Camberley Care Limited

Camberley Manor

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

The inspection took place on 5 and 10 November 2017. The first day of our inspection was unannounced. Following this we informed the provider we would return to the service within two weeks.

Camberley Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Camberley Manor accommodates up to 60 people in one building which is divided into three units. One of the units specialises in providing care to people living with dementia, one provides care to people assessed as requiring nursing care and the third units supports people with residential care needs. At the time of our inspection there were 53 people living at the service.

There was no registered manager in post. 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. At the time of our inspection an interim manager was in post. On the second day of our inspection we were introduced the newly appointed manager of the service. They told us they intended to apply to register with the Care Quality Commission.

At our last inspection on 1 and 14 June 2017 four breaches of regulations were identified. The concerns found related to insufficient, skilled staff being available to meet people's needs, risks to people's safety not being adequately managed, safe medicines practices not being followed, people's dignity not always being respected and people's health care needs not being monitored. In addition we made recommendations regarding how complaints processes were managed and the effectiveness of quality assurance systems.

Following the last inspection, we met with the provider and asked them to complete an action plan to show what they would do and by when to improve the key questions of safe, effective, caring, responsive and well-led to at least good. At this inspection we found that whilst improvements had been made in some areas, there were continued concerns regarding the quality of the service provided to people. We also identified additional concerns regarding people's safety and the leadership of the service

There was a lack of consistent leadership. There had been numerous changes in the management structure of both the service and organisation which had led to instability within the service. Quality assurance processes were in place but systems were not effectively monitored to ensure they were embedded into practice. Actions arising from audits were not consolidated into an overall action plan to ensure shortfalls in the quality of the service were addressed. The central complaints log did not record all complaints made which meant the service was unable to accurately monitor and identify trends in the concerns raised. Records were not always accurately maintained. Not all care records contained up to date information regarding the care people required.

Safeguarding concerns were not always identified and acted upon. We identified a number of concerns which had not been reported to the local authority safeguarding team to ensure that appropriate action was taken to keep people safe. The local authority told us they had on-going concerns regarding how the service managed safeguarding incidents. Accidents and incidents were not always recorded and tracked to minimise the risk of them happening again.

Risks to people's safety were not consistently managed well. Although improvements were seen in the way medicines were managed, errors in recording and administration were still occurring. Safe moving and handling techniques were not always used by staff. People's fluid intake was not effectively monitored and the risk of dehydration had not been identified for two people we observed. In some areas risks were managed well. People received the support they required when mobilising and where people were identified as being at risk of choking appropriate action had been taken.

Staff did not always receive training and supervision in line with provider's policy. Records relating to the support staff received were not up to date to enable the management team to monitor supervision and training. Staff told us they had received an induction when starting at the service. People told us they had on-going concerns regarding the high level of agency staff used. The interim manager had taken steps to ensure that the same agency staff were regularly used to provide consistency. Recruitment of permanent staff was on-going and the provider told us that following recruitment checks they hoped the service would be fully staffed within the next few months. There were sufficient staff deployed to respond to people's needs in a timely manner. Safe recruitment processes were in place to ensure staff employed were suitable for their role.

People's dignity was not always respected. Several people had not received support to clean their teeth and records showed there were a number of incidents of people being found wearing two continence aids. We observed occasions when staff did not interact appropriately with people. On other occasions we found that staff engaged well with people and treated them with kindness. People's privacy was respected and independence encouraged. People were offered choices regarding their day to day routines and these were respected by staff. People received the support they required with regards to their religious and cultural needs.

Improvements had been made in the meals provided and people had a choice of nutritious food. Staff were aware of people's dietary needs. People had access to a range of healthcare professionals and appointments were recorded. The principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were followed to ensure people's legal rights were protected. People's needs were assessed prior to them moving into the service to ensure they could be met. Improvements had been made to the way in which the service responded to people's needs to ensure people were now receiving the care they required. Information regarding people's wishes when nearing the end of their life was not consistently recorded. We have made a recommendation regarding this.

People lived in a clean and well maintained environment. Staff were aware of infection control procedures and we observed these were followed. Cleaning schedules were in place and all areas of the service were cleaned to a high standard. Maintenance records were up to date and equipment used was regularly serviced. The provider had developed a contingency plan to ensure people would continue to receive care in the event of an emergency.

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

Services in special measures will be kept under review and, if we have not taken immediate action to

propose to cancel the provider's registration of the service, will be inspected again within six months.

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

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

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.

During the inspection we found six breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

The service was not safe.

Safeguarding concerns were not always identified and appropriately reported.

Action was not always taken following accidents/incidents to minimise the risk of them happening again. Accidents and incidents were not comprehensively monitored.

Risks to people's safety were not always identified and managed although in some instances these were managed well.

Plans were in place to address staffing concerns regarding high agency use.

Safe recruitment processes were followed.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always receive training and supervision to support them in their role.

People had access to healthcare professionals.

Improvements had been made to the food people received and choices were available.

People's legal rights were protected as the principles of the Mental Capacity Act 2005 were followed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always treated with dignity as their personal care needs were not always appropriately addressed. In some areas of the service people received the support they required.

People were supported to maintain their independence.

People's religious and cultural needs were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Complaints were not always appropriately responded to and recorded.

People's wishes regarding end of life care were not always recorded. We have made a recommendation regarding this.

People's needs were assessed prior to moving into the service and staff were aware of the care people required.

There was a range of activities provided both within the service and in the local community.

Is the service well-led?

Inadequate

The service was not well-led.

There was a lack of consistent leadership within the service.

Quality assurance systems were not monitored and not effective in driving improvements.

Records were not accurately maintained and updated.

The provider had failed to notify the Care Quality Commission of significant events in line with statutory requirements.

Camberley Manor

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 was prompted by concerns raised regarding staffing levels at the service and the care people were receiving. During the inspection we identified that safeguarding concerns were not being reported to the local authority safeguarding team and that accidents and incidents were not routinely recorded and actioned. Following the inspection we alerted the local authority to our concerns and shared information regarding the specific incidents we had identified. The local authority safeguarding team are currently working with the service in order to minimise the risks to people's safety and care.

The inspection took place on 5 and 10 November 2017. The first day of our inspection was unannounced. Following this we informed the provider we would return to the service within two weeks. The inspection was carried out by three inspectors, a nurse specialist and an expert by experience. The nurse advisor specialised in the care of older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed records held by the Care Quality Commission (CQC) which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the registered person is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection.

As part of our inspection we spoke with nine people who lived at Camberley Manor and observed the care and support provided to them. We spoke with six relatives, six staff, the interim manager, interim care services manager, the new manager and the quality and compliance director. We also reviewed a variety of documents which included the care records for ten people, four staff files, medicines records and various other documentation relevant to the management of the service.

Inadequate

Is the service safe?

Our findings

At our inspection in June 2017 we found concerns regarding the safety of people's care. People were not always supported by sufficient, skilled staff who knew their needs well. Medicines were not always managed safely and staff did not always follow guidance to keep people safe. At this inspection we found that a number of improvements had been made and staffing levels were now more stable. However, there were on-going concerns regarding the management of risks to people's safety and safe medicines management. In addition, we identified concerns regarding the reporting and investigation of accidents, incidents and safeguarding concerns.

People and relatives told us they felt the service was safe. One person told us, "I need support for walking but no real risks. They have changed my frame to one which gives me more stability." Another person told us, "I would say I feel safe." A third person told us, "The staff are lovely. They are never rough with me." One relative told us, "I think he's safe although he has had a few falls. They have placed sensor mats. If he gets out of bed they are alerted immediately."

Despite these comments we found that safeguarding concerns were not always identified, reported and acted upon. Staff received training in safeguarding and described the action they should take should they have concerns. However, records showed a number incidents had not been reported to the local safeguarding authority as required and appropriate action had not always been taken to keep people safe. These included three occasions when people had been found to be wearing two continence aids at the same time. This practice puts people at risk of developing pressure sores and should therefore be reported to the local authority safeguarding team. The manager had spoken to staff regarding this practice however, this had not been effective as these concerns continued to occur. On the fourth occasion this practice was observed an investigation was conducted, systems implemented to ensure all staff were aware this was unsafe practice and the safeguarding authority informed. Following this action no further instances were identified.

Three incidents of aggression between people had not been reported to the safeguarding authority. The manager was unable to explain why the incidents had not been reported. The local authority safeguarding team told us they had on-going concerns regarding how risks to people people's safety were being addressed. They informed us of a number of incidents which they were currently investigating.

The failure to act on safeguarding concerns was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accidents and incidents were not routinely monitored and investigated. In August 2017 the local authority had identified a number of concerns regarding how accidents and incidents were reviewed and the action taken to ensure people were safe. Despite their intervention we found this continued to be the case and that action had not been taken to ensure lessons were learned from these concerns. The accident and incident log was not fully up to date. We observed two people with extensive bruising to their face and other areas of their body. Neither incident had been recorded or reviewed in line with the provider's policy. In addition

three people had sustained unexplained bruising and/or skin tears. There was no evidence to show that the cause of these injuries had been investigated or action taken to help reduce the risk of them happening again. Internal quality audit reports from August and October 2017 also identified the same issues. Following the inspection the provider told us they had changed the way in which concerns were reported and addressed to minimise risks to people. We will continue to monitor the effectiveness of these measures.

Risks to people's safety were not always identified and effectively addressed. People's hydration needs were not adequately monitored. A senior manager told us that where people required their fluid intake to be monitored this should be reviewed during the day and at the end of the day. Where people were found to not have consumed adequate amounts, staff should encourage more fluids to people and offer fruits and foods with high water content. Records did not evidence that this was taking place. Fluid charts for three people were regularly not totalled either during the day or at the end of the day. We found fluid levels for each person fell below an average desired level.

One person's records showed that over a ten day period their fluid intake was recorded as below 800mls on seven occasions and on two occasions this was recorded as below 300mls. This was particularly important for two people who had specific conditions which increased the risk of developing urine infections. Two people whose fluid levels were not being monitored were not supported to drink adequate amounts. During the second day of our inspection one person remained in their room for the majority of the morning. The person required support to drink and this was not provided for three hours. The person came into the lounge area for their lunch where they were supported to drink half a glass of fluid. The person's care records did not identify they were at risk of dehydration.

People were not always supported safely with their moving and handling and mobility needs. On one occasion we observed staff members placing their arms underneath a person's arms and pulling them to a standing position. This is known as a 'drag' lift and puts the person and staff members at risk of injury. The Royal College of Nursing provides the following guidance about the use of this lift technique, 'Unless there is an emergency (needing immediate action to avoid serious harm to a patient's health) drag lifts must not be carried out.' On three other occasions we observed staff placing a foot on the bottom rung of people's walking frames. This poses a risk of the staff member and frame becoming unsteady which could lead to the person or staff member falling. On other occasions we observed people received appropriate support and staff appeared confident in using moving and handling equipment.

Although some improvements had been made in relation to the management of medicines on-going concerns were identified during this inspection. Since the last inspection daily audit s of medicines had been implemented. However, these were not effective in ensuring safe medicines practices were consistently followed. Each person had a medicines administration record (MAR) in place. During the first day of our inspection we identified gaps in the recording of six people's medicines within the previous week. As the medicines were no longer in the dispensing packs staff told us they assumed they had been administered but not signed for. Daily stock checks had been recorded and stated that no gaps in recording had been identified.

On the second day of our inspection we noted that one person's morning medicines had not been administered. The nurse on duty confirmed they had not been notified of this omission by night staff. Following our inspection we were notified of an incident where one person did not receive their medicines and this was not noted for two days. The provider informed us that additional checks had been implemented and clinical staff were now cross checking their colleagues work for greater transparency. We will monitor the effectiveness of this during our next inspection.

The provider's policy was not consistently followed where people required medicines to be administered covertly (without the person's knowledge or consent). Covert medicines forms were not fully completed to ensure people's views were considered and guidance to staff on how the persons medicines should be administered was not available to staff. Topical creams had pharmacy labels on the boxes but not on the tubes and were not routinely dated when opened to ensure they were used within safe time limits. We found tubes of cream open, without opening dates, mixed with recently delivered creams. Staff tidied the cupboard and disposed of them when it was brought to their notice.

The failure to effectively monitor accidents and incidents, to manage risks to people's safety and to ensure that safe medicines processes were in place is a repeated breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In some areas improvements had been made to the way medicines were managed. MAR charts contained an up to date photograph of the person with any allergies staff needed to be aware of. Where people had been prescribed as and when required medicines (PRN) guidance was available to staff on how these medicines should be administered. Medicines were securely stored with sufficient medicines available in stock to ensure people had access to their prescribed medicines. When administering medicines staff followed correct procedures and took time to explain to people what their medicines were for.

In some areas we found that risks were identified and measures implemented to keep them safe. People's weight was monitored regularly and action taken where a significant variation was noted. One person's records showed they had lost a significant amount of weight. The GP had been contacted and support provided by the dietician. The person had been provided with dietary supplements and high calorie foods which had led to them maintaining a steady weight. Where people were assessed as being at high risk of falls guidance was clear for staff on how to support them. We observed where people required support to mobilise this was provided. Staff were present in communal areas to ensure they could respond to people's mobility needs quickly. Sensor mats were placed in people's rooms to alert staff when people began to mobilise in their room so they could attend promptly.

There were some improvements in the way risks relating to people who displayed behaviours which may challenge others were managed. The service had been working with the local authority intensive support team to support a number of people. We observed there was a calm atmosphere in the unit supporting people living with dementia and appropriate staff support was available to them. We viewed care records for two people who required one to one support due to their anxiety. Detailed guidance was available to staff which included possible triggers to anxiety and steps to take to proactively support them. We spoke to staff members supporting individuals who described the support people required. This included their routines and interests in addition to how to support the people with their anxieties. This had led to a reduction in the number of incidents occurring.

People and relatives told us they had on-going concerns regarding the high use of agency staff. One person told us, "There are a few regular people but mainly agency. Some are not so good. It is a difficult job." Another person told us, "There's a lot of agency and they're not always patient." One relative told us, "There are enough staff, it's the agency we are having issues with as there are so many of them. I notice at the weekend the staffing levels are less." Another relative said, "There is probably not enough staff, but it's the agency staff that concerns us. It's the little things like we come in and find she's only got one hearing aid in, or the batteries are dead and they aren't working. It seems like she is neglected in that way."

Staffing levels had increased since our last inspection although there was still a high use of agency staff. The interim manager told us that they were trying to use regular agency staff and records confirmed this was the

case. Staff told us this had helped bring some stability to the staff team. One staff member told us, "Most people from the agency have worked here four or five months. We try and get regular agency staff so they [people] see the same faces." Another staff member told us, "The agency staff on this unit are really good. We do want our own staff but I can't fault the agency staff who come here." Staff told us that managers regularly asked their opinion regarding the skills of the agency staff and where concerns were identified with individual agency staff they did not return. The interim manager confirmed that the level of agency use had decreased significantly recently and permanent staff members had been recruited subject to recruitment checks. We observed that there were sufficient staff available to meet people's needs. Call bells were answered promptly and staff were available in communal areas to respond to people's requests.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS).There were also copies of other relevant documentation including full employment histories, professional and character references, interview notes and immigration status information in staff files. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with people.

Appropriate checks were completed to ensure the building remained safe for use. Regular health and safety checks were completed and prompt action was taken to address any maintenance issues with equipment The provider had developed a contingency plan which gave detailed guidance of the action to take in the event of unforeseen circumstances occurring. The plan was regularly updated and ensured that people would continue to receive care in the event of an emergency.

Safe infection control practices were followed. Staff received training in infection control. We observed that when supporting people with their care needs gloves and aprons were available for staff use. The laundry area was divided into clear zones to ensure that clean items were not contaminated by soiled items. Cleaning equipment was colour coded to minimise the risk of cross contamination. The building was cleaned to a high standard.

Requires Improvement

Is the service effective?

Our findings

At our inspection in June 2017 we found concerns regarding how people were supported with their healthcare needs. At this inspection we found that improvements had been made in this area. However, we identified additional concerns regarding the training and supervision provided to staff.

We asked people and relatives if they felt staff had the skills required to provide their support. One person told us, "Most are very good." Another person told us, "In the main, especially the regular staff." One relative said, "We have no problems with the staff' experience." Another relative told us, "I believe the nurses have the skills but it's up to the carers to ensure the information is passed on to them and I think that's where it falls down."

Whilst staff told us they were able to request support from managers, structured supervisions were not regularly completed. Staff supervision records were not monitored or accurately maintained. We asked the manager to provide an up to date list of the supervisions provided to staff. The information provided was difficult to interpret as it contained a number of staff who had left the service whilst new staff had not been added. The interim manager acknowledged that the list needed to be updated and did not reflect that staff were regularly provided with supervision. The interim manager added, "We are behind with the supervisions."

Staff told us that they received supervisions although this was generally on an ad hoc basis. One staff member told us, "We can ask for support and approach the managers when we need anything." Another staff member told us that supervision was difficult due to the numerous changes in the management structure. They said, "I have had supervision in the past but not for a while." This meant that staff performance was not routinely monitored to ensure that they were working in line with the provider's policies and clearly understood the responsibilities of their role. On the second day of our inspection the regional trainer was observing staff practice and giving immediate feedback to staff which had recently been implemented. Although they told us that their observations would be discussed with the interim manager, there was no system in place to record and review any concerns identified.

Staff had not completed all mandatory training and training was not always effective in providing staff the skills they required to meet people's needs. The interim manager told us that a new e-learning training system had been implemented to track the training provided by staff. They told us that as this was a new system they had been given until January 2018 to ensure all staff were up to date. Following the inspection the provider told us that in addition to e-learning training a range of face to face training sessions were completed by staff. The e-learning training system showed a 76% compliance rate for training across the service. Areas of low compliance with training included recording and reporting, end of life care and understanding distressed behaviour. Areas with high compliance rates included example infection control, safeguarding, moving and handling, dementia awareness. However, the failure to ensure safeguarding concerns were reported and the use of inappropriate moving and handling techniques demonstrated that this training had not always been effective.

The failure to ensure that staff received effective training and supervision to support them in their role was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Both regular and agency staff received an induction when starting work at the service. Staff told us they had found the induction process useful in helping them to settle into their role. One staff member told us, "I had an induction which covered the basic training and shadowing other staff. I think this helped me know people's needs." An agency staff member told us, "I have worked here for four months; I know everything about the residents. I had a short induction when started which included an introduction to people's needs." The interim manager told us that new staff were also supported to complete the Care Certificate, a set of agreed standards that health and social care staff should demonstrate in their daily working lives.

People's views of the food served at the service differed. One person told us, "There are good choices, we are asked each mealtime." Another person said, "It has improved, depending on who is on. They serve some lovely fish. There are always drinks available and you can have a glass of wine if you want with lunch." A third person told us, "Food is very good and plenty to drink." Other people told us that they found the food could be too rich for their tastes. One person said, "I do have a problem with the food. There are too many sauces and it's too dressed up." One relative told us, "He doesn't enjoy the food. They don't really cater for the age group in here. Too many condiments and sauces."

Records showed that people's opinions of the food served were noted and used to inform menu planning. The majority of the feedback received was positive. We observed the hospitality team speaking to people during the inspection to gain their views. Following the inspection the provider told us that this was part of a range of methods used to ensure that people's views regarding the food provided were understood and responded to. In addition the service had offered food tasting experiences, investigated each complaint regarding the food and completed motivational training for catering staff to ensure expectations were clear. People were offered a choice of food and drinks at lunchtime and alternatives to the set menu were available. Tables were nicely laid and people received their food promptly from attentive staff. Where people required their food to be of a modified consistency such as pureed this was attractively presented. Staff were aware of people's dietary needs and the support they required to eat their meal. Snacks were available throughout the day. A café area in the foyer gave people and their visitor's access to drinks, cakes and biscuits and we saw this area was well used.

People received on-going support with their healthcare needs. People and their relatives told us that the GP and other health professionals visited regularly. One person told us "Doctor comes in every week, you just have to ask. The optician came in this week and there is a chiropodist." One relative told us, "He did see the Doctor a couple of days ago for antibiotics." Care records showed that people had access to health professionals including GP, district nursing team, dietician, chiropodist, opticians and the community psychiatric nursing team. Records of appointments were recorded in people's care records. Where people were living with specific health conditions such as diabetes and epilepsy, care plans were in place which gave guidance to staff on how to monitor their health needs. Staff we spoke to were aware of the signs to look for that people may be experiencing pain and the relevant action to take. Clinical review meetings were held in the service to monitor areas including infections, hospital admissions and pressure areas.

The Mental Capacity Act 2005 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and

hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's legal rights were protected as the principles of the MCA were followed. Where required capacity assessments had been completed for people in areas including the administration of covert medicines, the use of bed rails, one to one support and locked doors to individual units. Records included evidence that best interest decisions regarding people's care had been reached with involvement of people's families, staff and medical professionals where appropriate. DoLS applications had been completed where restrictions to people were in place and were tracked with the local authority.

Staff we spoke with were aware of their responsibilities regarding the MCA. One staff member told us, "Some of them [people] are unable to make decisions for themselves so we must act in their best interests." Another staff member said, "We must offer choices wherever possible and remember people are able to take risks. If we think someone does not have capacity we would speak to the nurse so an assessment can be done." During the inspection we observed people were offered choices regarding day to day decisions and these were respected by staff.

People lived in an environment which was suited to their needs. All areas of the building were accessible to people as two lifts were available. Chairs in communal areas were of a good height and design. There were areas of specific interest for people integrated into the design including an indoor putting green, indoor garden area, a shop and small pub, The Camberley Arms. Areas of the service and amenities were clearly sign posted in both written and pictorial format. People's rooms were personalised with photographs and personal ornaments.

Requires Improvement

Is the service caring?

Our findings

At our inspection in June 2017 we found that people were not always treated with dignity and respect by staff. At this inspection we found that although improvements had been made additional concerns were identified.

We received mixed responses regarding how people were treated by staff. One person told us, "Most are kind and caring. They always greet me by name and are very patient with us." Another person said, "Very kind and caring. If you need them to help you they come immediately." One relative told us, "They are always very kind to him and always offer a cup of tea or coffee when I come in." In contrast, one person told us, "Some are okay but some are not very patient they make me feel like I'm a burden." Another person told us, "They are okay. I have confidence in certain members. Some staff can be a little cold." One relative told us, "They speak to her nicely but don't always do things she needs which I don't believe is kind."

People's dignity was not always respected. One the first day of our inspection one person had already received their morning personal care. However, we observed they had not had their teeth brushed or mouth cleaned. Their mouth and lips had a yellow residue over them and their toothbrush was dry. The staff member supporting them had said they had refused this but had not offered an alternative way of cleaning their mouth to make them more comfortable. The person did not have a drink or their call bell within reach. We spoke to a senior staff member who ensured the person received the care they required. Toothbrushes of two other people who required support to clean their teeth were also dry. One person's toothbrush was congealed with toothpaste and had not been used for some time. As reported in the safe domain, records showed that on three occasions people had been found to be wearing two continence aids on three occasions which was undignified for the people concerned. In contrast we found that people in other areas of the service had received personal care in line with their needs.

Not all staff interacted positively with people. We observed two occasions where staff did not speak to people whilst supporting them with their lunch. Another staff member was heard to continuously prompt one person at lunchtime, saying their name every few seconds. There was no other verbal interaction to help the person relax and enjoy their meal. We observed one staff member come into the lounge and take a pillow from behind the head of a person who was asleep. They then knelt down to wake the person up and take their photograph whilst saying, "You look beautiful today." The person appeared confused and the staff member did not give an explanation as to why she was taking the photograph.

On the second day of our inspection the manager informed us that as a result of our findings an additional staff member had been allocated on the two floors where people's needs were highest. They were taking the role of dignity champion to ensure people's needs were met in a respectful manner. In addition the training manager was conducting observations of the care people received. They told us that when the observed staff practice in a specific area could be improved they were discussing this with them immediately.

The failure to ensure that people's dignity was respected at all times was a continued breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed other occasion's staff interacted positively with people. Staff sat beside people when speaking to them and took the time to speak when passing people in the corridor. We observed staff kneeling in front of people chatting whilst they gave them a hand massage. One person requested a cup of tea and biscuits. The staff member acted on this request and on return told the person, "Here you are, I got your favourite biscuits." We observed people were offered choices regarding where they wanted to sit and staff paid attention to their comfort, asking if they wanted extra cushions or to put their feet up. Staff complimented people on their appearance and used appropriate touch when speaking to people or offering reassurance. When one person started to look anxious staff opened their arms and offered them a hug which the person accepted.

People's privacy was respected. One person told us, "They always knock before coming into my room." Another person said, "They help me shower and dress if needed and always close the door. I see both male and female carers. I am not bothered but they did ask." We observed staff knock on people's doors before entering and greet people as they entered. Personal care was provided in privacy. We observed that when people used the bathrooms in communal areas staff waited outside the door for people to indicate they were ready for support.

People were supported to maintain their independence. At our last inspection one person had told us that staff had supported them to improve their mobility and their aim was to not have to rely on their wheelchair. During this inspection we observed them using an exercise cycle and walking with the aid of a walking frame. They told us, "The staff have been marvellous at getting me back on my feet. I know if I use this (cycle) I'll keep going a lot longer. I'm so pleased with myself." Another person told us, "They leave me to do the bits I can but wait outside the door so they can help when I need it." We observed people moved freely around the service and had the equipment they required to support their mobility. Where people required adapted crockery and cutlery this was provided to enable people to eat independently. We observed staff supporting one person to wash up after breakfast which they clearly enjoyed.

People told us they were involved in decisions regarding their care. One person told us, "They are most helpful and will listen to anything I ask. They are making me a special starter today as I don't like the soup." Another person said, "They do speak to me about my care." One relative told us, "They discuss any changes with us." We observed people were involved in day to day decision regarding their care such as what time they wanted personal care, where they preferred to spend their time and the gender of staff they would prefer to provide their care.

People's cultural needs were respected. Regular church services were held in the service and people were supported to attend their preferred place of worship where appropriate. One person was supported to attend church on a daily basis by a group of volunteers. As the person needed to leave Camberley Manor at an early hour night staff supported them to be ready on time. Records showed that people's religious and cultural needs were discussed during assessment and this information was used to inform people's care plans.

Visitors were made to feel welcome when visiting the service. One relative told us, "I always feel welcome. They always offer a cup of tea or coffee when I come in." Another relative told us, "Nothing is too much trouble for them; they've been brilliant and don't make us feel as though we're in the way." There were no restrictions on the times people could receive visitors. We observed visitors were made to feel welcome by staff who greeted them by name. In addition to the café area there were family rooms available on each floor to enable people to receive their visitors in a private area if this was their preference. We observed the café area was well used by people and their families.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in June 2017 we found that people did not always receive responsive care as their needs were not always known to staff and guidance was not always followed. We also made a recommendation regarding how complaints were monitored. At this inspection we found that staff present were aware of the needs of people they were supporting. However, we identified that the planned improvements to the complaints process had not been completed.

We received mixed responses from people and relatives regarding how complaints and concerns were responded to. One person said, "My family have complained on my behalf but I wouldn't say it helped much." One relative told us, "I've expressed my concerns regarding my Mum's care but always get the same response about how they are trying to improve staffing. They don't seem to be able to get things right." In contrast one person told us, "They have been very good and available when I have needed to speak to them." One relative told us, "We complained about an agency staff once. They sorted it within hours and they (agency staff) never came back again."

Complaints received were not always recorded to in line with the provider's policy as details of how complaints were responded to were not clearly recorded. This meant that people's care did not always improve as a result of complaints being raised. The provider maintained a complaints log which they shared with us following the inspection. We had been made aware by a relative of a number of concerns that had been shared with the service although these were not entered on the log to give detail of the action taken.

During the inspection we made the interim manager aware of one person's concerns regarding their care the previous night. The interim manager told us the person's family had also reported this as a complaint. This had not been recorded on the complaints log we received three weeks after the date of the interim manager becoming aware of the concern. We asked the newly appointed manager how the complaint had been responded to. They told us they had not been made aware of the complaint. They took action to ensure the person was now happy with the support provided. During the first day of the inspection the interim management team made a number of references to people and relatives complaining about staffing issues although again, this was not reflected on the log received two weeks following the inspection. When asked about this the interim manager stated these weren't actual complaints but more comments received when talking to people. The lack of recording of complaints meant we could not be confident that the information received reflected the number of complaints made and if concerns were being addressed. Although complaints were reviewed by senior managers within the organisation any trends could not be effectively monitored if they were not receiving accurate information.

The lack of accurate complaints monitoring was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed prior to them moving into the service to ensure their needs could be met. Assessments viewed were comprehensively completed and covered areas including personal care, mobility, diet and nutrition, cultural needs and hobbies and interests. People told us they had been involved in the

assessment process. One person told us, "They were very thorough and asked about everything. My daughter was with me, everything was explained."

We asked people and their relatives living in other areas of the home if they believed they received the care they required for their specific needs. One person told us. "I feel I am well looked after here." Another person told us, "At the moment yes. Things have improved." One relative told us, They look after her as though she's one of their own. If there are any changes they are straight on the phone to let us know. They've always paid attention to how she likes things like doing her nails and putting her make-up on."

Although care plans were not always up to date this did not impact on people's care as their needs and preferences were known to staff. Staff we spoke with were able to describe people's life histories and tell us about the support people required. This was particularly evident in the area where people were living with dementia. At our previous inspection we found staff were not aware of people's needs or the support they required. The service had worked with the intensive support team to look at how they could make improvements in this area. We observed the atmosphere was calm and staff knew people's needs and personalities well. They spent time with people individually and were vigilant to people's needs. It was clear from their conversations with people that staff were aware of people's life histories and conversations were used to provide reassurance. We observed staff anticipating people's needs, offering to go for a walk or take part in an activity when they sensed people were becoming anxious.

We received contrasting views from two relatives regarding the support their relatives received when nearing the end of their life. One relative told us they had visited the service more frequently as they were concerned about the quality of end of life care provided. They told us they had needed to ask staff to support their Mum to wash in the afternoon as this had not been done since the previous day. They also commented that on one occasion it had taken an hour to provide pain relief. In contrast relatives of another person told us, "They couldn't have been kinder. They're looking after us as well as Mum. They are constantly checking on her and staff come from other floors to ask how she is. We've stayed overnight and were offered a bed. We went to get a drink in the middle of the night and when we came back staff had changed the chairs to make us more comfortable. They really have been amazing and explain everything to us."

We found that people's care records did not consistently give guidance regarding their wishes when they reached the end of their life. Care records for two people did not contain information regarding the care they wished to receive. For other people whose records we viewed information was available regarding the type of treatment they would prefer and if they would prefer to go to hospital or remain at the service.

We recommend that end of life wishes for all people living at Camberley Manor are known to staff.

People had access to a wide range of activities in line with their personal preferences. We observed people singing along with a visiting entertainer and enjoying a firework display. People were supported to play various games and individuals receiving hand massages whilst chatting with staff. The activities programme was varied and included a number of visits to places of interest, lunch outings and shopping trips. In addition to the group activities we observed staff from the activity team spending time with people on an individual basis. People told us they enjoyed the activities provided by the dedicated activities team. One person told us, "I enjoy the exercises and small games. They have something going on most days." Another person told us, "Some of the talks are very interesting. They are willing to listen to any ideas you have. On Wednesday we assisted in making the Christmas cake."

Inadequate

Is the service well-led?

Our findings

At our last inspection in June 2017 we identified concerns regarding the effectiveness of quality monitoring systems and the way in which records were maintained. There was a lack of management oversight and the provider told us they implemented a number of changes to address the concerns identified. During this inspection we found that although improvements had been made in some areas the systems implemented had not been wholly effective in ensuring people received a safe, effective, caring and responsive service which was well-led.

We asked people and relatives if the felt the service was well-led. We were told that whilst the interim manager was approachable there were on-going concerns regarding the overall management of the service. One person told us, "Apart from occasionally being asked how things are we don't really see them. The management don't have enough staff and there's no leadership and no continuity." Another person told us, "Don't know them (Manager). There is one who brings her dog into see the residents. I don't know if that's the manager." A third person said, "There have been lots of complaints. There's no co-ordination. They have to learn to cater to their resident's needs." One relative told us, "We have had two or three managers since my mother has been here. You say something then the manager leaves. We have asked (management) if my mother can try living on another floor, but nothing has happened."

There had been a number of changes within the management team which had led to a lack of consistent leadership. The last registered manager had left in April 2017. Since that time there had been three managers in post. A fourth manager had started in a permanent position between the two days of our inspection. In addition there had been a number of changes to key staff within the management structure. At provider level there had also been changes of directors within the wider organisation. Staff told us that although the most recent interim manager had improvements they felt unsettled by the instability of the management team.

One staff member told us, "Everyone who comes in has their own way of doing things. We need some stability." Another staff member told us, "(Interim manager) has been very good but we look forward to having a stable manager." The lack of stability within the management team along with high agency staff usage had led to a culture of reacting to concerns from people, relatives and external agencies rather than developing a positive forward looking culture where all staff shared a common vision for the service and values were embedded into practice.

The provider had not ensured prompt action had been taken to rectify concerns following our last inspection in June 2017. During this inspection we found that although a number of improvements had been made, there were outstanding concerns which had still not been addressed. At the end of our first day of inspection we informed the management team that we would return to the service within the next two weeks to complete the inspection. On our return we observed that the provider had made a number of additional resources available to ensure planned improvements, such as updating care plans, were actioned more quickly than originally planned. The management team acknowledged this had been the case. As these resources were available within the organisation it was unclear why they had not previously

been utilised to support the management team within the service. This would have helped to ensure that improvements to the care people received were implemented more promptly and systems embedded into practice prior to our inspection.

Quality assurance systems were not always effective in ensuring that shortfalls in the service were identified and addressed. The service had a number of audit processes in place including quality assurance audits, provider visits, care plan audits and information returns to head office. However, action had not been taken to that shortfalls identified had been responded to. Action plans generated from the audits were not consolidated into one plan to give an overall view in order prioritise the action required. We spoke with the quality and compliance director who acknowledged that a single home improvement plan was required to ensure quality assurance processes were effective. The interim manager told us they had concentrated on ensuring that the shortfalls in quality identified in the last inspection were addressed. This meant that concerns which had developed in other areas of the service had not been adequately addressed. Following the inspection the provider informed us that a comprehensive action plan had now been developed to incorporate findings from all audits. We will monitor the effectiveness of this during our next inspection.

The management team had implemented a number of systems in order to monitor the safety and quality of the service. Managers described the systems and how they should work in practice. However, the concerns identified during the inspection demonstrated that these processes were not being consistently followed and their effectiveness monitored. For example, the interim manager told us that following the involvement of the local authority accidents and incidents were being discussed at daily meetings, reports being signed off by managers and the information being entered onto the accident/incident log. We found this process was not being followed as actions taken by managers had not always adequately addressed concerns. A number of reports had not been entered onto the central log to enable any developing trends to be identified.

As reported in the key question of safe, systems for monitoring people's fluid intake were in place but not consistently followed by staff. Daily audits of medicines management systems had been introduced in order minimise the risk of mistakes occurring. However, the concerns identified during the inspection showed that this system was not effective in identifying errors. Senior staff attended a 'stand up' meeting each morning. This included senior managers and heads of activities, hospitality, housekeeping and the head of each unit. The interim manager told us the meetings were used to discuss any challenges that day, for example staffing levels and any changes in people's needs. They told us that staff were allocated specific tasks to complete during the meeting. During the inspection the interim manager told us that no minutes were kept of these meetings. However, following the inspection the provider forwarded daily minutes of the meetings. Although these demonstrated the meetings took place and a set agenda was used there was no reflection on the tasks allocated to staff and if these had been achieved.

Although a staff survey had been completed, action had not been taken to share the findings with staff and ensure that positive changes were implemented. We were informed that a staff engagement session had been booked but the previous manager had failed to inform staff of the date. The new manager told us that a date to run the session had been booked.

The service did not always work effectively with partner agencies. The local authority told us that when requesting documentation regarding people's care from the service this had not been made available in a timely manner and regularly required prompting before the information was supplied. However, in other areas the service had engaged with agencies to improve the experience of people living at Camberley Manor. As reported, the service had worked alongside the Intensive Support Team which had resulted in positive changes in the unit supporting people living with dementia.

Records were not accurately maintained. Senior managers acknowledged that people's care plans and risk assessments were not fully up to date. Care plan audits had been completed although the work required as a result of the audits was not always completed promptly. We viewed two care plans which contained numerous notes where information was missing or required updating. The interim management team told us that they were aware that most of the missing information had previously been completed. They believed it had been removed by staff and not replaced. The quality and compliance manager told us, "The new risk assessments and care plans are good but they've not all been updated. We're aware that needs doing." This meant that staff did not always have the most current information regarding people's safety and care needs. This was particularly concerning due to the high level of agency staff use. As previously reported records including accidents/incidents, safeguarding concerns and complaints were not always appropriately recorded.

The failure to have working and effective quality assurance systems and to ensure records were accurately maintained was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Residents and relatives meetings were held at the service. Records showed that the majority of the concerns raised were regarding the high use of agency staff. As reported the service had taken action to address these concerns by using regular agency staff and the recruitment of permanent staff. The interim manager told us that in addition to using tradition advertising of staff vacancies they had also completed leafleting of the local area. Transport to collect staff from the local railway station had been arranged as it was acknowledged the service was difficult to reach by public transport. Senior managers from the organisation had attended the meetings to ensure that they were aware of people's concerns.

The provider had not notified the Care Quality Commission (CQC) of all significant events that had happened in the service. Services that provide health and social care to people are required to inform the CQC of important events. There had been a number of safeguarding concerns and incidents where people had received injuries. These had not been notified to ensure we were able to monitor the service provided effectively.

Failing to submit statutory notifications is a breach of Regulation 18 of the of the Care Quality Commission (Registration) Regulations 2009.

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 Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider had failed to ensure that people's dignity was respected at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had failed to ensure safeguarding concerns were reported and acted upon.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure that accurate complaints monitoring was in place.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure that staff received effective training and supervision to support them in their role.

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 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had failed to effectively monitor accidents and incidents, to manage risk to people's safety and to ensure that safe medicines processes were in place.

The enforcement action we took:

Warning notice issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure that working and effective quality assurance systems were in place and records were accurately maintained

The enforcement action we took:

Warning notice issued