HC-One Limited

Camberwell Green

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Overall summary

Camberwell Green provides nursing care for up to 55 older people, some of whom have dementia. When we visited the home there were 35 people living there.

This inspection took place on 26 February and 12 March 2015 and was unannounced. The service was last inspected on 7 August 2014 when we found the service was not meeting the regulations in relation to handling people's medicines, supporting workers, and they did not have care plans to describe the support needs of people who had unintentional weight loss. We found at this inspection that improvements had been made.

The service had a manager who was appointed in December 2014. Her assessment to be registered with the Care Quality Commission was underway at the time of our visits and she was registered on 2 April 2015. 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 this inspection we found two areas where improvements were required. A person was occupying a

Summary of findings

bedroom in which the fire door was damaged and it had taken too long for it to be repaired, leaving the person at risk in the event of a fire. The arrangements for dealing with emergencies did not ensure that people were safe as the staff did not have easy access to a master key to enter people's bedrooms when necessary. Although there were management systems to identify, manage and assess risks, they had not operated effectively to recognise the issues of concern which we found. You can see what action we told the provider to take at the back of the full version of the report.

Since our previous inspection improvements had been made to the management of medicines. We found some areas of concern on one unit in the auditing systems used. We brought this to the attention of the provider and they dealt with it quickly. At this inspection we found there were enough staff to provide care for people who required it.

The provider made suitable arrangements to protect people from the risk of abuse and staff were knowledgeable about the action to take in response to concerns of this kind.

People were protected by safe processes to recruit qualified and experienced staff whose suitability had been properly checked before they began work in the home. Staff received support and training in relevant topics which assisted them to provide good care for people.

The manager and staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and people were not deprived of their liberty unless it had been authorised.

People were supported to eat and drink enough and to have meals appropriate to their needs. The GP visited weekly and there was access to a range of health care professionals for advice.

People's privacy and dignity were respected. Most interactions we observed between staff and people were kindly and warm. One person was supported to have her pet dog living in the home with her.

People had access to the medical assistance they needed. Health care professionals gave advice to nursing staff to inform their care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe. A fire door which was fitted to a bedroom had been damaged and repairs had taken too long to complete. This meant the person sleeping in there had been at risk if a fire had broken out. Arrangements to enter people's rooms in an emergency would have led to delays.

Staff were knowledgeable about how to recognise signs of potential abuse and were aware of the reporting procedures.

Assessments identified risks to people in relation to, for example, falls and pressure sore management and plans were in place to deal with them and keep people safe.

Staffing levels were appropriate to keep people safe and meet their needs. The provider made sure staff were safe to work with vulnerable people by taking up references and checks before staff began work.

Is the service effective?

Good

The service was effective. Staff were trained and supported to meet people's needs. Staff liaised with health professionals and followed advice to look after people well. People's nutritional needs were assessed and met.

The requirements of the Mental Capacity Act 2005 (MCA) Code of Practice and the Deprivation of Liberty Safeguards (DOLS) were met. Staff were trained and understood the legal requirements in relation to MCA and DOLS.

Is the service caring?

Good

The service was caring. We observed interactions which showed caring and compassion from staff to people.

We saw people being treated with respect, kindness and compassion. People's dignity and privacy was respected.

Is the service responsive?

Good

The service was responsive. People's individual needs were considered.

Advice was sought from specialists when required and this was used to make sure the service appropriately responded to people's changing needs.

People and their relatives felt confident in raising concerns about the service.

Is the service well-led?

Requires Improvement

The service was not well led. The service was regularly assessed by the manager and the provider with a view to improving people's quality of life. However the assessments had not identified the shortfalls we noted so improvements could be made.

Summary of findings

Staff felt the service was well led and they were able to raise concerns with managers of the service.	

Camberwell Green

Detailed findings

Background to this inspection

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

The inspection was carried out by two inspectors, a specialist pharmacist inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before we visited the home we reviewed the information we held about the home, including records of notifications they are required to tell us about. We also had contact with two specialist nurses and two social care professionals involved with the service.

During our inspection we spoke with six people living at the home and three relatives. We also spoke with 10 staff, including the manager and members of the nursing, care and ancillary staff teams. We spoke with the managing director and the project manager who were at the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at a range of records, including six care plans, three recruitment records, health and safety records and quality assurance checks. After our visits the manager and project manager provided information we requested, including training records and action plans.

Requires Improvement

Is the service safe?

Our findings

Some aspects of the home were not safe so people were not always protected from risks associated with an unsafe environment. In one unit we saw a bedroom door was damaged and were concerned that as it was a fire door it would not protect the occupant from fire. We were told the damage happened when the person had mistakenly locked the door and could not unlock it. Staff did not have access to a master key with which to open the door. The key had been taken off the premises in error, so staff entered the room by removing the lock and damaging the door. The person who occupied the room was given the opportunity to move rooms while arrangements were made for the door to be replaced but they chose not to. Although the manager had tried to order a new door this had not been possible through the provider's usual system. When the issue was escalated to senior managers the door was replaced on the same day.

The manager described the usual arrangements to access the master key in an emergency. They were complicated and relied on reaching the manager by phone who would then give instructions about the location of the master key. These arrangements were not suitable to provide prompt assistance in an emergency and could have left people at risk.

We found that the registered person had not protected people against the risks associated with unsafe premises. This was in breach of regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regular checks were made of the fire alarm and emergency lighting systems and the fire extinguishers. Fire drills were conducted. A fire drill took place in January 2015 and the manager said she was dissatisfied with the staff response to the alarm being activated and felt the response time was too slow. A meeting had been held with staff to discuss the shortfalls and the frequency of fire drills had increased. The water system was checked to make sure it was safe.

People had access to enough staff to care for them. Planned staffing levels were based on the numbers and needs of the people who lived at the home. A rota was planned to provide sufficient numbers of staff in all units.

There was a registered nurse on duty in each of the units. They worked alongside carer workers in each unit. The number of carers varied between the floors. We did not hear many calls for assistance while we were at the home, and those we did hear were answered promptly. Generally staffing levels were suitable but on one occasion a carer was not available to care for people as they were providing support to another person. A carer remaining on the unit on one of these occasions said "It's so busy I haven't had a break yet." We were told that in the week following our visit an additional staff member was to be allocated to the team to assist staff at particularly busy times.

When we last assessed the management of medicines at the service in August 2014, medicines were not managed safely. At this inspection, we found that the process for prescribing and supply of medicines had improved. Medicines administration records were accurate and up to date, providing evidence that people were receiving their medicines as prescribed. We looked at the prescribing and use of sedating medicines for agitation and saw that these were not being used inappropriately or excessively. End of life care plans were in place and anticipatory medicines had been obtained for two people nearing end of life so that they would have the necessary medicines to relieve pain and other symptoms without delay.

There were protocols for medicines to be given when required, such as pain relieving medicines, were now available for people who were not able to communicate verbally when they were in pain. Staff administering medicines had sufficient information to be able to administer these medicines. We spoke with three nurses responsible for administering medicines, and they were able to explain how they assessed whether people were in pain at every medicines round. However these informal pain assessments were not recorded, therefore there was no written evidence that pain assessments were carried out regularly to ensure people were not left in pain.

Two people were regularly refusing their essential medicines. Appropriate procedures were in place and were followed to ensure that people without capacity to consent to taking their medicines continued to receive essential medicines.

The provider made suitable arrangements to protect people from the risk of abuse. Staff had training in safeguarding procedures and they were aware of the action to take if they had concerns that people may be at risk of

Requires Improvement

Is the service safe?

harm. Staff could call a confidential helpline if they wished to raise concerns through the provider's whistleblowing procedure. Posters about the helpline were displayed in the home.

Staff assessed risks presented by people's conditions with the aim of keeping them safe. We saw a range of risk assessments including those which related to the use of bed rails, moving and handling, falls and the risk of developing pressure ulcers. Action was taken to manage these risks, for example specialist equipment was provided for people assessed as at risk of developing pressure sores and there was a plan to ensure that a person's position was moved regularly to reduce the pressure to parts of their body.

People living at the home had a range of physical needs and some required equipment to assist people to move safely. If people used a hoist with staff assistance to move, they were supplied with an individual sling to use and people had walking aids which met their individual needs. We saw staff making sure people used their walking aids and staying close by and observing them while they were walking to make sure they were safe.

People were cared for by staff who were judged to have suitable skills and experience to do so. Recruitment processes were safe. We looked at three recruitment records and found appropriate checks and references were taken up before staff began work at the home. The checks included criminal records, nurse's registration with the Nursing and Midwifery Council and people's employment history. Appointments to posts were confirmed when staff had successfully completed a six month probationary period.

People were cared for in a clean and hygienic environment. Staff had protective clothing available, such as gloves and aprons and they were used appropriately. Staff had been trained in infection control procedures. The building was visibly clean and had a pleasant smell.

Good

Is the service effective?

Our findings

Staff provided care which was directed at meeting people's needs. A relative told us they said they were satisfied with the care the home provided and they felt staff were experienced and skilled for their roles. Another relative said they were pleased there was a settled staff group to care for their relative. They said the staff had got to know them and knew their needs. . They said, "We've had a lot of changes, we've got a good team now, I hope they stay." Another visitor said they were glad there were now permanent staff available to look after the people who lived at the home as they felt it was "better for them than having lots of agency staff". They said their relative had been "upset" during the period when many different staff were caring for them but they were "settled now."

The provider supported staff to carry out their work. They received training in subjects the provider had decided were mandatory for their roles. These included issues concerned with health and safety such as moving and handling, emergency procedures, fire safety, and infection control. They were trained in care planning, equality and diversity and safeguarding people. Staff had also received training in preventing pressure sores from a tissue viability nurse

People were assisted by staff who were supported and happy in their work. Staff said they received regular supervision from senior staff where they had the opportunity to talk about their work and receive advice and guidance about how to meet people's needs. At our last inspection staff had not been adequately supported as they had not received appraisals. The provider had acted on this and staff received appraisals which identified areas of good practice and their training needs, it was intended that these would be carried out annually.

A staff member said a good thing about the home was a sense of "team work" which had previously been lacking but now was present. Another staff member told us there had been a "difficult" period at the home but felt it had improved.

The manager and staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff received training in the MCA and DoLS as part of their mandatory training. Applications to restrict some people's liberty had been made and the manager was awaiting the outcome of the assessments. Mental capacity assessments had been conducted. If people did not have capacity to take part in important decisions, for example about a medical matter, best interests meetings were held in line with the requirements of the MCA.

People had support to have enough to drink. On each floor there were containers of soft drinks and cups so drinks could be offered to people easily. Staff used these during our visits and offered people drinks frequently. People told us the food was "OK" and another person said it was "alright". There had been several changes of chefs and the post was not permanently filled during our visits. Recruitment for a new chef was underway.

At our last inspection we found that people who had unintentional weight loss did not have care plans which described the support they required with meals. At this visit this had improved and there were details of how to support people to have sufficient food. People were assessed using the Malnutrition Universal Screening Tool' (MUST) to check whether people were at nutritional risk. If they were, then staff wrote a care plan to address their needs. One care plan included details of foods the person particularly liked and could be offered on occasions when their appetite was poor. This reduced the risk of the person missing meals and helped to increase their intake of food. Advice was sought from speech and language therapists about how to care for people with swallowing difficulties. This advice was recorded in people's care plans together with instructions about the consistency of food people required. This enabled people to be supported appropriately when eating and reduce the risk of people choking.

The GP visited the home once a week and was available for consultations outside of the visits if concerns arose. The 'out of hours' doctor service was used when necessary as was emergency medical help. Advice was available from medical professionals such as physiotherapists and the members of a care homes support team, to enable staff to provide people with care specific to their needs.

The building was suitable for the needs of the people who lived there. There were two lifts which allowed access between all of the floors, one was big enough to accommodate someone using a stretcher. All doorways were wide and there was level access allowing people with

Good

Is the service effective?

mobility needs and wheelchair users to move around easily. People could access a safe enclosed terrace from a ground floor lounge. This gave people access to fresh air and the opportunity to watch events in the local area.

Good

Is the service caring?

Our findings

Staff looked after people with care and compassion. Visitors told us they felt the staff cared for their relatives and they felt welcomed when they visited. We saw contact between people and staff that showed a caring attitude. We saw one person who liked to be with staff and as they ensured they were close to them for reassurance. The person looked settled and comfortable in their company. As well as nursing and care staff showing a kind attitude we saw staff from the catering and administrative team being helpful to people, asking if they needed assistance and talking to them warmly. There was a calm atmosphere in the home and staff spoke to people gently and with warmth.

Staff were observant of people's well-being and comfort. A member of staff noticed when a person was not sitting comfortably and put an extra cushion behind their back so they could relax. We saw a person singing and conversing with a member of staff with warmth and humour. The person was smiling, looked relaxed and then sang along to the music playing.

Although of the majority of our observations were of staff being caring we saw an interaction which concerned us. We entered a person's bedroom, with permission, and saw a person in bed. They were crying and we felt they were distressed, we also saw they had insufficient bedding. We told a member of staff about this. They went into the person's room and although they rearranged the bedcover they made no attempt to comfort the person. We felt this showed an uncaring attitude. The manager shared our concern when we told her about the incident and she agreed to follow it up.

Staff had decorated bedroom doors with people's names and photographs and this helped people to find their way to their private spaces. At our last inspection in August 2014 'memory boxes' had been fitted by bedroom doors but were empty. A memory box can contain personal items which can help people to reminisce and recall events and people from their past. We saw at this visit that improvements had been made and the memory boxes contained items of importance to the people. For example the contents of several boxes included flags of people's country of origin, many contained photographs and items relevant to the person's interests or former profession.

One person was supported to have their pet dog living with them at the home and staff supported their relationship. Although the dog had lived there for a long time at our last inspection there was no information about the pet, or how the person was supported to care for them. At this visit we saw that details had been recorded about the dog's care and suitable arrangements were made for the dog's care.

People's privacy and dignity were respected. We observed that staff closed doors when people were using the toilet and being assisted with personal care. People were well dressed and groomed and had the opportunity to have their hair done by hairdressers who visited the home every two weeks.

The home provided care for some people who were at the end of their lives. They had links with a local hospice. Two staff were participating in a training programme provided by the hospice to increase staff knowledge and understanding about this area of care. Care plans were clear and documented people's wishes about the end of their lives and how they wished to be cared for. The home had discussions with family members about people's preferences, wishes and their spiritual needs.

Good

Is the service responsive?

Our findings

Staff provided care which met people's needs. A visitor told us they were happy with the way their relative was looked after. They said the staff team "knew people as individuals" so could meet their needs. They said they were involved with their relative's care plan and gave staff written information to help them get to know them and their history.

At our last inspection we found care plans did not reflect people's care needs. At this visit we found that improvements had been made. Each nurse is now allocated a reasonable number of care plans they are responsible for updating and reviewing each month. The stability of the staff team has helped as staff knew the people well so care plans are more reflective of their individual needs.

Generally the care plans were up to date and reflected people's assessed needs. However in one person's plan we saw they had a mental health need documented. However there were no details on how the condition was to be managed, or any signs for staff to be aware of that might indicate deterioration in the person's condition. We were concerned that the person may experience a relapse and without adequate information staff could miss signs of their deterioration.

At our last inspection we found that charts to record people's food and fluid intake were inaccurate. The provider had taken action to address this shortfall. Charts were reviewed by nursing staff and shortfalls addressed. A staff meeting included discussions about the purpose of the recording and spot checks were made to monitor their completion. The provider recognised that this was an area that needed on going attention and that had been built into their regular monitoring.

Care plans were reviewed at least every month and more often if necessary. For example if a person had a fall their care plan and associated risk assessments were reviewed to ensure they were accurate and any changes identified were made. This ensured that the care plans were responsive to changes in people's conditions. After such an event people's condition was monitored and assistance was sought from the GP or accident and emergency department if necessary.

The plans included information about people's cultural, religious and spiritual needs. The manager told us they had begun discussions with representatives from places of worship with the aim of increasing opportunities for people to express their spirituality. In one of the lounges a religious radio station was playing. A member of staff told us the people in the room were from the same religion. We saw people listening to the music which played. Some people were engaged in this activity, some smiled, tapped, sang and hummed along to the music, other people sat quietly and looked relaxed.

People had the opportunity to take part in activities. We saw people joining in a quiz which people said they enjoyed and did on most days. A game of musical bingo was arranged but we observed that few people were engaged in it, although they smiled when the music was played as part of the game. The manager is aiming to review and expand the range of activities available for people to take part in.

A relative told us they felt able to approach the manager with concerns and was confident they would be dealt with properly. People had opportunities to give their views about the home. People could make complaints about the care provided or other aspects of the home. A relative told us they felt able to approach the manager with any concerns they had and felt confident the matter would be dealt with. The complaints procedure was displayed in the main entrance hall of the home. Staff said that if anyone raised a complaint with them they would inform the manager so it could be investigated. No complaints had been made since the manager had been in post.

Meetings had been arranged to take place every three months for people who live at the home and their relatives. The manager wanted to use these meetings to give the people and relatives the opportunity to raise concerns with her. Information was in the reception area of the home about how people could give their experience of the home on a website which gathered feedback about care services. A formal survey of people's and relatives' views had not been conducted recently, but was planned.

Requires Improvement

Is the service well-led?

Our findings

Some aspects of the home did not demonstrate that it was well led so people could not be sure that management arrangements consistently met their needs. The provider had put in place procedures and checks to provide assurance that the home was operating to meet the needs of the people who lived there. However the systems had not prevented some shortcomings. For example there were checks and audits to make sure medicines were being managed safely but we saw that these checks were not always carried out properly or effectively on one unit.

Specifically the daily checks of controlled drug stocks had not picked up a stock discrepancy, the checks of the medicines fridge temperature were not carried out properly, the daily checks by nurses to see if prescribed creams were being applied regularly by care staff were not being done often enough, and daily stock counts of some medicines were not recorded clearly or accurately. We saw that some of these issues with medicines had not been identified during the providers own overall medicines management audits in January, February and March 2015.

In addition the provider had a procedure in place to notify nursing staff about medicines alerts. We saw evidence that the manager had notified nursing staff of a recent alert on the risks of unsafe storage of food thickeners, but staff had not taken action on this alert. Not acting on this medicines safely alert may have placed people at risk.

The provider took immediate action on the issues we noted, by making sure food thickeners were removed and stored safely on the day of our inspection, by investigating the controlled drug stock discrepancy, obtaining new medicines fridges and arranging medicines retraining for staff, which was due to be completed by 20 April 2015. They wrote to us setting out the action they would be taking to address the issues they had identified during their own internal audits, this was due to be completed by 24 April 2015.

Audits of care plans were being carried out and this formed part of the quality assurance systems in the home. Nevertheless they had not addressed the shortfall we identified about the lack of a care plan about a person's mental health need.

We found that the registered person had not protected people against the risk of inappropriate or unsafe care and treatment by means of regular assessment and monitoring the quality of the service provided. This was in breach of regulation 10(1)(a) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management of the home was more stable than over the last two years when there had been several changes of manager and the management of the home had been unsettled. Since December 2014 a manager has been permanently in post and since our visits had been registered with the Care Quality Commission. A deputy manager was appointed in February 2015 and was providing clinical leadership to the home. The manager had been given support to take over the management role, including a handover from the previous post holder, training in the provider's management systems and assistance from senior managers from the organisation.

The feedback we received was that the manager had settled well, people and their relatives were familiar with her and staff believed she was responsive. One member of staff said the manager was "very nice and if you tell her about something she sorts it out very quickly."

Visits had been made to the home by senior managers. During our first visit we met both the regional project manager and the managing director of HC-One. They were regular visitors to the home and we saw them talking with people who lived at the service and staff. We heard from staff they felt supported by the senior managers, one said, "I can talk to the regional manager about anything I am concerned about."

The regional project manager wrote reports of his visits. They showed he assessed the quality of the service provided by talking with people and staff about their experience of Camberwell Green. They also observed care practice and did checks and other records in the home. If improvements were identified an action plan was created with target dates for completion of the work.

The quality of the home was also assessed at visits made by an HC-One quality inspector who made recommendations to improve the experience of people who lived in the home. A recent improvement they had identified was to introduce the use of discreet labelling for

Requires Improvement

Is the service well-led?

people's clothes as they noticed that some people's clothing was marked in a way that detracted from their dignity. The manager was making arrangements to make the improvement.

Notifications of events had been made to CQC as required. There were systems to learn from incidents. The form on which they were recorded incidents included a section to detail the action taken to prevent such incidents recurring, such as reviewing risks of falls and environmental assessments and evaluating the care plan to assess whether changes were needed.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected from avoidable risk of harm because the provider had not taken all reasonable steps to ensure the health and safety of people using the service. Regulation 12(2)(b)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Service users were not protected against the risks of inappropriate or unsafe care by means of the effective operation of systems designed to enable the registered person to identify, assess and manage risks relating to the health, welfare and safety of service users. Regulation 17(2)(a)