beliefs. The registered manager reported these services were well attended and families had given positive feedback about them. In addition an annual memorial service was held to celebrate the lives of people who had passed away.

The home was accredited to the 'Gold Standards Framework' (GSF) and had been awarded 'Beacon' status. This award is recognition at the highest level for the quality of care provided to people at the end of their lives. The GSF was mandatory training for staff. The registered manager advised they had produced a video explaining the goals of the GSF, and leaflets and a display board provided additional information for relatives. Advance care planning was completed with people and their families on their admission to Camelot, which meant their wishes for care at the end of their lives, were discussed and documented. Relatives said their views and wishes for end of life care had been sought, and this was approached in a dignified and sensitive manner. The 'clinical lead' nurse with responsibility for 'end of life care' had been given dedicated time for this role. They previously worked for a hospice and used their experience and knowledge to provide effective support to families following the death of their relative. In the provider information return (PIR), the registered manager planned to, "Explore the possibility of recruiting and training people who will be able to spend time with residents in their final days of life and that do not have family or friends to be with them".

Good

Is the service responsive?

Our findings

People living in the home received personalised care which met their needs. For example, staff explained that the bath rota was not rigid, with staff sometimes supporting people to have a bath when the opportunity arose, or respecting people's preferences not to have a bath on their allocated day.

Staff had a good knowledge of people's individual needs; people were offered choices about their daily lives and staff worked flexibly around their wishes. We saw one person stoop to pick up something from the floor. A staff member approached to ensure their safety and assist them, finding the person had picked up a leaf. They told the person they would throw the leaf away, indicating the person should give them the leaf, but the person was reluctant to give it to them. The staff member then talked with the person, they agreed to walk together so the person could throw the leaf away themselves, and did so, with the person looking content and purposeful about this.

Each person had their needs, risks and choices for care assessed by the registered manager and deputy manager before they moved into the home and on admission. Relatives told us they were involved in this process, as well as key health and social care professionals. Many people referred to the home had complex needs. The pre-admission assessment allowed the registered manager to determine whether they could safely provide care for this person and to balance their needs with those of others in the home. "We won't say yes until we think they can be safely managed". A health professional told us," Camelot is asked to take the most 'difficult' people, and they are open and honest about why they can't take them. The current mix of residents means they can't take people whose behaviour would increase the risks to other people living there". This assessment also allowed the home to prepare the environment, ensuring the correct equipment was available and staff had the right skills to meet the person's individual needs.

In the provider information return (PIR), the registered manager stated, "we prevent and manage challenging behaviour effectively and positively through multi-disciplinary care planning and close links with carers". Most care plans seen provided detailed guidance for staff, supporting them to understand and meet people's needs effectively and keep them safe. For example, the care plan of one person with sensory loss, advised staff that the person listened to English and translated it into their first language. The aim was to enable the person to "effectively express their needs and emotions and communicate to staff and residents as they wish". Staff were directed to," speak slowly and clearly, giving [X] time to process the information. Be aware of and assess non-verbal communication. Anticipate their needs, particularly for personal space. Speak slow and low when explaining things to [X]. Give them time to process information, use diversion techniques if aggression becomes heightened".

Care plans were person centred, and supported people to make choices. One person who was," able to make minor decisions and choices re day to day life"…should be," encouraged to choose their own clothes, offer choice between 2 garments. Support [X] to retain sense of who they are." We saw staff had tried to involve people in developing their care plans, as these records included the person's comments. Staff had also recorded when the person was unable to answer, or had not retained information discussed with them for very long.

The home aimed to review care plans monthly, with formal reviews arranged annually or where there had been significant change in the person's needs. The GP and community mental health professionals were involved, along with the person and their family where practical. This was an opportunity to review risk assessments, medication, and care provision to ensure the care plan continued to meet the person's needs.
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Activities took into account the needs of people living with dementia. They were designed to help people reminisce, and stimulate conversation. People were able to participate in daily activities, led by a team of four part-time staff and an activities co-ordinator. We observed a lively music and movement session, which was well attended. People were actively participating and appeared to be enjoying themselves. Each person had a personalised activity care plan, which ensured they had the opportunity to engage in an activity every day, either in a group, or one to one in their room. There were 'activity boxes' full of interesting items, games, puzzles and art equipment to promote one to one time between organised activity sessions. Staff were encouraged to spend any free time chatting with people and their families, and developing 'life story books' with them. This helped them to get to know the person and created an opportunity for discussion about their previous life and achievements. A 'sensory room' provided a calm environment where people could relax, and a 'cinema room', screened generation-related musicals and programmes on a large screen TV.

Small animals and fish were kept at the home as pets for the benefit of people living there. This included an aviary. The registered manager showed us a webcam display that had been set up so one person with an interest in it could still see the birds when they were no longer able to go outside.

People were supported to access their local community and go out on trips in the home's minibus, either to places chosen by them, or to the local garden centre or tea rooms for afternoon tea.

People were encouraged to personalise their room with things that were meaningful to them, for example family photographs, pictures, furniture or ornaments. They could choose whether they wanted to have a shower or bath, and what colour they wanted their room to be painted.

There were no restrictions on people visiting, and people were encouraged and supported to develop and maintain relationships that mattered to them. The registered manager told us families were encouraged to become part of 'Camelot life' and said, "You know you're getting it right when relatives come in and make themselves a drink!" Relatives said they had a good rapport with staff, and found them to be very supportive and approachable. One relative said, "When my loved one first came here I became so upset when I visited, but staff were lovely to me and very reassuring, I thought that if they treat me like this they must be like it with them". They told us they were kept well informed about their family member and of any changes.

The provider had a written complaints policy and procedure. Written information about how to raise a complaint was given to people and on display in the home. The names and photos of senior staff on duty were displayed at the entrance, so people knew who to report to. Relatives told us they had confidence in the registered manager and would feel comfortable in taking any concerns to them. We saw complaints had been thoroughly investigated, and failings acknowledged in writing, along with improvement actions taken. In the provider information return (PIR), the registered manager advised, "The outcome of the investigation and complaints are shared with staff through team meetings and handovers, so any lessons learnt are shared." The registered manager had also introduced the 'You said-We did' initiative, which meant concerns raised were posted on a board in the reception area, along with the response. For example, concerns about the cleanliness and tidiness of the home resulted in a new post being created for a housekeeper. They told us, "It's really important for people to know they can change the home and that we're taking on board what

they're saying".

Good

Is the service well-led?

Our findings

The home was managed by a person who was registered with the Care Quality Commission as the registered manager for the service. We saw they were visible around the home, knew people well, and spent time talking with them. People, relatives, staff and other professionals were complimentary about them. One person told us," [Manager's name] is beautiful, I can't say a word against them. If I was worried I would go to see them. They are simple and lovely, not complicated, they would sort it". Relatives commented, "Good manager, they are around all the time", and," The manager is lovely, approachable and helpful". Staff told us the registered manager was supportive."[Manager's name] is doing well. Carer's listen to them". Care records showed a health professional had commented, "[Managers name] expertise and knowledge is such that [the person] requires minimal support from outside agencies".

The registered manager had been proactive in developing a culture of transparency and openness. Details of actions taken as a result of quality surveys, suggestions and complaints were displayed on the 'you said we did' boards. The registered manager told us how the 'see something, say something' campaign had given staff the confidence to report concerns, as well as give positive feedback when staff had done something well. The increased awareness of staff about how to make a referral and how to spot potential abuse, had led to a rise in the number of 'Safeguarding Adults at Risk' referrals. The registered manager told us," It's not about 'grassing people up'. I saw it working in the NHS and introduced it here. The manager can't be everywhere. People know I have an absolute zero tolerance of anything like that and the writing's on the wall".

The registered manager told us they wanted Camelot to provide a real home for people. They wanted people to feel safe and listened to, for staff to know them really well, and to be able to respond and understand their needs. They emphasised the importance of supporting and developing staff in order to achieve this. In the provider information return (PIR), they stated," A well led service has the right people in the right jobs at the right time and we are working hard to achieve this through the careful selection and the development of our workforce". They told us how they wanted to 'build on staff'. "It's all about retention and incentives. We should pay for longevity, and provide additional training. Good training incentivises people".

The line management system provided clear lines of responsibility and accountability. This meant all staff received supervision, both individually and within their staff teams, and were monitored effectively. Staff were consulted and involved in decisions about the service through regular staff meetings, and said they felt listened to. These meetings also provided an opportunity for staff to be kept informed about developments at the service, learn from complaints and compliments and make specific training requests. Staff had access to a range of policies and procedures to guide their practice, which were regularly reviewed and updated. Additional information was visible on staff notice boards, for example related to training and courses.

The provider had a range of quality monitoring systems which were used to continually review and improve the service. Regular audits were in place to monitor the care and environment at the home, looking at areas such as medication, accidents and incidents, falls and equipment. Audits of care plans were completed

every two months to check records were person centred and up to date. The registered manager told us that previously ten percent of care records were reviewed but this did not allow them to carry out a full audit. The number of care records reviewed had therefore been increased, but as we saw during the inspection, risk assessments and care plans were not always being reviewed.

People's views were sought, residents and relatives meetings were held regularly, and improvements made in response to feedback. Questionnaires were sent out to people, their relatives and professionals twice a year and results shared with staff. Action plans were agreed and implemented as appropriate. For example, the 'resident of the day' initiative was set up in response to feedback that people were not involved in developing their care plans. In the provider information return (PIR), the registered manager stated their intention to increase people's involvement by developing "a simple questionnaire that can be completed monthly by residents who are nursed in their bedrooms, so they have a louder voice in feeding back".

Staff were complimentary about the provider, who was a frequent visitor to the home. Comments included, "[Providers name] is very good. If it's the weekend we can ask for advice on things. They pop in and out, and make you aware they are around... They will roll their sleeves up and help if we are struggling" and, "If there's something to be done they'll get it done." The registered manager attended regular management meetings with the provider and had found them to be fair and supportive of their proposed service developments.

Friends and family members were encouraged to get involved in the running of the home via the 'Friends of Camelot', who were proactive in raising funds for the benefit of the people living there. The family member of a previous resident had been recruited as a volunteer to spend one to one time with people, and the registered manager planned to recruit some more.

The registered manager spoke about their aim to continuously improve the service. They planned to develop resource links with hospitals and other homes, for example sharing ideas and resources with other activities co-ordinators. In the provider information return (PIR) they stated their intention to create a learning environment for staff by becoming a placement provider for student nurses. "We aim to do this by training our qualified nurses to become mentors".
The registered manager, along with the provider, kept themselves informed of developments in care provision and best practice by attending conferences and events. This led to improvements in the home, for example, ensuring the lighting was good to help people's cognitive function. A new electronic patient record was going to be introduced to keep care records up to date, along with an electronic medicines administration system which would minimise risks by reducing the possibility of human error. Community links would be further developed, for example as part of a local project linking schools, care homes and businesses to raise awareness of dementia.

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 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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments and risk management plans were not reviewed regularly. 12(2)(a)