Make-All Limited

Cameron House

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**

Summary of findings

Overall summary

The inspection took place on the 3 and 6 April 2018 and was unannounced. Two inspectors carried out the inspection.

Cameron House is registered to provide accommodation for up to 18 older people. There were 15 people, most living with dementia, at the home at the time of the inspection. The home is situated in a residential area of Ryde and is an adapted building with bedrooms provided over two floors in single or shared double occupancy rooms. A stair lift provided access between the floors. There is a communal lounge, conservatory, a dining room and appropriate toilet, bathing and shower facilities. Externally there is a level enclosed garden.

Cameron House is a 'care home'. People in care homes receive accommodation and personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

A registered manager was in place. 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 previous inspection of the service in February 2017 had identified one breach of the Health and Social Care Act 2008 and associated Regulations in relation to a duty of candour. We found this was now in place and when required people or relatives were provided with a written explanation and apology for any incidents.

A quality assurance process was in place. However, this had not identified the areas of concern we found during this inspection. Medicines were not always managed safely and people had not always received these as prescribed. We also found that not all risks to people were managed safely and people had not always received the care they required. This was a breach of regulations. These concerns had not been identified by the provider's quality assurance systems. We discussed these and some other minor issues with the registered manager who was responsive to the issues raised and undertook to take action.

People were treated with dignity and their right to privacy was respected.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home. Staff were suitably trained and felt supported in their work they worked well as a team and with external professionals.

Where necessary Deprivation of Liberty Safeguards (DoLS) applications had been made. Equality and diversity was seen to be actively supported with people being able to express themselves. Staff offered people choices and respected their decisions.

People received the personal care they required and were supported to access other healthcare services when needed. People were supported and encouraged to be as independent as possible.

Staff were aware of people's individual care needs and preferences. People had access to healthcare services and were referred to doctors and specialists when needed.

People received a varied diet and where needed were supported to eat their meals in an unrushed manner.

People felt safe and staff knew how to identify, prevent and report abuse. People and external health professionals were positive about the service people received.

People were encouraged to maintain relationships that were important to them.

People and relatives were able to complain or raise issues on a formal and informal basis with the registered manager and were confident these would be resolved. This contributed to an open culture within the home.

Plans were in place to deal with foreseeable emergencies and staff had received training to manage such situations safely.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are currently considering our regulatory response.

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 always safe.

Medicines were not always managed safely and people had not always received these as prescribed.

Risks to people were assessed however, these were not always managed effectively and equipment to protect people from the risk of pressure injuries was not used correctly.

People felt safe and staff had received training in safeguarding adults. There were appropriate systems in place to protect people by the prevention and control of infection.

There were enough staff to meet people's needs and recruitment practices helped ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff acted in the best interests of people and followed legislation designed to protect people's rights and freedom.

People received effective care and had access to health professionals and specialists when needed. When people were transferred to hospital, staff ensured key information accompanied them to help ensure they received ongoing healthcare support.

Staff were competent, suitably trained and supported in their roles. People were positive about the quality of the meals and were supported to eat and drink enough.

Adaptations had been made to the environment to make it suitable for people living there.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion. They interacted positively with people and promoted their independence.

Staff supported people to maintain relationships that were important to them.

Staff protected people's privacy and respected their dignity.

People and family members where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

Staff knew people well and demonstrated an in-depth knowledge of their individual needs.

People's wishes and preferences for the care they wished to receive at the end of their life was clearly recorded which would, if provided, help to support people to have a comfortable, dignified and pain-free death.

People were provided with a range of activities.

The registered manager sought feedback from people using the service and had a process in place to deal with any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The registered manager used a number of audits to check the quality and safety of the service; however these were not always robust in identifying concerns.

There was a clear management structure in place and staff understood the roles and responsibilities of each person within the team structure.

There was a positive and open culture and the registered manager and provider of the service had a robust oversight of this.

The manager and provider of the service actively sought feedback from people using the service and their families.

Cameron House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 unannounced and was carried out on 3 and 6 April 2018 by two inspectors.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including previous inspection reports and notifications of significant events the provider sent to us. A notification is information about important events which the provider is required to tell the Care Quality Commission about by law.

During the inspection we spoke with two people who lived at the home and to six family members. We also spoke with the registered manager, deputy manager, five care staff, the housekeeper and the cook. We spent time observing the care and support people received in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We received feedback from three health and social care professionals who had contact with the service.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, three staff recruitment files, records of complaints, accidents and incidents and quality assurance records.

Requires Improvement

Our findings

Visitors told us they felt their relatives were safe at Cameron House. One relative said, "When they were at home I was worried a lot but not now." Another relative told us, "I do feel they are safe here." A person told us, "I feel safe here, there are no problems."

Medicines were not always managed safely. Medicine Administration Records (MAR) had not been fully completed and where recording gaps had occurred subsequent care staff had not identified these and raised this with the staff member concerned or informed the registered manager. For one person we saw a medicine remained in the blister pack but had been signed as given on the MAR chart, meaning the records were inaccurate and the person had not received their medicine. Some people were prescribed regular dose medicine which needed to be administered at least four hours apart. There was no system to ensure that an adequate gap was in place between administrations meaning the person could receive these too close together placing them at risk. When people were asleep when medicines were due to be administered, staff had not always taken action to offer these again at a later time. One person was seen to have been asleep in the morning on a number of occasions missing essential medicines. Action had not been taken to request the GP to review these and prescribe these at a later time when the person would be awake.

We found one person had not received essential medicines including those prescribed for their heart and blood pressure for five days and another person had not received regular medicine for pain for three days as no supplies were available. Medicines systems had not ensured these were reordered with sufficient time for them to be available before existing supplies ran out. The registered manager told us about problems they had experienced with their GP and pharmacy and were moving to an alternative pharmacy which would be able to provide a more consistent supply.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems were in place to ensure people received prescribed topical creams and a formal pain assessment tool was available should people be unable to say that they were in pain. Medicines were stored securely and administered by staff who had received suitable training and had their competency assessed on a regular basis.

Some people were at risk of developing pressure injuries and we saw special pressure-relieving mattresses had been provided via district nurses. However, we found that these were not always being used correctly.

We checked pressure relieving mattresses and we found that they had the wrong type of bed sheets on, which would reduce the effectiveness of the pressure relieving equipment . We also found that mattresses were not always set to the correct weight for the person, meaning their effectiveness was compromised and the person would be at risk of developing pressure injuries. The registered manager confirmed that there was no process to check mattress settings on a regular basis and arranged to add this to weekly manager audits. People were usually supported to change position regularly to reduce the risk of pressure injuries. However, on the first day of the inspection we identified that two people were at risk of pressure injuries. They did not receive personal care at lunch time and therefore remained seated without the pressure area relief they needed which placed them at risk of pressure area and moisture injury to their skin.

The failure to ensure the correct management of pressure relieving equipment and that people received the care required to meet pressure area risks, was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following a fall, the risks posed by the home's staircase had been reassessed and discussed with the local safeguarding team. A movement alert monitor was put in place to inform staff when people were walking up the stairs. Most of the time we saw staff responded promptly to this however, on the first day of the inspection we saw that on two occasions people not assessed as independent on the stairs, had walked to the top of the stairs before staff responded to the alarm. The registered manager said they were mindful of the risk posed by the stairs when allocating bedrooms and accepting new admissions. However they were unable to completely remove the risk. A stair chair lift was provided and we saw this was used safely with staff remembering to use the safety lap strap.

Other individual risks were managed safely. Risk assessments had been completed for all identified risks, together with action staff needed to take to reduce the risks. Risk assessments were in place for moving and handling, mobility, fluid and nutrition, skin integrity and falls. People were supported in accordance with their risk management plans. Moving and handling assessments clearly set out the way staff should support each person to move and correlated to other information in the person's care plan. Staff had been trained to support people to move safely and we observed support being provided in accordance with best practice guidance. People who were at risk of skin damage used special cushions and were assisted to change position to reduce the risk of pressure damage to their skin. Where people were at risk of choking on their food, they had been referred to specialists for advice and were provided with suitable food and drinks to reduce the risk. Staff showed that they understood the risks to people and we saw that their health and wellbeing risks were assessed, monitored and reviewed regularly.

Where there were specific individual risks, action was taken to support the person. For example, we heard the registered manager talking with an Occupational Therapist to arrange a review. This was because the person's mobility had decreased and they were not always safe when using a particular piece of equipment. People were also supported to continue some activities which carried a risk where this was their choice and would enhance their lives. For example, some people continued to use the stairs unaided as they were able to do so. The registered manager reviewed all falls in the home on a monthly basis to identify any patterns or trends; none had been identified, but they described the action they would take if a common theme emerged.

The provider's policy was that fire detection and management equipment would be tested weekly, however, records showed that this had not always occurred. An external specialist had completed a fire risk assessment which had identified improvements were required to some fire prevention and management systems. We saw action was being taken to address these areas and smoke resistant strips were being added to all doors within the home. Staff were clear about what to do in the event of a fire and

arrangements were in place with another home owned by the provider in the same town, should this be required in the event of an emergency evacuation. In addition, each person had a personal emergency evacuation plan detailing the support they would need if the building needed to be evacuated. Gas and electrical appliances were serviced routinely. Staff also checked the temperature of all hot water outlets on a monthly basis, including those in people's rooms.

One relative told us, "[The home] always looks clean." Staff had attended infection control training, they had access to personal protective equipment (PPE) and wore this whenever appropriate. The cleaner said they had cleaning schedules and sufficient time to complete these. Overall the home was clean, although we identified additional cleaning was required in one bathroom and one mattress required replacing which was done immediately. The home's washing machine had broken down prior to the inspection. This had led to a build-up of soiled laundry preventing access to hand washing facilities in the laundry. On the second day of the inspection this had been resolved however, we saw red bags containing soiled laundry had been placed directly on the floor. We identified this to the registered manager who took immediate action to purchase a container for soiled laundry bags. Shortly before the inspection, the home was awarded five stars (the maximum) for food hygiene by the local environmental health team. The home had systems to ensure a safe water supply and prevent the risk of Legionella disease.

The provider had appropriate policies in place to protect people from abuse. Staff said they would have no hesitation in reporting abuse and were confident the registered manager would act on their concerns. One staff member told us, "I would speak to [name of registered manager] and could always go to you [CQC] or social services." Another staff member said, "[name of registered manager] is so approachable, any issues I will raise with them." Staff had received safeguarding training and knew how to identify, prevent and report abuse. They were confident the registered manager would take the necessary action if they raised any concerns and knew how to contact the local safeguarding team if required. There was a notice in the office which provided staff with the contact details for the local social services safeguarding team. The registered manager was aware of the action they should take if they had any concerns or concerns were passed to them. They followed local safeguarding processes and had responded appropriately to allegations or concerns of abuse. Records confirmed that the registered manager had reported incidents appropriately and promptly to the local safeguarding authority.

There were sufficient staff to meet people's care needs. A visitor said, "I think there are enough staff, they usually seem to be available." Another visitor told us, "If we need to talk to staff they always make time for us". During the inspection we saw that staff were busy but responded promptly and compassionately to people's requests for support. Staff told us there was usually enough staff to meet people's needs. One staff member told us, "I think there are enough staff on duty". They added that the registered manager would help out if needed.

Staffing levels took into account the number of people who were living at the home and the level of support they needed. The registered manager said they were aware of the busy times and had increased the number of care staff during the evening. A named member of care staff not on duty was 'on call' each day. The registered manager explained that this meant they could contact the staff member to cover for an unexpected need such as a person requiring support to attend hospital. Absence and sickness were covered by permanent staff working additional hours which meant people were cared for by staff who knew them and understood their needs. A visitor told us, "It's usually the same staff and I'm getting to know them all."

The provider had safe recruitment procedures in place, which included seeking references, obtaining a full employment history and completing checks through the Disclosure and Barring Service (DBS) before employing new staff. The DBS helps employers make safer recruitment decisions and helps prevent

unsuitable people from working with people who use care and support services. We found these checks had been completed before new staff started working with people.

Good

Our findings

People, their families, and a healthcare professional, told us they felt the service was effective. A family member told us, "[Person] is always clean and is well cared for." A healthcare professional said, "The staff know them [people] really well." However, on the first day of the inspection we identified that two people had not received mid-day personal care as required. The registered manager investigated this and we saw that they usually received care at this time. The registered manager identified that it had been a particularly busy day and staff had not wanted to disrupt some entertainment that was taking place so had not moved people to receive care. They addressed this with the staff concerned.

Care files detailed people's individual needs, showing consideration for their assessed needs and their personal preferences. Pre-assessments were carried out by the registered manager prior to people moving into Cameron House. The registered manager told us that they considered if the home was able to safely meet the needs of people before agreeing to them moving in, as well as the location of vacant rooms. Care staff told us they had been provided with information about new people prior to them being admitted. They said this helped them to understand the person's needs and how they should be met. Care plans showed that relatives had been consulted during the pre-admission process. The registered manager said they consulted with external health professionals already involved with the person's care as part of the pre-admission assessment. Care records contained information provided by the person's GP detailing past and present medical needs and current medicines.

People were supported to access appropriate healthcare services when required. Their records showed they had regular appointments with health professionals, such as chiropodists, opticians, dentists and GPs. Additional healthcare support had been requested by the staff when required. For example, the home had contacted an occupational therapist for advice around the most suitable hoist sling to use for a person whose needs had changed. All appointments, visits and communication with health professionals and any outcomes, were recorded. Staff knew people's health needs well and information in relation to how these should be managed, was clearly documented within people's care files.

A range of well-known tools were used to monitor people's health and wellbeing in line with best practice guidance. For example, staff used the Malnutrition Universal Screening Tool (MUST) to help calculate the person's body mass index and identify the need for nutritional support. Other nationally recognised tools were used to assess a person's risk of developing pressure injuries and to monitor their bowel movements.

Following a safeguarding investigation, the registered manager had reviewed how information was sent

with people should they need to go to hospital in an emergency. There were now clear procedures in place to help ensure that people received consistent support when they moved between services. The registered manager told us that new services were provided with up to date information form about the person, medicine administration records and medicines and if required the person would be accompanied by a member of staff.

Where people had specific needs in relation to their lifestyle choices we saw through interactions with care staff and care records, that their needs were being considered and met. Care staff demonstrated a good understanding of people's needs and wishes. For example, they told us how they supported people's human rights, how individual people like to be supported and what was important to them.

People were supported to have enough to eat and drink. Drinks and snacks were offered throughout the day and evening. People and their families were complimentary about the food. When we asked people if they enjoyed their food their comments included, "Very good" and a relative said "The food is good, [name of relative] eats well here." Staff were supportive to people during meal times. People were supported to eat independently and where necessary specialist cups, crockery and cutlery were provided. When assistance was required, this was provided by staff in a relaxed and unhurried way. People's nutritional needs were assessed to help identify if they were at risk of malnutrition and if a referral was needed for specialist assessment by a GP, dietician or speech and language therapist (SALT). Staff were aware of which people needed soft or pureed food. Care files reminded staff to offer choices and provided individual information about preferences. These detailed help people needed with food, such as 'help to cut up food' and '[person's name] loves rich tea biscuits with hot drinks'. When required, people's weight and their food and fluid intake was monitored, so any action could be taken regarding weight loss or gain.

Staff protected people's rights and acted in the best interests of people. One person told us, "They know what I like to do each day, they are respectful of that, yes." A relative told us "They ask us what I think [person's name] would have wanted." Staff followed the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Many people living at Cameron House had a cognitive impairment and were not able to give valid consent for certain decisions. This included the delivery of personal care, the administration of medicines, the use of bedrails and the use of pressure relief mattresses. Staff therefore made these decisions on behalf of people. Assessments of people's capacity to make specific decisions had been undertaken and then if required a discussion with the person's family and any other professional's involved had occurred to agree what would be in the person's best interests. There were best interest decisions around general care and treatment, and where necessary for specific decisions such as the use of movement alert mats or bed rails.

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 the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We found staff were following the necessary requirements. They had applied for DoLS authorisations where needed and these were awaiting assessment by the local authority.

Staff described how they sought verbal consent from people before providing care and support. They said

they were led by the person and always acted in the person's best interests. One staff member said, "I know all of the resident's well, their care plans give a lot of information about their care needs and what they want." Care staff explained that one person had not wanted to get dressed and remained in their pyjamas and dressing gown. They said "We will try later and see if they are ready then."

Adaptations had been made to the home to make it more supportive for the people who lived there, within the structural limitations of the building. A refurbishment plan for the home was underway with communal rooms and corridors having been redecorated and new carpets fitted. Handrails were fitted in corridors however these were not contrasting colours to the walls behind meaning people with poor eyesight may not distinguish them. The registered manager had researched environments for people living with dementia and was aware of how signs and the decoration within the home could promote people's well-being and independence. They explained that as areas of the home were refurbished consideration of this research was being used when choosing floor coverings and wall decorations. The home had a flat rear garden which people could access in warmer weather. Action was underway by the provider to replace a garden wall which had blown down in a winter storm. Once repaired the garden would be secure.

People's needs were met by staff who were skilled, competent and suitably trained. One person told us, "The staff are very nice." All visitors praised the staff and told us they felt staff knew how to care for their relatives.

New staff completed an effective induction into their role. This included time spent shadowing, (working alongside experienced staff) until they felt confident they could meet people's needs. A staff member told us, "[When I started] I did lots of training and worked alongside other staff until I was able to work on my own." Staff who were new to care were supported to complete training that followed the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life.

People were cared for by staff who had received appropriate training. A staff member said, "There's lots of training." Experienced staff received regular training in all key subjects and were supported to gain vocational qualifications relevant to their role. Training was provided by some in house computer training and via external trainers. Most care staff had obtained or were undertaking a care qualification. The registered manager monitored staff training and had systems in place to identify when staff were due for refresher training, which was then booked. Staff demonstrated an understanding of the training they had received and how to apply it. For example, when communicating with people living with dementia, they used short, simple questions, remained calm and gave people time to respond. When using equipment to support people who were unable to walk, staff spoke with people continuously providing relevant instructions and reassurance for the person.

Staff told us they felt supported in their roles. Staff had annual appraisals where they discussed their performance and development needs, together with three-monthly sessions of supervision, with a manager, to discuss their progress and any concerns they had. Each session of supervision also focused on a particular theme relevant to the staff member's role, such as medicines management or infection control. The registered manager also covered some shifts enabling them to observe and directly supervise staff whilst they were working.

Good

Our findings

People were cared for with kindness and compassion. One person living at the home told us "Oh, they're brilliant. [The staff] always stop to say good morning or ask if there is anything I need." Relatives were also happy with the care that their family members received at Cameron House. One relative told us "[Person's name] was straight in the door and she settled straight away." Another visitor said "Everyone here is really nice, everything is good."

Relatives of people living at the home were consistently positive about they care their loved ones received. One person told us that the care home had a very 'homely' atmosphere and they always found the environment to be clean and tidy. Relatives told us that care staff were kind and well trained to complete their job role well. They added that they were free to visit when they wanted too and were always made to feel welcome. One relative told us that their family member had a companion who visited the home once a week to join them for lunch, which the care home were able to accommodate for. People's bedrooms were personalised with photographs, pictures and personal possessions of their choosing.

We saw positive and caring interactions between staff and people living at the home throughout the inspection. Staff treated people kindly and spoke to them in a respectful and friendly manner. Staff took the time to talk to people and respond to them, even if they were in the middle of recording notes or carrying out an administrative task. For example, one staff member pulled up a chair next to a person in the dining room and asked the person if they would like to sit with them as they were on their own. People were included when activities were happening and were always asked if they would like to participate. People appeared comfortable and cheerful around staff members. During handover, staff spoke warmly and responsively about people living at the home. They asked relevant questions to gain key information, which demonstrated their knowledge of each individual.

Care files had limited information relating to people's past history or hobbies. We raised this with the registered manager, who told us that they were in the process of creating an individual profile for each resident called 'This Is Me'. We saw an example of this for one person, which documented key information for staff to use as guidance.

People received care and support that was individual to them and were supported by staff who had a good knowledge of their likes and dislikes. People's care plans were personalised for each individual and gave clear and detailed information regarding people's preferences around their specific care needs. For example, one person's medical profile stated that they liked to take their medicines 'one at a time on a

medication spoon with a cup of water'. Another care plan said '[person's name] likes to have a bed light on'. Care plans also gave information about what people can and cannot do in order to promote their independence.

During the inspection, a new person arrived at the home from a hospital discharge. We observed care staff welcoming the new person and taking the time to introduce them to other people living at the home. The new person was supported in an unhurried way and staff kept them up to date with what was going on.

Staff were respectful towards people and their property. One person told us "[The staff] will always knock on the door and ask if they can come in, there's no problem there." We observed staff knocking people's doors, waiting for a response, and gained permission before they entered someone's room. People's confidential care records were stored electronically on a secure system used by the home. Staff who were authorised to view people's records had their own log in and password for the system, which was accessed via mobile tablet computers. We saw that where a tablet had been inactive for several minutes, it would automatically lock itself with a password protection, so that other people could not readily access the information. Backup records were also stored in a paper file, which was kept securely in the main office.

People's dignity was protected when they received personal care. Staff described the practical steps they took in make sure that people's privacy was always preserved. For example, covering people with a towel and talking to them so that they knew what they were going to do. A cordless telephone was available for any phone calls people wanted to take in private.

People were supported to make choices in their day to day lives and their decisions were respected by staff. One person told us that they did not get involved in many activities and liked to stay in their room or find a quiet place in the home to read. We later saw that this person was laughing and joking with staff, being offered hot drinks and respectfully being left to read when they wanted too.

Staff spoke to us positively about their job and told us that everyone working at the home got along well and worked as a team. We spoke to one new staff member who told us "[The staff] are so friendly, the girls [existing care staff] have made me feel really welcome." Another said "I love it, it's a friendly home."

Good

Our findings

People told us they received personalised care and support that met their individual needs. One relative told us that the home always made contact with them, when their loved one needed support during appointments. "They know to contact me, they don't rush on themselves, it's less stressful for [name of relative] that way." A healthcare professional told us "I was very impressed with how they responded when a person became agitated." This was also the view of the other healthcare professionals we spoke with.

Assessments of people's needs were completed by the registered manager before people moved to the home. This information was then used to develop an appropriate care plan in consultation with the person and their relatives, where appropriate. Care plans which included people's physical and mental health needs contained sufficient information to enable staff to provide appropriate care to people and were reviewed monthly, or sooner, if people's needs changed.

People's daily records of care showed care was usually provided in accordance with people's needs. The home had recently moved to a computerised care planning system which staff were still becoming familiar with. Care staff members were able to describe the care and support required by individual people. For example, one care staff member was able to describe the support a person required to reposition and meet their hygiene needs. This corresponded to information within the person's care plan. People's wishes and preferences were also recorded in their care plans, including their preferred daily routines, when they liked to get up and go to bed, and where they liked to take their meals. One person had not wanted to sleep in their bed. The registered manager told us they had arranged for the person to have a recliner chair in their bedroom and provided a pressure relieving cushion. This meant the person could sleep safely and comfortably in a chair, as was their preference. At lunchtime a person asked for ice-cream instead of the planned pudding. The cook organised this immediately.

Care records showed relatives and where possible people, were included in planning their care and were kept informed about anything which may affect them or their relative. The registered manager explored people's cultural and diversity needs during pre-admission assessments and included people's specific needs in their care plans. For example, a person was supported to continue to attend a nearby church for religious and social occasions. The registered manager was aware of how to contact various religious leaders if required and said they would seek information to ensure people's individual religious or cultural needs were met. Cameron House used pictures to help people make food choices. However, the registered manager said these were not in use at the time of the inspection as people able to make a choice, could express this verbally.

Handover meetings were held at the start of every shift and provided the opportunity for staff to be made aware of any relevant information about risks, concerns and changes to the needs of the people they were supporting. We saw that relevant individual information was provided to staff at the start of their shift. This included, if the person had eaten and drunk well and if they had received personal care. The registered manager and care staff were aware of symptoms that people could have, that would indicate some common health problems.

Although no-one was receiving end of life care at the time of this inspection, we viewed records for a person who had recently received end of life care at Cameron House. The registered manager spoke positively about their desire to provide people with high quality care at the end of their lives, to help ensure they experienced a comfortable, dignified and pain free death. People's end of life wishes were discussed with them and their families and recorded in their care plans. The registered manager had links with the local hospice and were aware of how to seek support if required. The records showed that care and support had been provided for the person and for their family members. The person's individual request not to stay in bed had been met and they had been supported to sit in a recliner chair for part of each day. Staff members had involved the community nurses. Changes to the person's needs had been monitored, with further medical advice sought when required.

Activities were organised by staff or provided by external professionals at the home. Staff told us that if they were busy then activities did not occur as planned. The registered manager had attempted to address this by employing an apprentice who would be primarily responsible for individual activities. The apprentice had decided not to continue in the home and the registered manager was seeking to recruit a new apprentice. Since the previous inspection the registered manager had developed the conservatory to provide a suitable second area where people could receive visitors away from the main lounge and where activities could be provided. They described plans to further improve this.

People's views about the service they received at Cameron House were sought by the registered manager. Each month the registered manager met individually with people or, where more appropriate, spoke informally with relatives and discussed their views about the service they were receiving. People and their families felt able to approach the registered manager at any time. Their comments included, "I am always kept up to date about what is going on" and "We can always talk to the manager when we want to." People told us they felt able to raise concerns or complaints with the management, although they all said they had not had cause to complain and no complaints had been recorded in the previous year. A complaints procedure was in place. A copy was given to people and their relatives when they moved to the home within the service user's guide. The registered manager identified that they spoke with people and relatives wherever possible meaning they could resolve any issues before the need for formal complaints were made.

Requires Improvement

Our findings

At this inspection we identified a breach of regulation 12 as medicines were not always managed safely. We also found that not all risks to people were managed safely and people had not always received the care they required. These concerns had not been identified by the provider's quality assurance systems.

The registered manager told us that they and senior staff undertook a range of audits and where these had identified action was required, this had occurred. The registered manager also undertook some unplanned 'spot' checks attending the home at weekends or evenings to monitor staff. Records viewed confirmed these occurred at various times of the night and had not identified any areas of concern. Although audits were taking place, these were not effective at identifying issues.

During the course of the inspection each time we informed the registered manager of our findings in an area that required improvement, they were responsive and acted to address our concerns. For example, when we returned on the second day of the inspection action had been taken by the registered manager to address any issues we had found. These are detailed in the various preceding sections of this report. The registered manager told us how procedures had changed following safeguarding concerns and incidents within the home. The actions taken were appropriate to reduce the likelihood of recurrence. This demonstrated that the registered manager was reactive when shortfalls were identified. However, they did not have effective systems of governance in place to ensure that they were able to proactively prevent shortfalls in the service from occurring, or to recognise when the service was not meeting the fundamental standards associated with the Regulations of the Health and Social Care Act 2008.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in February 2017 we found the provider was not following a duty of candour as is required. A duty of candour requires that where accidents or incidents occur people or their representatives are provided with a written explanation and apology. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection there was a procedure in place and it was being followed to ensure written information including an apology, was provided should an untoward incident occur.

All services registered with the Care Quality Commission (CQC) must notify the CQC about certain changes, events and incidents affecting their service for the people who use it. Notifications tell us about significant

events that happen in the service. We use this information to monitor the service and to check how events have been handled. The service had submitted notifications to CQC about all incidents and events required

People were happy living at Cameron House and visitors told us they felt it was well-led. One person told us, "I don't have any complaints. They look after me well here." A relative said "We wish Cameron House was closer to where we live, otherwise it's wonderful." Another family member said, "I would recommend the home, the staff and manager are very good." People and visitors felt able to approach and speak with the registered manager and were confident any issues would be sorted out. Many visitors, including external healthcare professionals, were able to name the registered manager, showing that the management team made sure they were available to people and visitors.

Staff told us they were happy, motivated and worked well as a team. For example, we saw all staff working together to put away a delivery received at the home. All staff said they would be happy for a member of their own family to be cared for at Cameron House. Staff comments included: "I'd not done care work before and everyone has been so helpful"; "We all work together"; and "It's a friendly place to work and the manager is good, they help out on the floor if needed".

Since the previous inspection the manager had completed the registration process and was now the registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements of the health and social care Act 2008 and associated regulations about how the service is run. The registered manager told us they were able to make day to day decisions about the home without always consulting the provider. For example, they arranged to purchase new mattresses during the inspection and told us they had access to funds to make local and online purchases as required.

The registered manager was clear about how they wished the service to progress to provide a high level of care for people living with dementia. They had researched how they could enhance the environment and were developing the signs and information for people to promote independence and positive lives. The refurbishment of the home was ongoing however, the registered manager described how choices of wall and floor covering had been made involving people and staff. This reflected best practise guidance for dementia suitable environments. The registered manager said their goal was to "refurbish the whole place" and confirmed that the provider was supporting them with this. A new deputy manager had just commenced work at the home. They told us that they were focusing on empowering care staff and supporting them to develop their skills so they could provide an improved service. The registered manager was in the process of completing their Diploma level 5 in health and social care and was up to date with other necessary training.

People and relatives described an open and transparent culture within the home, where they had ready access to the management at all times. Visitors were welcomed, the provider notified CQC of all significant events and the home's previous inspection rating was displayed prominently in the entrance hall. Positive links had been developed with the community. Staff and people had been involved in an event aimed to raise funds for activities and also to promote the home in the local community. This had involved a cake bake sale outside the home which had been well received by the local community. The registered manager was also developing links with the local church who were looking to provide volunteers to visit people and provide individual activities.

The provider had an extensive range of policies and procedures which had been adapted to the home and service provided. We saw these were available for staff in the office and were told policies were reviewed yearly or when changes were required. This ensured that staff had access to appropriate and up to date

information about how the service should be run.

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person has failed to ensure the safe and proper management of medicines and failed to ensure the correct management of pressure relieving equipment and that people received the care required to meet pressure area risks. Regulation 12 (2)(b)(g)

The enforcement action we took:

We have added a condition to the location registration requiring them to send us regular action plans.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider has failed to operate effective systems to assess, monitor and improve the service. Regulation 17 (1)(2)(a)(b)(f)

The enforcement action we took:

We have added a condition to the location registration requiring them to send us regular action plans.