Camberley Care Limited

Camberley Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 1 and 14 June 2017. The first day of our inspection was unannounced. Following this we informed the provider we would return to the service within two weeks.

We carried out an unannounced comprehensive inspection of this service on 19 October 2016. The provider was breaching legal requirements as people's healthcare needs were not always addressed in a timely manner and guidance on specific healthcare needs was not always provided for staff. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to this breach. We undertook an unannounced focused inspection on 1 June 2017 to check that they had followed their plan and to confirm that they now met legal requirements. However, due to additional concerns identified during this inspection we returned to the service on 14 June 2017 to complete a fully comprehensive inspection.

Camberley Manor provides accommodation, nursing and personal for up to 60 older people. The home is set over three floors. The second floor provides care and support for people who are living with dementia. At the time of the inspection there were 52 people living at Camberley Manor.

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. The registered manager had left the service in April 2017. At the time of our inspection the service was being managed by a peripetetic manager and regional support manager who supported us during the inspection. We have been informed since the inspection that a new manager has been appointed.

There were insufficient staff deployed throughout the service to ensure people's needs could be met safely. People's needs were not always addressed in a timely manner and people requiring supervision were left unattended for periods during in the day.

Risks to people's safety were not always safely managed as staff did not always have access to guidance to enable them to take appropriate action to protect people.. Where guidance was available staff did not always follow this. Behaviour monitoring forms were not appropriately completed and reviewed by staff to ensure people's needs were identified and met.

Safe medicines practices were not always followed as medication administration charts were not always completed and stock control was not always effective. Medicines were stored safely. People's healthcare needs were not always identified by staff and during the first day of inspection we found people requiring nursing care were not routinely seen by a nurse.

People were not always treated with dignity and their privacy was not always respected. Staff were heard to

use derogatory language on occasions and not all staff acknowledged people when entering their rooms.

People did not always receive responsive care as staff were not always aware of their needs and care plans did not contain up to date guidance. Records regarding people's care did not always reflect their needs. People gave us mixed responses regarding the quality of the food provided although the majority of people said they had noticed recent improvements. The provider was working alongside people to address these. concerns.

Complaints received by the service had not always been acted upon. However, systems were now in place and people's concerns were being responded to. We have made a recommendation that the provider continues to monitor complaints to ensure systems are embedded into practice.

Quality assurance systems were not always effective in addressing concerns and driving improvement. People, relatives and staff told us there had been concerns within the service which they felt were now being addressed by the management team. There was an action plan in place and this was being shared with staff throughout the service. Concerns identified during the inspection were responded to by senior managers in a timely manner. Details of their responses can be found in the main body of the report. We have made a recommendation regarding continued monitoring of the service to ensure timely improvements are made and embedded into practice.

Robust staff recruitment procedures were in place to ensure staff were suitable to work at the service. Induction and training programmes for staff had improved and staff told us they were now receiving the training they required. Staff received supervision to monitor and improve their performance.

Each person had a personal emergency evacuation plan in place and fire systems were regularly checked and maintained. The provider had developed a contingency plan to ensure people would continue to receive care in the event of an emergency.

People's legal rights were protected as the principles of the Mental Capacity Act 2005 were followed and staff understood their responsibilities. People were provided choices regarding their day to day lives. People had access to a range of activities and were supported to maintain their hobbies and interest. We observed instances of staff treating people with kindness and people were encouraged to maintain their independence.

In some areas we found risks were well managed and accidents and incidents were reviewed to minimise the risk of reoccurrence. The service had implemented additional measures to identify where people were experiencing pain or infections.

People and their relatives had the opportunity to feed back their views of the service provided through regular meetings and annual questionnaires. Visitors told us they were made to feel welcome and were updated on any changes or concerns regarding their family member's care.

Staff meetings took place regularly and staff were able to share any concerns with the management team. Staff told us that in recent months communication had improved and they now felt supported by the management team.

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 always safe.

Staff were not always deployed effectively to ensure people's safety.

Staff did not always follow guidance to keep people safe

Medicines were not always managed safely for people.

Safe recruitment processes were in place to ensure staff were suitable to work in the service.

Contingency plans were in place to ensure people's care would not be compromised in the event of an emergency.

Is the service effective?

Requires Improvement

The service was not always effective.

People's healthcare needs were not always identified and outcomes of appointments were not always recorded.

Staff received training and supervision to support them in their role.

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

People's nutritional and hydration needs were met although some people told us the quality of the food required improvement. The provider had implemented measures to address this.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed some instances where people were not treated with dignity. On other occasions we observed people were treated with kindness and respect.

People were supported to maintain and develop their independence.

Visitors were made to feel welcome to the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive responsive care as care plans were not regularly updated or read by staff.

There was a wide range of activities available and people were supported to maintain their hobbies and interests.

Complaints were responded to and action taken to minimise the risk of concerns re-occurring. However, complaints were not always responded to in writing. We have made a recommendation regarding this.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance systems did not always identify concerns and did not always lead to improvements within the service.

Records in relation to people's care were not always reflective of the support they required.

People, staff and relatives told us they felt things were improving in the service and felt listened to by the management team in place.

Regular staff and residents meetings were held to gain feedback regarding the quality of the care provided.

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 took place on 1 and 14 June 2017 and was unannounced. The inspection was carried out by three inspectors and a nurse specialist. The nurse advisor specialised in supporting older people.

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. We also contacted the local authority and the clinical commissioning group (CCG) for information they held about the service.

As part of our inspection we spoke with nine people who lived at the home and observed the care and support provided to them. We spoke with seven relatives, eight staff members, the regional support manager, peripatetic manager and commercial director.

We also reviewed a variety of documents which included the care plans for 12 people, medicines records and various other documentation relevant to the management of the home. These included training, support and employment records for five staff members, quality assurance reports, policies and procedures, menus and accident and incident reports.

Inadequate

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at Camberley Manor. One person said, "We need protection. We know we have it." One relative told us, "I trust the staff with my life. I have no concerns." However, the majority of people and relatives we spoke to said they felt staffing levels needed to be improved. Comments included, "When I ring the bell they will come in straight away but usually say they'll be back in a minute. It may be a minute but it's often a long time.", "I think they could improve things in the evening. I like to go to bed early but now there are people here with more needs I have to wait.", "There's not enough staff on the ground, they're all very good but seem stressed and fragile. "And, "There are not enough staff here to meet people's needs. That needs to be sorted. I often go into the lounge and there's no staff there."

Sufficient staff were not always appropriately deployed to meet people's needs safely and in line with known risks. On the second day of our inspection we observed staff in the communal lounge of the unit supporting people living with dementia. On one occasion we noted there was only one staff member in the lounge who was writing notes whilst the person they were supporting on a one to one was sleeping in their chair. We approached them to ask where the other staff were. They told us they had not noticed they were on their own as they were busy writing. They then left the room with the person they were supporting. This meant that people were left in the lounge without support for a period of 12 minutes. Four of the people in the lounge were known to display challenging behaviour towards others and two people were assessed as being at high risk of falls. We observed one person trying to get up from their wheelchair during this time. The person's care plan stated it was important for staff to monitor the person as they may lean forward and fall out of their chair. Another person known to display behaviours that challenged others was stooped over a person, talking loudly to them whilst they were sleeping.

We spent time observing people's care on the unit for people with residential care needs. Although people living in this area were not assessed as having high needs, two people from the nursing unit preferred to spend their day in this communal area. Both people were assessed as being at high risk of falls. During a period of one hour and twenty minutes staff were only present in the lounge on two occasions for a total of four minutes. On two occasions people asked us if we could find a staff member for them. On one occasion it took five minutes for us to find an available member of staff. A review of one person's records identified they had been assessed as living with advanced dementia. We observed the person sat outside with another person for an hour in the afternoon. The person sitting with them told us, "Sometimes they (the staff) could do with a bit of help. Leaving (name) here, they are not checking on them. I'm being left here looking after (name)."

We spoke with five staff about the staffing levels within the service. Four staff told us they did not feel staffing levels were sufficient to meet people's needs. One staff member said, "For the needs of people on this unit there aren't enough staff. We have lots of incidents and it's hard to support everyone." Another staff member told us, "There's not enough (staff). The residents are needing their needs met all at once. The bells are ringing. If there was an emergency we wouldn't be able to deal with it. Lots of people need two for assistance and there are only four carers on this unit." A third staff member said, "There aren't enough staff.

It's really hard to care for all these people with aggressive behaviours." We discussed staffing levels with the regional support manger. They told us that a dependency assessment was used to determine the staffing levels required and that these levels were met. They told us that when call bell audits were completed this showed that response times were within five minutes. However, staff told us that they would always respond to call bells as soon as possible but often had to ask people to wait for their care as they were supporting others. Following the inspection the provider gave assurances that additional management cover was being provided on all units to ensure that staff were appropriately deployed in order to meet people's needs safely. The provider also provided evidence that staffing levels on two units had been increased following the inspection.

People were not supported by sufficiently skilled staff who knew their needs well. The regional support manager told us that the recruitment of the right care staff had been difficult and there was currently a high level of agency use. They told us that they tried to ensure that the agency staff used were regular to minimise disruption to people's care. However, we observed that agency staff did not always know people's care needs well which meant there was a risk of their needs not being met. People told us they felt that the high use of agency staffing impacted on the care they received. One person told us, "They've had some awful agency staff; they did get rid of one when I complained. The person went onto describe an incident they had experienced which they had found degrading as an agency staff member had failed to change their bedding when it had become soiled. The person had expressed their concerns to permanent staff members who had ensured they were comfortable. Another person told us, "I wish they would do away with all this agency. They don't all know what they're doing and you have to constantly tell them." The minutes of residents and relatives meeting highlighted that this concern had been raised as it was felt people's care was being compromised by not having consistent staff. One staff member told us, "It makes it hard with having agency all the time. The majority are okay but they don't know people as well as they should." Another staff member said, "The main improvement needed is not as many agency staff so people have continuity and we can build a team." The regional support manager told us they had recently had a number of permanent staff start work at the service and more staff had been recruited subject to recruitment checks. As described in the paragraph below regarding how risks to people were managed, the agency member of staff had not read the care plan for the person they were responsible for. They had not been given instruction in the care they needed. This shows that in this case the use of agency staff who did not know people's needs affected the care people received. We asked another two agency staff members about the needs and preferences of the people they were supporting. They were only able to give us basic information regarding people's personal care needs which did not reflect a person centred approach. Both agency staff members told us they had not read people's care plans or risk assessments.

Failing to ensure that sufficient numbers of skilled staff were deployed in the service was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not always follow guidance in order to keep people safe. On the second day of our inspection we were informed that one person was receiving one to one support from staff due to an increase in their behaviour towards others. We spoke to the agency staff member providing the support who told us, "I know that (name) is on a 1:1 because (they) can be aggressive when (they're) upset." They said that this was all they had been told about the person and had not read their care plan. They were unable to describe possible triggers to the person's behaviour, positive interaction plans or how to react in the event of an incident. Another person, who was living with dementia, had been assessed as being at risk of choking and required their food to be pureed to prevent this. We observed another person hand them a piece of toast. Staff intervened to try to take the toast away but the person refused. They asked the person to make sure they drank tea with the toast before leaving them to eat without supervision. After a few minutes the person started to cough. We alerted staff by pressing the emergency call button. Staff attended immediately and

offered the person support. Another person's care plan detailed that they required one to one support due to their behaviours and that staff should remain with them whilst they were drinking. We observed a staff member supporting the person to sit down with their drink. They then moved away from the person and did not observe them whilst drinking. The person then left the room without the staff member noticing.

Behaviour monitoring charts were not always effectively reviewed and were not always completed by staff. This meant that risks were not always addressed and that staff were not always provided with detailed guidance on how to support people safely. One staff member told us, "It's constant here, getting hit and scratched. We don't report everything that happens. I always do if it's another resident though." Another staff member told us, "A few weeks ago I completed eight incident forms. I was bitten and scratched and not once did the manager come and ask it I was ok. You get so you don't bother." One person's records showed a high number of incidents of aggressive behaviour towards both staff and other people. The guidance for staff in supporting the person lacked detail and did not clearly identify how staff should react to support the person. Records showed that the person's anxiety could increase quickly. However, the guidance provided was that the person should be checked every 30 minutes and did not reflect that constant supervision was required when the person was in communal areas.

Safe medicines practices were not always followed which meant people were at risk of not receiving their medicines in line with prescribed guidelines. Each person had a medicines administration record (MAR) in place. We found a number of gaps in the recording on MAR charts and staff did not always complete MAR charts immediately following the administration of medicines. We reviewed MAR charts following the lunchtime administration round and found that not all medicines had been signed for. We spoke to a staff member about this, they told us, "They've been done but I've forgotten to sign." We checked the medicines for the people concerned and found this was the case. There were significant gaps in the recording of when topical creams had been applied. One person's administration chart showed they required topical creams to be applied three times daily although this had only been recorded as being administered on six occasions during the previous month. Topical creams were not always dated when opened to ensure they were used within the timescales advised. MAR charts did not always contain an up to date photograph of people to help staff identify they were administering medicines to the correct person. This was particularly concerning due to the high level of agency staff used who may not know people well. Following the inspection the provider informed us that all MAR charts had been updated and photographs of people were in place.

Stock control of medicines was not always effectively monitored. One person's records identified they were prescribed medicines for pain relief on an as required basis. Staff told us they had run out of this medicine two days ago and were awaiting a delivery. Although the person's records showed they had not required the medicines during this time it would not have been available should they have been experiencing pain. Another person was due to receive their medicines at 5pm although there were none in stock. The staff member told us, "We're hoping they will be delivered in time. The (staff) who signed all the medicines in at the beginning of the cycle didn't do things properly so we've run out. I was on leave and had to pick it all up when I got back." Prior to leaving the inspection staff confirmed that people's medicines had been delivered. A senior staff member told us there were on-going concerns regarding the supply of medicines from the pharmacy. They provided evidence of discussions with the pharmacy to address these concerns. Following the inspection the provider informed us that as a result of these concerns the pharmacy used had been changed.

Not ensuring that all reasonably practicable steps were taken to mitigate risks to people's safety and not following safe medicines practices was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were stored securely in line with the guidance provided. Medicines trolleys were locked at all times between use and stored in locked rooms. Medicines were stored at the correct temperature and there was documented evidence of destroyed and returned medicines. Staff supported people to take their medicines in a sensitive manner and where appropriate explained what medicines they were administering. Where people received their medicines covertly (without the person's knowledge or consent) appropriate procedures were followed to ensure this was in the person's best interests. Guidance was available to staff regarding the administration of PRN medicines (as and when required) which detailed when people may require their medicine and how it should be administered.

With the exception of behaviour monitoring forms we found that accidents and incident forms were reviewed and monitoring was completed to identify trends. One person had experienced a number of falls. Additional monitoring had been implemented and the person had been assessed as requiring equipment to support them when walking. This had led to a reduction in the number of falls the person had experienced.

Risk assessments regarding other areas of people's care were detailed and covered areas such as skin integrity, nutrition and maintaining a safe environment. Where risks had been identified control measures had been implemented to keep people safe and where appropriate, referrals had been made to relevant professionals. One person's care records identified they were at risk of malnutrition. Staff were aware of the person's needs and a high calorie diet was provided. Where people were at risk of skin breakdown appropriate pressure relieving equipment was in place to minimise risks.

Staff were aware of their responsibilities in reporting safeguarding concerns and had received training in this area. Staff we spoke to were able to identify the different categories of abuse and describe the signs they should look for. One staff member told us, "I would tell the person in charge. Discuss what I had seen and explain how the resident is. They will contact CQC and safeguarding." Another staff member told us, "If I feel someone is at risk I would use the whistle-blowing policy and tell safeguarding." Where safeguarding concerns had been identified they had been appropriately reported to the local authority safeguarding team to ensure the service was monitored and concerns could be investigated.

Robust recruitment procedures were in place. Staff recruitment files contained evidence that appropriate information was obtained prior to staff starting work at the service. Checks were made to ensure staff were of good character and suitable for their role. Staff files we looked at contained evidence that the provider had obtained a Disclosure and Barring Service (DBS) certificate for staff before they started work. DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. Staff files also contained evidence that face to face interviews had taken place and references were obtained to demonstrate that prospective staff were suitable for employment.

Each person had a personal emergency evacuation plan (PEEP) in place. These provide staff and emergency services with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. These records were available at the entrance of the service to ensure they could be accessed quickly. Fire alarm systems and evacuation plans were tested regularly to ensure people would be supported safely in the event of a fire. A contingency plan was in place which highlighted the action which should be taken should an emergency occur, such as power failure, extreme weather or a gas leak. Clear guidance was available and alternative accommodation had been identified in the event the building could not be used to ensure people's care would not be compromised.

Requires Improvement

Is the service effective?

Our findings

At our inspection in October 2016 we found that people's healthcare needs were not always addressed in a timely manner and guidance on specific healthcare needs was not always provided for staff. At this inspection we found that some improvements had been made but there were still areas of concern.

People's healthcare needs were not known by all staff caring for them and outcomes of healthcare appointments were not always recorded. One person's records identified they were suffering from a complex health condition. This was not detailed in the person's care plan and no guidance was available to staff regarding how to support the person in this area or the signs to look for which would alert them to concerns. Although the care staff we spoke to were aware of the condition, the nurse we spoke to regarding the person was unaware of their diagnosis. They told us they had not had the opportunity to read the person's care records. Another person's records showed that a relative had identified concerns regarding their family member's health which resulted in the person requiring a minor operation. Staff had not identified these concerns and the outcome of the operation was not recorded. One relative told us, "Dad had a dressing on when he came out of hospital. It was hanging off for two days. Staff didn't notice so I had to ask them to change it." Following the inspection the provider informed us that a new handover form had been implemented which highlighted key safety needs and diagnosis for each person. We will assess the effectiveness of this in ensuring people's needs are known to staff during our next inspection.

Following our inspection in October 2016 pain monitoring charts had been implemented to aid staff in identifying when people may require attention from a medical professional. However, at this inspection we found on one unit these had not been completed for people who required them for the past 12 days. A staff member told us, "They haven't been done. I couldn't find the right forms on the system." This meant people were at risk of pain and of infections not being identified. The regional support manager ensured these forms were located and were in place during the inspection.

On the first day of our inspection we found that there were seven people living on the unit for people living with dementia who were assessed as receiving nursing or healthcare funding. However, there was no nurse deployed to monitor the healthcare needs of the people concerned on a regular basis. The regional support manager told us that care staff would alert a qualified nurse of any concerns which arose. Daily records showed that nurses would visit the unit to support people who required dressings to be changed but did not routinely monitor people's health and well-being. Following the first day of our inspection the provider took immediate action to ensure that nursing staff were deployed on the unit and nursing staff were present during the second day of our inspection.

Failing to ensure that people's healthcare needs were identified and effectively monitored was a repeated breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

With the exception of the above we found people were supported to maintain and improve their health as they had access to relevant health and social care professionals when required. One person told us, "The staff are on top of all the medical things." A relative told us, "They deal with things promptly. Mum's teeth are

loose and they've been in touch with the dentist. They follow-up and get things done." We observed that infections were now being identified and acted upon in a timely manner. People had access to a range of healthcare professionals including district nurses, tissue viability nurses, opticians, dentists and chiropody services. People told us they had access to their GP when required as they visited the service regularly. One person told us, "The GP comes in once a week and I see them if I need to. If I needed any help going to hospital appointments the staff would take me."

At our last inspection in October 2016 we made a recommendation that the provider monitored the quality of food provided to ensure that people's individual preferences were met. At this inspection we received mixed responses regarding the quality of the food available. Comments included, "Food – I'm not over impressed. They could do better. We have three choices at lunch. We get the menu that day. If we don't like it we phone the kitchen for something else.", "The food could improve, I like English food but they try and fancy things up. The alternatives aren't always good either.", "It used to be atrocious but things are starting to improve.", "It's well cooked and nicely presented." And, "It's very nice, it always is here." The regional support manager told us they had identified people's concerns regarding the food and had implemented a number of measures to address this. The menu had recently been adjusted to take into account people's preferences and a food tasting lunch had taken place to seek people's views. Senior staff from all departments were spending time with people during lunch and people's views of the food were being feedback to the catering staff. We observed the chef took time to spend with people following lunch to check they had enjoyed their meal. The meals presented on both days of the inspection looked and smelt appetising. During the second day of our inspection a number of people told us they had seen recent improvements.

Where people required specialist diets staff ensured their nutritional needs were met. The chef was knowledgeable about people's dietary needs and kept records of people's individual preferences. Attention was paid to the presentation of meals for people who required soft or pureed diets. Staff were attentive to people who required support to eat and this was done in a caring and respectful manner. People's weight was regularly monitored and action was taken where significant changes were identified. High calorie foods were incorporated into the menu for those people who were at risk of malnutrition. We observed one person was reluctant to eat; staff made them a milky drink which they enjoyed. We observed people were offered regular drinks throughout the day.

Staff who had joined the service in recent months had received an induction and had the opportunity to shadow more experienced staff members. One staff member told us, "I had a good induction. The basic training was covered and I spent time with other carers so I knew the routines." However, staff who started working at the service prior to this date had not all received a comprehensive induction into the service. The regional support manager told us they had identified that not all staff were receiving a comprehensive induction and had changed the process to ensure this was now in place. One staff member told us, "I didn't really have an induction. I did some e-learning and shadowed for a day and that was it. Things have improved since the new managers have been in place and staff have longer to learn the job. We are constantly having training now."

People were supported by staff who had received mandatory training in areas including moving and handling, safeguarding, health and safety, food hygiene and basic life support. A training matrix was maintained which identified when refresher training was required and records showed this was completed. Staff also completed a dementia awareness course although the provider had recognised that this was an area where staff required additional training. More in-depth training had been arranged for staff with regards to supporting people living with dementia and understanding distressed behaviour.

Staff received regular supervision to support them in their role. Records of staff supervision and appraisals were maintained which showed that staff received supervision in line with the provider's policy. Staff told us that supervision gave them the opportunity to discuss their practice and any concerns. One staff member said, "I have supervision with the nurse. They observe our practice and will give you help and advice. It's nice to have the reassurance."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether staff were working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's legal rights were protected as systems were in place to ensure the principles of the MCA were followed. Where appropriate, capacity assessments had been completed in relation to specific decisions. Assessments included details of the decision to be made, discussions with the person, if they were able to retain and weigh up the information and a conclusion. Where it was determined that people did not have the capacity to make a decision best interest meetings had been conducted with those closely involved in people's care. Detailed records were kept of why decisions had been reached and what options had been explored. DoLS applications had been submitted to the local authority where restrictions were in place such as key padded doors, covert medicines and one to one support. A tracking sheet had been implemented to enable the registered manager to monitor when applications had been submitted and approved. Where people had capacity to make decisions, their rights were respected. We viewed records for one person who wished to continue eating foods which they had been told would have an adverse effect on their health. Staff had respected this decision although continued to support the person in promoting a diet that was healthy for them. One staff member told us, "If people have the capacity to make decisions you've got no right to make decisions for them even if you don't agree with them."

Staff we spoke to were knowledgeable about the MCA and were able to describe how this affected their work. On staff member told us, "I have a card in my pocket (describing the MCA principles). I assume capacity. I would do a capacity assessment if required. I would contact the GP or psychiatrist and inform the family. I would ask them all if they agreed with the decision. I will apply for DoLS if necessary. There are DoLS in place for people for things like bed rails, keypad lock, covert medicines." We saw that people were offered choices throughout the day regarding the activities they would like to participate in, food, drinks and where they would like to spend their time.

Requires Improvement

Is the service caring?

Our findings

The majority of people and relatives we spoke to said they felt staff were caring and treated them with respect. One person told us, "I get on well with all the staff generally. (Staff name) is marvellous; I think the world of her." Another person said, "The carers are good, kind and caring." One relative told us, "The staff are very pleasant and patient. Mum takes a lot of time and can be a real nuisance but they're always calm and never get annoyed with her." Another relative said, "I think they are all amazing and very kind with Dad."

Despite these comments we observed occasions where people were not treated with dignity and their privacy was not respected. We observed a staff member dancing with a person who was wearing a pink hat. The person put the hat on the staff member's head. The staff member removed the hat and placed it on a gentleman who was sat down. The gentleman appeared to be uncomfortable with this and it looked undignified for them. Another staff member removed the hat. During the morning of the inspection maintenance staff were completing call bell checks in people's rooms. They entered people's rooms without knocking. One person who was cared for in bed was calling out at the time they entered. They did not speak to the person and we heard the person's tone change whilst they were in the room, indicating they were disturbed by their presence. We heard a conversation between staff in a communal area discussing one person's personal care needs. A staff member was heard to say, "I'll do her before I go." During lunch one person complained of being cold and wrapped a napkin round their arms. They asked staff if the air conditioning could be turned off. Staff replied that it was only on a low setting. They did not offer to get the person extra clothing to keep them warm. We reported the above concerns to the regional support manager during the inspection. They took immediate action to investigate these issues with the staff concerned.

We spoke to one person who described an incident the previous weekend which they said had led to them feeling embarrassed by the care they received. Whilst being supported to bed the person said staff had told them they would have to wear the same continence aid they had been wearing during the day as they could not find any more in their size. They told us they had protested about this and another staff member had gone to find supplies on another floor. They added, "It's not the first time they've nearly run out. It was touch and go with how many they had a few weeks ago. I've spoken to the person who orders them and they tell me they've ordered more every week now." The regional support manager confirmed this was the case.

Failing to ensure people were treated with dignity and respect was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw other occasions where people were treated with care and kindness by staff. We observed staff paying people compliments regarding how they looked and using people's preferred names. On one occasion a person was sleeping in the dining room, staff knelt beside them and stroked their arm to wake them before encouraging them to go into the lounge to join in a game. When passing people in the corridors staff took time to stop and ask how they were. We observed the housekeeping staff chatting nicely with people when they were cleaning in communal areas and in people's rooms. With the exception of the above incident, staff knocked on people's doors before entering and introduced themselves to people. When supporting people with their personal care doors were kept closed to protect people's dignity. When we

were speaking to one person they asked staff if they could have tea with us. Staff responded kindly, when the tea arrived the person said, "They make it just how I like it."

People were supported to maintain and develop their independence. One person told us that prior to moving to the service they were unable to mobilise independently following a fall. They said staff had supported them to complete regular exercises and they were now able to walk short distances. They told us, "I was very determined but on days when I thought I couldn't do it they encouraged me. They gave me such confidence." Another person's told us, "I'm quite independent. Staff check to see what I need but otherwise I'm able to get on with it. I want to keep going as long as I can and they understand that."

Relatives were made to feel welcome when visiting the service. We observed family members visiting throughout the inspection. Staff greeted them warmly and took time to chat with them. One relative told us, "We're made to feel welcome when we come and can stay as long as we want." Another relative told us, "I always look forward to visiting. The receptionist in particular is worth her weight in gold. If I can't get through to Dad on the phone then I ring and (name) will go and make sure he knows." Each floor had family rooms and quiet areas where people could meet with their families if they preferred not to greet them in their room. Relatives told us they were kept informed of any changes regarding their family members care. One relative told us, "They will ring if there's anything wrong. They know I'm always here so minor things they tell me when I visit." Another family told us, "Yes they keep us informed."

Requires Improvement

Is the service responsive?

Our findings

We received mixed responses from people and their relatives regarding how responsive the service was to their needs. One person told us, "The staff are nice but not always organised. I can tell them what needs doing for me but others can't. I wouldn't want to be here if I couldn't. " Another person told us, "I get the care I need every day and they come and check if I need anything." One relative told us, "You have to mention things several times before anything is done." Another relative told us, "We think he is very lucky to be here. We have noticed a big difference with him. They have him walking better."

People did not always receive responsive care as care plans did not always contain up to date information and were not always read and followed by staff. One person's care plan stated that they liked to get up for breakfast and enjoyed company and chatting with staff. It further stated that the person could become distressed and staff should reassure them by talking about the person's past profession. Due to the person's behaviours and mobility concerns they were required to be checked every 30 minutes. We heard the staff member supporting the person in their room using an exasperated tone when talking to them. We discussed this with the staff member concerned when they left the room. They said the person had been trying to hit them. They told us they were unaware of the person's history or guidance in place relating to their needs as they had not read their care plan. We observed that with the exception of this interaction the person remained in their room until lunchtime without support or checks being completed. A senior staff member told us the person would not normally be in their room all morning and that staff should have brought them into the lounge. Another person's care plan stated that it was advisable for the same staff member to support them until lunch time so that trust could be built. We observed the staff member supporting the person appeared distracted and requested another staff member take over their support at 11am. We spoke to a relative who told us, "The care and staff are fantastic but the reason Dad moved here was because he was so isolated. He's still incredible lonely. Even though he has people around him they don't speak to each other." They told us staff were aware of these concerns. We reviewed the person's care plan and found there was no information regarding how the person was feeling or guidance for staff as to how friendships could be encouraged.

Failing to ensure people received person centred support in line with their needs was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed on other occasions staff responded well to people's needs. One person told us that they had been struggling to cope as they were sensitive to heat and their room was too hot for them in the summer. They said they feared they would have to move to another service. Staff had supported them to try a room on the other side of the building which was in a shady area and had a door to the garden. They found this room suited their needs better. They told us, "I must say they handled it very well, I'm much more comfortable here." Another person who was living with dementia could become anxious when being approached by people. We observed staff opened their arms and greeted the person warmly when approaching them. This signified to the person they were friends and they hugged staff to greet them.

People and their relatives told us that complaints to the service had not always been addressed although

they had seen recent improvements in this area. One person told us, "I've made complaints before and they've just been ripped out of the book, nothing's been done. " Another family member told us, "I started keeping a diary of everything as I didn't feel things were being listened to. I have to say since the new people have been in charge things are better. They've met with us to discuss our concerns and things have been done. On the whole I think things are good now." Minutes of relatives meetings confirmed these concerns. Minutes from a recent meeting reflected several families had made complaints but never heard anything back. The provider had responded by saying they had identified this concern and gave assurances that action would be taken where complaints were raised.

During the inspection we found complaints had been responded to in line with the provider's policy. Action had been taken to address concerns raised and written responses provided to complainants. However, following the inspection we were contacted by a relative who informed us they had recently made a complaint regarding the manner in which they had been spoken to by the peripatetic manager and concerns regarding the conduct of some staff members. They had received a verbal apology from the provider but had not received a written response. We spoke to the provider who gave assurances that the concerns had been appropriately addressed and an apology provided to the family member for not confirming this in writing.

The complaints policy was made available to people and their relatives who told us they would feel comfortable in raising concerns with the management team. Suggestion boxes were also made available on each unit to ensure people were able to raise concerns in confidence.

We recommend the provider continues to monitor the complaints process to ensure this is embedded into practice.

People had a range of activities they could be involved in throughout the week. People told us they enjoyed the activities provided. One person told us, "There's always things going on and the activity manager is just lovely." Another person told us, "There's lots to do and you can join in as much or as little as you like. I've even started an art class." Group activities were held throughout the day and included music and exercise, games, quizzes, poetry groups, art and a gentlemen's supper club held in the on-site pub, 'The Camberley Arms'. People were able to choose what activities they took part in and suggest other activities they would like to complete. Regular feedback was sought on the activities offered and people's preferences were taken into account. The activity manager told us, "Whatever residents ask for I listen and make it happen. For example, one person really enjoys baking so we hold a baking club each week which she loves." The service hired a mini-bus each week to enable people to go on trips to local shops, garden centres, museums and other places of interest. Visiting entertainers were booked on a regular booked, based on feedback from people attending. These included musicians, theatre groups, pantomime performances, small petting groups and an art therapist. We observed people engaged in activities during both days of the inspection. Staff were encouraging with people and ensured that everyone was able to join in to the extent they wished.

In addition to group activities people were able to maintain hobbies and interests and staff provided support as required. One person had always enjoyed completing crosswords but was unable to continue due to problems with their sight. The activity manager provided them with a large print crossword each day, enabling them to continue with their hobby. Another person enjoyed poetry but did not like to join in group activity. A member of the activity team spent time reading poetry with them each day. The activity manager told us, "I understand how important it is for people to have one to one time with staff. I allocate a staff member each day to spend time chatting with people, having a hand massage or a manicure. One person loves to wash up and this makes them feel valued so we make sure she can do this."

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff told us they felt the service had experienced a period of instability but the management of the service was improving and their concerns were now being listened to. One person told us, "Since (new management team) have been here things have improved a lot. They have listened and are sorting things out. They couldn't have done more." One relative told us, "Things are improving. If you have a concern now they deal with it which didn't happen before." A staff member told us, "Since (new management team) have been here things have been much better. They have an open door policy. Staff are starting to pull together and work more as a team."

Quality monitoring systems were not always effective in driving improvement where concerns had been identified. A range of audits were completed by the management of the service including medicines, accident and incidents care records and infection control. Reports of audits were forwarded to the provider for monitoring. In addition, provider visits were conducted on a regular basis to monitor the quality of the service provided. These reports contained good detail and paid attention to the experiences of people and staff. However, where concerns had been identified these had not always been acted upon promptly to ensure that improvements were made. We viewed medicines audits completed on all units over a three month period. Audits had identified concerns including gaps in administration signatures, missing photographs and topical creams not being recorded. Audits showed little improvement in these areas and our findings during the inspection supported this. Following the inspection the regional support manager informed us that medicines competency assessments with staff had been reviewed both internally and by the new pharmacy supporting the service to ensure all staff were aware of their responsibilities.

Provider visits reflected concerns regarding the deployment of staff and the leadership provided on individual units. During our inspection we identified this was an on-going concern and that staff did not receive guidance and direction from senior staff. Following the inspection the regional support manager informed us that additional support would be provided by senior managers having an increased presence on individual units.

Records regarding people's care were not up to date and did not always reflect the people's needs. One staff member told us, "The care plans are a mess. We're trying to work through them and update them." The regional support manager informed us they were aware that support plans required updating to ensure they were more person centred. They told us two staff members from another service were supporting staff to update care plans on the nursing unit. We observed the staff members were present during the first day of our inspection. They told us they were speaking to people and staff regarding people's needs before updating their care plan. However, we did not see them engage with people or staff during the inspection. We asked to view the information they had gathered to update the plans but they were unable to provide any evidence of this. On the second day of the inspection we viewed one person's care plan which had been updated. There was no information included regarding the person's health condition and the emotional support they may require whilst managing this condition. The information regarding their continence needs was out of date and information regarding the person's mobility needs was contradictory. We found that some people's files contained old care plans and updated versions which meant it was not always clear

what people's needs were and presented a risk that people may receive care which was not appropriate.

We discussed our concerns with the manager, regional support manager and commercial director. They told us that following concerns being identified additional management support was being provided to the service. An action plan was in place which clearly identified concerns and the new management team were in the process of addressing these concerns. The commercial director said that the provider had identified that the concerns within the service should have been addressed at an earlier stage. As a result the quality auditing process had been changed to ensure additional information was available regarding the quality checks in place. They told us that improvements had been seen throughout the service during recent months. The people, relatives and staff we spoke to reflected this was the case and that senior managers were now more visible in the service.

We recommend the provider continues to monitor the quality of the service closely to ensure timely improvements which should be embedded in to practice and sustained.

There was no registered manager in post. The registered manager had left the service in April 2017 and at the time of the inspection the service was being managed by a peripatetic manager. The manager was supported by the regional support manager who based at the service full time. The provider informed us that they were in the process of recruiting for the manager's post. Following the inspection we were informed a manager had been appointed.

Staff we spoke to told us that they had not always felt supported by the management of the service but felt that things were now improving. It was clear from staff responses that the management team in place were having a positive impact on staff morale. One staff member told us, "I was ready to leave at one point because there wasn't any support. Things have improved now and are changing. I get thank yous from managers and I think they're listening to carers." Another staff member said, "I haven't always felt supported. Since (management team) have been here there is a big improvement. We get greeted, they ask how we are, they meet us, they show an interest in us, you see them round the building interacting, helping. It makes you feel good. Staff are supported now, there's a huge difference. Its re-assuring they are here."

Regular staff and team meetings were held in the service. Daily meetings with senior managers of all departments had been implemented to discuss any concerns which had arisen and plans for the day ahead. The enabled the manager to ensure they were aware of what was happening in the service and respond quickly. More in-depth senior meetings were also held on a regular basis. In addition, departmental meetings were held monthly and staff were encouraged to attend a full staff meeting each month. Minutes showed that staff were able to raise any concerns and these were responded to. The service action plan was an on-going theme throughout all meeting minutes. This demonstrated the provider understood the need to ensure that all staff were working towards the same goals and understood their responsibilities.

Resident and relatives meetings were held on each unit every three months. Relatives told us that in the past they had not been provided with a written record of meetings and felt this was due to the concerns which had been raised. They told us things had now improved, "It felt as though everything was being covered up but now we get minutes and everything is more open. Things are definitely changing for the better." Minutes of recent meetings showed that robust discussions were held regarding any concerns within the service and these were responded to. A concern expressed by all people in recent months was the high use of agency staff and poor retention of permanent staff. The service had taken action to ensure additional staff were recruited and people told us this had led to positive improvements. In order to improve staff retention pay rates for staff had been reviewed. Mangers had also met individually with staff who were planning to move

on to listen to their concerns. This had led to a number of staff members withdrawing their notice and remaining at the service.

Feedback was also gained from people and relatives from an annual survey of people's views. The 2017 survey had recently been completed and was being analysed at the time of our inspection. Following the inspection the provider sent an analysis of the results. They informed us these would be shared with all those involved using a 'You said/We did' format to ensure people were aware of the planned action to resolve concerns.

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that people's healthcare needs were identified and effectively monitored. The provider had failed ensure people received person centred support in line with their needs.

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 people were treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that all reasonably practicable steps were taken to mitigate risks to people's safety and that safe medicines practices were followed.

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 sufficient numbers of skilled staff were deployed in the service.