Make-All Limited

Cameron House

Inspection report

78 Pellhurst Road
Ryde
Isle of Wight
PO33 3BS
Tel: 01983 564184

Date of inspection visit: 30 November and 3 December 2015
Date of publication: 11/02/2016

Ratings

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

Overall summary

This inspection took place on 30 November and 3 December 2015 and was unannounced. The home provides accommodation and personal care for up to 18 older people living with dementia. There were 15 people living at the home when we visited.

There was a registered manager at the home. 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.

People's safety was compromised. People were not always supported to move safely, and necessary moving and handling equipment was not available in all parts of the home. Action had not been taken to investigate and reduce the risk of incidents between people or where people had experienced frequent falls. General and individual risk assessments had been completed but were not always followed.

There were not always enough staff to meet people's needs at all times.

Summary of findings

Quality assurance systems were largely informal with formal audits not being completed. There was regular contact by the provider and registered manager with people, relatives and staff.

Medicines were managed in a satisfactory way however there was a lack of information as to how some 'as required' medicines should be administered.

Recruitment records showed pre-employment checks had been completed. Staff received appropriate training and were supported through the use of one to one supervision and appraisal.

Legislation designed to protect people's legal rights was not fully applied. Best interest meetings to make decisions on behalf of people who lacked the ability to make these decisions had not been held. Staff were offering people choices and respecting their decisions appropriately.

The Deprivation of Liberty Safeguards (DoLS) were applied correctly. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

Care plans provided comprehensive information about how people wished to be cared for and staff were aware of people's individual care needs. People had access to healthcare services and were referred to doctors when needed.

People and their relatives were positive about the service they received. They praised the staff and care provided. People were also positive about meals but did not receive the support they required at all meals. People did not have adequate mental and physical stimulation.

People and their relatives were able to complain or raise issues on an informal basis with the registered manager and were confident these would be resolved. Visitors were welcomed and there were good working relationships with external professionals. Staff worked well together which created a relaxed and happy atmosphere, which was reflected in people's care.

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

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?
The service was not always safe.

People were not always assisted to move safely and necessary equipment was not available in all parts of the home. Action had not been taken to investigate and reduce the risk of incidents between people.

There were not always enough staff to meet people's needs at all times.

General and individual risk assessments had been completed but were not always followed.

There was a lack of information about the use of some 'as required' medicines.

Plans were in place to deal with foreseeable emergencies.

Requires improvement

Is the service effective?
The service was not always effective.

Legislation designed to protect people's legal rights was not always applied for individual people. Best interest decision were not made prior to covert administration of medicines.

People were offered a choice of suitably nutritious meals but did not always receive appropriate support to eat and drink. The nutritional intake of people at risk of malnutrition was monitored effectively.

People could access healthcare services when needed and received the support with personal care they required.

Staff were suitably trained and supported.

Requires improvement

Is the service caring?
The service was caring.

People were cared for with kindness and treated with consideration. Staff understood people's needs and knew their preferences, likes and dislikes.

People (and their families where appropriate) were involved in assessing and planning the care and support they received.

People's privacy was protected and confidential information was kept securely.

Good

Is the service responsive?
The service was not always responsive.

Requires improvement

Summary of findings

All necessary action was not always taken after an accident or injury to reduce the risk of this reoccurring. Care plans provided individual information about how people wished to be cared for but lacked some information as to what action staff should take when people were upset or agitated.

People were not provided with adequate mental or physical stimulation.

People and relatives were able to complain or raise issues with the manager and were confident these would be resolved.

Is the service well-led?

Requires improvement 

The service was not always well-led.

Quality assurance systems were largely informal with a lack of structured audits. Policies and procedures had been reviewed and were available for staff.

There was an open and transparent culture within the home. The provider sought feedback from people and staff and acted when requests were made.

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.

This inspection took place on 30 November and 3 December 2015 and was unannounced. The inspection was conducted by one inspector.

Before the inspection we reviewed information we held about the home including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. Before the inspection, the registered manager 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 improvements they plan to make.

We spoke with three people and met other people living at the home and spoke with six family members. We also spoke with the registered manager, deputy manager, five care staff, housekeeping staff and the cook.

We looked at care plans and associated records for three people, additional records of care people had received, staff duty records, two recruitment files, accidents and incidents reports, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with three health and social care professionals to obtain their views.

We previously inspected this service in November 2013 where no concerns were identified.

Requires improvement

Is the service safe?

Our findings

People were not always safe. We observed staff physically lift a person from the floor following a fall. The method used was inappropriate and placed the person at high risk of injury. Staff should have used moving and handling equipment but they told us this was not available on the first floor of the home where the person was accommodated in. We identified that the person had fallen eight times in the previous week and staff told us they would have been lifted from the floor on each occasion. Staff were aware of the risks to themselves and the person but had not acted to ensure the person's safety or that moving and handling equipment was available.

Whilst viewing incident logs we identified there had been three occasions in the previous six months when service users had had altercations with each other. These had resulted in physical injury to one or both of the people concerned. There was no record of the action staff had taken to reduce the risk of future incidents between the people.

The failure to take action to protect people from abuse is a breach of regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they had completed safeguarding training which was confirmed by records of training viewed. They were able to tell us what action they should take if they suspected a person may have been abused.

In other areas of the home suitable moving and handling equipment including hoists and standaids were available. We saw these were used correctly by two staff with full explanations provided to people as the equipment was used. People, relatives and staff said that moving and handling equipment was always operated correctly by two members of staff. Individual moving and handling risk assessments had been completed.

There were not always enough staff to meet people's needs at all times. A relative told us they did not think there were enough staff. They explained they had purchased a baby monitor so staff could listen in case their relative required help. This was only in use when the person was in their bedroom, however the relative would have liked this also to be in use when their family member was in the communal lounge. The relative said this was because "staff were often not in the lounge for long periods of time". Another relative expressed similar concerns about staffing levels saying there were no staff available in the hallway or communal areas of the home. Other relatives said staff were very busy.

Staff told us that at times they felt there were not enough staff. Staff told us three staff were required to meet one person's personal care needs and that 11 other people required two staff to meet their needs. Three staff were rostered to work throughout the day with two staff at night. In the afternoon one of the care staff had to prepare, serve and clear away the evening meal including washing up by hand. Staff estimated this took a minimum of one and a half hours during which time they were not available to support people. Staff told us that if any of the 12 people who needed more than one person to support them with personal care required care during this time, then no staff would have been available to observe and support the remaining people or respond to call bells.

One person's care file had a care plan for when they were agitated. This directed staff to "give lots of reassurance" and elsewhere in the care file it stated the person should receive "1-1 support when agitated". We saw the person was agitated during both days of the inspection. Staff tried to spend time with them but were frequently diverted to other people and other duties. They were unable to provide the level of individual attention the person required or was detailed in the care file.

This also meant staff could not always provide person centred care. For example, at lunch time we saw people sat waiting up to half an hour for meals. People were already wearing clothing protectors and were watching other people in the room being provided with their meals. When people required a high level of support with their meals staff were interrupted frequently and had to leave the person. This meant their food became cold whilst waiting for staff to return or another care staff member to assist them. At lunch time we saw there were no staff in the lounge where several people were eating. We saw a person walk into the lounge from the dining area with a spoon and take a spoonful of food from another person's plate. We told staff who removed the plate of food from the person but did not replace it or remove the spoon of food from the

Requires improvement

Is the service safe?

other person who continued to walk around with this before eating it. People who required support or prompting did not receive the individual support they required with their meals.

Staffing levels were determined by the registered manager but no formal method was used to determine how many staff were required to meet people's needs. Staff told us they felt they had to volunteer to cover extra shifts "or there would not be anyone to do it". Some staff told us they had been working up to sixty hours each week. To commence the week of our inspection the provider had arranged for two staff from a nearby home (they also owned) to undertake some shifts at Cameron House. These staff told us they had not previously worked at Cameron House and were included as one of the three staff on shift. These staff were dependant on the existing staff to tell them what to do and had not received an induction to the home or people's needs.

The failure to ensure sufficient staff are deployed is a breach of regulation 18 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were not always managed safely. People were prescribed medicines to be given 'as required' for pain management, agitation and constipation. Medicines Administration Records (MARs), and daily records of care, did not demonstrate why 'as required' medicines had been administered. MARs did not always show how many of a variable dose medicine had been given or how the decision as to how much to give had been determined. There was also no information as to how frequently some 'as required' medicines could be given without adverse effects on the person. More detailed information and care plans would have ensured consistent decision making by care staff as to when 'as required' medicines should be given.

The failure to ensure that there is clear information as to how 'as required' prescribed medicines are to be administered and records detailing why these have been given are maintained is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Some medicines must be stored in a special way and additional records held about their use, these are called controlled medicines. We found that whilst the home was correctly storing and recording the majority of controlled medicines this had not been done for one controlled medicine. As soon as this was identified staff arranged for the correct procedures to be instigated.

There were systems in place to support staff manage other aspects of medicines safely. Care files contained risk assessments showing that people were unable to manage their own medicines and the reason why. A formal pain assessment tool was available to help staff determine when 'as required' medicine for pain should be administered. Prescribed topical creams were seen to have a date when opened and a date when its use should be discontinued. This would help ensure topical creams were safe for use. When medicines required cold storage, a refrigerator was available and all medicines were stored securely. Appropriate arrangements were in place for the safe disposal of unused prescribed medicines. Only staff who had completed medicines administration training were permitted to administer medicines and observations of the administration of medicines showed staff completed this in a safe way.

Recruitment procedures were in place to help ensure that staff were suitable for their role. The recruitment files for two recently recruited staff showed that the necessary pre-employment checks including references from previous employers and criminal history checks had been completed.

People told us they felt safe. One person said "Yes I feel safe here" A family member said, "when I can't visit I don't worry, I know they will be safe and [name registered manager] will call me if there are any problems". Another relative said "I have never seen or heard anything that would make me worry" A third relative commented that the staff were very busy but responded in a very calm manner to people. We observed people appeared relaxed when staff approached.

Care plans included risk assessments which were relevant and individual to the person and included specified actions required to reduce identified risks. However, these did not cover all risks to people. For example, staff were using syringes to give three people their drinks. No risk assessments had been completed showing why this was required and how the high risks from this should be mitigated. Action described in risk assessments was not always followed by staff. We saw the person was shouting and banging their arm on their table placing themselves at

Requires improvement

Is the service safe?

risk of injury. In other instances action detailed in risk assessments was followed. We saw a person at high risk of skin breakdown due to pressure was sitting on a pressure relieving cushion and had equipment to reduce the risk of pressure damage available on their bed. We observed equipment, such as pressure relieving devices and bed rails, in use in accordance with people's risk assessments.

Not all risks posed by the environment had been assessed or action taken to reduce them. For example, there were no hand rails in the hallways. People were seen walking in these areas holding onto furniture and door frames. Accident records recorded that people were found on the floor in the hallways having fallen. In some instances people sustained injuries following these falls. Action had not been taken to assess and reduce the risk of falls in this area.

There were plans in place to deal with foreseeable emergencies. Staff had undertaken first aid and fire awareness training. They were aware of the action they should take in emergency situations. Personal evacuation plans were available for all people. Records viewed showed essential checks on the environment such as fire detection, gas, electricity and equipment such as hoists were regularly serviced and safe for use.

Requires improvement

Is the service effective?

Our findings

People's legal rights were not ensured as information about these was not available. People's ability to make decisions had been assessed and recorded, in a way that showed the basic principles of the Mental Capacity Act, 2005 (MCA) had been complied with. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Where assessments showed people lacked capacity to make decisions to consent to their personal care or medicines best interest decisions had not been completed. For example, one person's medicine was being given covertly, hidden in their food. The only documentation available was an undated, unsigned piece of paper which staff stated the consultant psychiatrist had written telling them to give the medicine covertly. Senior staff confirmed a specific mental capacity assessment showing the person was unable to make the decision to refuse medicines had not been completed. No best interest decision had been completed and the person's legal right to refuse medicines was not being upheld.

Care plans contained information where relatives or others had legal powers to make decisions on behalf of people such as in respect of their health or finances but the registered manager had not sought clarification of this such as obtaining copies of the legal documents giving the relatives the legal rights. This meant they could not be sure who could legally make decisions on behalf of people.

The failure to ensure the Mental Capacity Act 2005 is followed and people's legal rights protected is a breach of regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

A Deprivation of Liberty Safeguards (DoLS) application had correctly been made in respect of people whose assessment showed they lacked capacity to make certain decisions which would help protect their legal rights. DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. Two people had DoLS approved by the local authority. We saw the specific requirements which were in place were being complied with.

Within care plans there was individual information about people's ability to make or not make some decisions. For example, in one care file it stated "[the person] does have capacity to make choices about food and drink and alternatives to be offered if [the person] does not like what has been offered'. Further information also stated that the person could not say when they required personal care and was unable to express choices about activities.

Three people had been prescribed a thickening agent to be added to their drinks. This did not include information as to how much should be added to fluids or what the desired thickness should be for the individual person. At various times during the inspection we saw the same person receiving fluids of various thicknesses. Fluids which are too thick or too thin can increase the risks to the person.

People did not receive consistent support to ensure they ate well. One person said, "The food's good, there is plenty of it." A relative told us they had joined their family member in a meal and the food had been very good. At lunch time on both days of the inspection we saw the meal time was chaotic and did not provide a pleasant and sociable experience for people. The dining room had small tables suitable for about four people; however most people chose not to sit in the dining room. Where people did sit in the dining room a member of care staff gave them their meal and cutlery but did not remain in the room to support or encourage the person. Once the person finished their meal they got up and were subsequently given their desert in the lounge approximately half an hour later.

People were offered varied and nutritious meals which were freshly prepared at the home. Alternatives were offered if people did not like the menu options of the day. For example, we saw one person who regularly refused their evening meal was provided with porridge in the evening which they did eat. Drinks were available throughout the day and staff prompted people to drink often. Special diets were available for people who required them. Nutritional risk assessments had been completed for each person and staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. They monitored the weight of people each month or more frequently if required due to concerns about low weight or weight loss.

People received the personal care they required. One person told us they were supported when necessary with personal care and had a bath each week. Relatives we

Requires improvement

Is the service effective?

spoke with told us they felt personal care needs were met. One said "they always look cared for, hair brushed and clean clothes". We saw people were supported to have their personal care needs met in a sensitive way and looked well cared for. A separate record was held showing people were offered a weekly bath. During the inspection the daily recording form was amended to provide a place where staff could record personal care provision. A visiting health professional told us they felt people's healthcare needs were met. Two other health professionals were also positive about the care people received. Care records contained information about people's previous known healthcare needs and treatment. They also showed people were referred to GPs when changes in their health were identified.

Staff were provided with training relevant to their roles. New staff received induction training which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. A senior staff member told us that all staff, including those with care qualifications, were to undertake the care certificate. This was confirmed by staff and records of training viewed. Records also showed staff were up to date with essential training and this was refreshed regularly. Training was provided by a combination of computer learning with knowledge check, distance learning courses and hands on practical training provided by an external training company. Most staff had obtained recognised care qualifications relevant to their role or were working towards these.

Staff were supported appropriately in their role and received regular supervision. Supervisions provided an opportunity for senior staff to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. The process used was formal and directed senior staff to cover these topic areas. Senior staff and records of supervisions showed these included an element of observation, during which staff practices were observed and discussed. Staff also had a yearly appraisal with the registered manager. This was a formal process which provided opportunities for staff to discuss their performance, development and training needs. One staff member told us "The deputy manager is always available and works with us when needed." Another member of staff said, "the deputy manager is always supportive and we can contact them at any time if they are not here".

Good

Is the service caring?

Our findings

The person and relatives we spoke with praised the staff and said they treated people in a caring way. One person told us "The staff are nice." A relative told us their family member had said "it's good to be home" when they had returned from a short stay in hospital. Another relative described staff as "kind and caring" and said, "they always seem cheerful but really don't have the time they need". These views were echoed by the health care professionals we spoke with.

Staff treated people with consideration and respect. We observed people offered choices such as where to sit in the lounge or if they wanted to move to the dining room for lunch. We heard the cook thank a person who took their cup back to kitchen. Staff had taken the time to decorate a person's room with banners and balloons on their birthday. Relatives commented that staff had all wished their family member a happy birthday. When staff assisted people to move using equipment, such as a hoist or stand-aid, we observed they communicated with the person throughout. They told them what was happening, how long it would take and reassured them they were safe.

People were involved as far as possible in planning their own care. When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they needed. A family member told us "They asked me about (my relative's) life and what they enjoy etc. I haven't seen the care plan but know I could ask to see it." People's preferences, likes and dislikes were known. Care files contained individual information about personal preferences such as those around food and drinks. Support was provided in accordance with people's wishes. For example, staff were clear that people were never made to get up unless they were awake and ready to rise.

Staff ensured people's privacy was protected by speaking quietly and ensuring doors were closed when providing personal care. One room could accommodate two people. We saw screens were available and the room was arranged to provide two separate areas. A person stated that staff ensured their privacy at all times and they had not witnessed any concerns with privacy or respect from staff interactions with other people. Relatives also confirmed that privacy and dignity were ensured at all times. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view them.

Requires improvement

Is the service responsive?

Our findings

There was a failure to take all necessary action after an accident or injury to reduce the risk of this reoccurring. For example, accident records showed that in November 2015 one person was falling repeatedly from their chair. On one day they were listed as having had 'numerous falls from chair'. The person continued to fall for the next three weeks. We were told an attempt had been made to secure suitable furniture from an NHS care provider but this had been unsuccessful. Accident reports did not always show what action had been taken in response to injury. For example, where some people had fallen and there was a record they had banged their head it was noted that emergency and non-emergency services were contacted and additional observations of the person were completed. However, for the majority of accidents where it was recorded that the person had banged their head there was no action recorded. There was no record on accident forms to show that they had been reviewed by the registered manager and what action they had taken to investigate the cause of the accident. For one person we saw action had been taken following several falls including increased observation for 24 hours, a crash mat had been put in place and the gp had referred the person to the Occupational Therapist.

People did not always receive consistent care. Care files contained information as to how people should be supported when they were agitated and unsettled. However, they did not contain clear information as to when medicines for agitation should be administered or what other action staff should take prior to administering medicines to try to prevent the need for medicines. Records were not maintained showing what people were doing before incidents and how people responded to interventions by staff.

The failure to ensure that care is provided in a safe way and to do all that is reasonably practical to mitigate against risks to people is a breach of regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

People were not receiving the mental and physical stimulation they required on a regular basis placing them at risk of a decrease in their mental health. During the two days of the inspection we saw minimal activities occurring. Staff were seen spending short periods of time talking with people and one person was provided with a book to look at. In the mornings radio music was playing and later in the afternoon the television was turned on. We viewed the records of activities. These listed things like visit from family as the only activity some people received, for others it was listed they had watched a film or listened to music. An external activities provider attended the home once a week. We were told they did individual activities with people and were at the home for about an hour and a half. On alternative weeks a musical entertainer visited and we were told they played for an hour in the lounge. People who were cared for in bed would not have been able to attend this activity. Staff told us they usually did not have time for activities. People were therefore not receiving the mental and physical stimulation they required.

We recommend the provider increases the variety and amount of activities provided to ensure people receive the mental and physical stimulation they require.

One person told us that they were "happy with the care" they received at Cameron House. Relatives were positive about the service provided as were health and social care professionals who visited the home. One relative said they felt their family member received "good care". Another told us how staff had supported their relative when they had required emergency hospital treatment after a fall at night. They said "the [registered manager] went into the home at 1.30 am so a member of staff could go with [my relative] to hospital. Another relative told us how staff always accompanied their relative on emergency hospital appointments.

Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and health or care professionals. Relatives confirmed the registered manager and senior staff had visited their family member prior to admission and sought relevant information. Care plans provided detailed information about how people wished and needed to receive care and support. They each contained information of the individual care people required throughout the day and night covering needs such as washing, dressing, bathing, continence and nutrition. Reviews of care were conducted monthly by the registered manager or senior care staff member.

We saw staff followed the care plans. Records of daily care confirmed people had received care in a personalised way in accordance with their care plans, individual needs and

Requires improvement

Is the service responsive?

wishes. Care staff were able to describe the care individual people required and were aware of the information in care files which they had access to at all times. We observed the handover between the morning and afternoon care staff. Staff referred to people in positive terms, advice was given on tasks completed and any untoward incidents or 'as required' medicines which had been given. Staff talked about individual people in the detail that was required and appropriately without the handover being either excessive or too brief.

People were given opportunities to express their views about the service. Whilst not all people were able to express opinions about the service, the registered manager undertook monthly meetings individually with those who could. These followed a formal process and were recorded. The records showed topics such as meals, activities, daily living and care were discussed. People were happy with the service they received and had not suggested any changes. The registered manager had developed a questionnaire survey which had been sent to families to seek further feedback about the service and how it could be improved.

Relatives said they felt they were kept up to date about the home and any changes which were planned. They stated they felt able to approach the registered manager if they had any questions or suggestions about the service and that these would be listened to. For example, one relative said they had raised concerns about the meal clothing protectors which were old and worn through use and washing. We were told that soon after new meal clothing protectors had been supplied.

During the monthly meetings people were asked if they had any concerns or other comments. Relatives knew how to complain or make comments about the service and the complaints procedure was provided to relatives in a service user guide when people were first admitted to the home. Records showed there had been no complaints from staff since the previous inspection in 2013. There had been one complaint from a relative in November 2015 which concerned the poor state of the carpet in the lounge. We were told the provider was arranging for a new carpet to be provided.

Requires improvement

Is the service well-led?

Our findings

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We identified incidents which had not been reported to CQC although the registered provider had taken appropriate action to report some of these to the relevant authorities.

The failure to notify CQC of notifiable incidents was a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Relatives of people who had previously lived in other residential services all told us they were much happier with the care their family member received at Cameron House. One relative said "I thank God daily for Cameron House". Relatives said they were able to visit at any time and that staff welcomed them. They said staff and the registered manager were very good at keeping them informed about any incidents or accidents involving their family member. They added that this gave them confidence that if they were not contacted then everything was ok.

There was an open and transparent culture within the home. Visitors were welcomed, there were good working relationships with external professionals. One relative described the registered manager as "good" and "approachable". Similar comments were made by other relatives who felt able to raise issues and were confident these would be sorted out. All relatives were aware of who the registered manager was and said they felt able to approach them if they had any questions or worries about their family member.

Staff told us that the registered manager had not been spending much time at Cameron House but had been focusing more on the provider's new home which had opened nearby. The registered manager did not attend the home on the first day of the inspection although we were told they were at the other home approximately five minutes from Cameron House. The registered manager was present for about an hour and a half at the start of the second day of the inspection before leaving to go to the other home. The deputy manager told us they were in the process of applying to the commission to jointly register as the registered manager for Cameron House.

Staff told us they enjoyed working at the home and were well-motivated. Comments included: "I love working here". Another staff member told us I started working as an apprentice seven years ago and have been supported to become a senior care staff member. People, relatives and staff all used the term "family" when talking about the atmosphere and culture of the home. We observed staff worked well together which created a relaxed atmosphere and was reflected in people's care. We saw positive, open interactions between staff, people and relatives who appeared comfortable discussing a wide range of issues in an open and informal way.

Systems were in place to monitor the quality of the service people received although these were mainly informal. The registered manager completed monthly checks which covered a range of areas including the environment, staffing records and checking that care plan reviews had been completed. The deputy manager undertook weekly checks of the environment. Senior staff were auditing medicines to ensure these had been administered as prescribed and recorded as administered, however other formal audits had not been completed. Following discussion the deputy manager stated they would look at various formal audits such as for infection control, documentation, medication, incident monitoring and the environment.

The provider was a limited company with a nominated person responsible for the home. Each month the nominated individual visited the home and completed a review of the service talking to people, relatives and staff as well as viewing some records relating to the management of the service. However, they had not identified the concerns we found such as the absence of moving and handling equipment in part of the home and failure to analyse accidents and incidents. The registered manager and deputy manager undertook unannounced night spot checks. These were recorded and showed they had occurred between 12 midnight and 6am in June, August and October 2015. The records showed they had checked care and night check records and ensured staff were completing all allocated tasks correctly.

There were a range of policies and procedures which had been individualised to the home and service provided. These were reviewed internally by the registered manager and amended when required. This ensured that staff had access to appropriate and up to date information about how the service should be run. A folder containing policies

Requires improvement

Is the service well-led?

and procedures was available to all staff at all times in the locked cupboard where care files and related documentation was kept. Records relating to the running of the home were well organised and up to date.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person has failed to ensure that there is clear information as to how 'as required' prescribed medicines are to be administered and records detailing why these have been given are maintained. The registered person has also failed to ensure that care is provided in a safe way and to do all that is reasonably practical to mitigate against risks to people Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person has failed to ensure people were safe and protected from abuse. Regulation 13 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered provider has failed to ensure sufficient staff are deployed at all times to meet people's needs. Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered provider has failed to notify CQC of notifiable incidents. Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.
	The registered provider has failed to ensure Mental Capacity Act 2005 is followed and people's legal rights are protected. Regulation 11 (3)