Make-All Limited

Cameron House

Inspection report

Cameron House
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09 February 2017

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 6 and 9 February 2017 and was unannounced. Cameron House provides accommodation and personal care for up to 18 older people, including people with dementia and physical disabilities, who do not require nursing care. There were 16 people living at the home when we visited.

There was a registered manager for the home; however, whilst they retained oversight and responsibility for the service they were not in day to day charge of 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. A new manager had been appointed and was in the process of registering with CQC to become the registered manager.

At the last inspection, in December 2015, we identified breaches of regulation and told the provider to take action to ensure people were safe and their legal rights protected. The provider was also told to ensure there were sufficient staff available at all times and medicines were managed safely. The provider had also not ensured CQC were notified of all incidents in the home. We issued requirement notices. At this inspection we found action had been taken in respect of these areas, but improvement was needed in other areas.

At this inspection we found the provider had failed to ensure the rating from the previous inspection was displayed at the home and had also failed to ensure that information was provided in writing to relevant people after significant accidents and incidents occurred.

The manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions such as the use of specialist equipment to reduce the risks of falls or breakdown in skin integrity, which had been made on their behalf, had not been formally assessed or recorded.

People, visitors and external health and social care professionals were positive about the service people received. People were positive about meals provided and, where necessary, received support to eat and drink. People were supported and encouraged to be as independent as possible and their dignity was promoted.

Care plans provided information about how people wished to be cared for and staff were aware of people's individual care needs and preferences. Reviews of care were conducted regularly. People had access to healthcare services and were referred to doctors and specialists when needed. Medicines were managed safely and people received these as prescribed.

People felt safe and staff knew how to identify, prevent and report abuse. Staff offered people choices and respected their decisions. The home provided a suitable environment for people who were offered activities suited to their individual needs and interests.

There were enough staff to meet people's needs. The recruitment process helped ensure staff were suitable for their role. Staff received appropriate training and were supported in their work. Staff worked well together, which created a relaxed and happy atmosphere that was reflected in people's care.

People and relatives were able to complain or raise issues on a formal and informal basis with the manager and were confident these would be resolved. Visitors were welcomed and there were good working relationships with external professionals.

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

The manager was aware of areas for development of the service. Quality assurance systems were in place using formal audits and through regular contact by the provider and manager with people, relatives and staff.

We found one breach 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse and staff knew how to identify, prevent and report abuse.

Medicines and risks to people were managed effectively. Staff understood how to keep people safe in an emergency.

Recruitment practices ensured that all pre-employment checks were completed before new staff commenced working in the home and there were enough staff to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

The manager was aware of legislation designed to protect people's rights and freedoms; however, assessments of people's ability to make some decisions which had been made on their behalf had not been formally assessed or recorded.

People received the personal care they required and were supported to access other healthcare services when needed.

People received a varied diet and were supported appropriately to eat. Staff knew how to meet people's needs; they were suitably trained and supported in their work.

Improvements to the home's environment had been made.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion. Staff knew people well, interacted positively and supported them to build friendships.

People and their relatives were positive about the way staff treated them. People were treated with respect. Dignity and independence were promoted and people were involved with

planning how their care needs would be met.

Is the service responsive?

Good

The service was responsive.

People received personalised care and support. Staff demonstrated a good awareness of people's individual needs and responded effectively when their needs changed. When untoward incidents or accidents occurred, procedures were in place to ensure people received all the care they required.

People were offered individual and some group activities suited to their individual needs and interests.

The provider sought and acted on feedback from people. There was a suitable complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider had failed to ensure that the ratings from the previous inspection were displayed in the home and had also failed to ensure that information was provided in writing after significant accidents and incidents occurred.

People and their relatives felt the home was well organised. Staff understood their roles, were motivated, worked well as a team and felt valued by the manager.

A suitable quality assurance process was in place, including formal audits and informal monitoring of the service.

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 6 and 9 February 2017 and was unannounced. The inspection was undertaken 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. The 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 five people living at the home and six visitors. We spoke with the manager, five care staff and ancillary staff including the cook and housekeeping staff. We also spoke with seven visiting health and social care professionals. We looked at care plans and associated records for six people, staff duty records, staffing records, records of accidents and incidents, policies and procedures and quality assurance records. We observed care, support and activities 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.

Good

Is the service safe?

Our findings

Following the previous inspection in December 2015 we found improvements were needed to ensure people were safe. We made a requirement telling the provider they must make improvements. At this inspection we found improvements had been made and systems were in place to help ensure people were safe.

People told us they felt safe. One person said, "Yes, I do feel very safe here". Another person said "Absolutely, I feel safe here and with the staff", whilst a third person also said "I feel very safe". A visitor told us "Yes I'm sure [my relative] is safe here". Another visitor told us that when they were unable to visit they did not worry because they were confident their relative was safe and they would be contacted if there were any concerns. Without exception all the people and visitors we spoke with were sure they or their relative was safe at Cameron House.

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 manager would act on their concerns. One staff member told us, "I would speak to [name of manager]" Another staff member said, "If I had concerns I would contact the manager who would make sure everything is done correctly". All staff were confident the 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 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.

Following the previous inspection in December 2015 we found improvements were needed to ensure people received 'as required' (PRN) medicines safely. We made a requirement telling the provider they must make improvements. At this inspection we found improvements had been made and systems were in place to help ensure people received all medicines when they needed them.

People were supported to receive their medicines safely. One visitor told us, "[Name of relative] is on medicines and I do know that they watch her take them", whilst a person said, "The staff bring them". Some people were prescribed 'as required' (PRN) medicines for pain or anxiety but would not be able to say that they required these. There was individual guidance in their care plans and with Medicine Administration Records (MAR) so staff could identify when each person may require PRN medicines. This included guidance for staff as to other support the person may require and for pain medicine a formal pain assessment tool was available to guide staff.

All medicines were stored securely and appropriate arrangements were in place for obtaining, recording, administering and disposing of prescribed medicines. Some medicines must be stored in a special way and additional records held about their use; these are called controlled medicines. We found the controlled medicines storage box was not secured to a wall within the locked outer cupboard it was located in. The manager immediately arranged for this to be correctly secured and we saw this was completed the same day. The MAR charts documented that people had received their medicines as prescribed. Training records

showed staff were suitably trained and had been assessed as competent to administer medicines. On the first day of the inspection six care staff were completing initial or refresher medicines training with an external training provider. Following the training the training provider stated all the staff had passed the written assessment and had demonstrated a good understanding of medicines management. Staff supporting people to take their medicine did so in a gentle and unhurried way. They explained the medicines they were giving in a way the person could understand and sought their consent before giving it to them.

Safe systems were in place for people who had been prescribed topical creams and the majority of those checked contained labels with opening and expiry dates. This meant staff were aware of when the topical cream would no longer be safe to use. The home were storing some medicines that required cold storage. A refrigerator was available and records showed medicine refrigerator temperatures were monitored. This meant that any fault with the refrigerator would be noticed in a timely manner and the safe storage of any items stored could be assured.

Following the previous inspection in December 2015 we found improvements were needed to ensure sufficient staff were available at all times. We made a requirement telling the provider they must make improvements. At this inspection we found improvements had been made and sufficient staff were available.

There were sufficient staff to meet people's care needs. One person told us, "I have used my call bell and they are usually quick in responding". A visitor said, "I think there are enough staff, they are busy but the door is usually answered quickly". Another visitor told us, "As a family we telephone quite often, sometimes several times a day and the manager or staff always talk to us for as long as we need; they don't seem to be rushing 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 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 manager said they did not use a specific assessment tool to identify the number of care staff required to ensure people's needs could be met. However, they were aware of the busy times and had recently increased the number of care staff during the evening. A named member of care staff not on duty was 'on call' each day. The 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, "I do know all of the staff by name; it's usually the same ones I see".

Risks and harm to people were minimised through individual risk assessments that identified potential risks and provided information for staff to help them avoid or reduce the risks of harm. Staff showed that they understood people's risks and we saw that people's health and wellbeing risks were assessed, monitored and reviewed regularly. 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 pressure relief mattresses to reduce the risk of damage to their skin. Pressure relief mattresses were used appropriately, and people were assisted to

change position to reduce the risk of pressure injury. 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.

Where there were specific individual risks, action was taken to support the person. For example, where people had fallen, their risk assessments were reviewed and staff considered additional measures they could take to protect the person. This included special equipment to monitor people's movements and referring them to health professionals. People were also supported to continue some activities which carried a risk where this was their choice and would enhance their lives. For example, one person liked to be helpful and assist care staff with routine cleaning tasks such as dusting and polishing. The manager described how staff would supervise the person and would apply the spray polish to the cloth for the person.

Environmental risks were assessed and managed appropriately. Records showed essential checks had been completed on the environment such as fire detection equipment. Emergency procedures were in place. Staff knew what action to take if the fire alarm sounded, completed regular fire drills and had been trained in fire safety and the use of evacuation equipment. Staff told us they received fire training which was confirmed by records. One staff member told us, "I have had fire training several times now". People had individualised evacuation plans which identified the support and equipment they needed to leave the building in an emergency situation. Records showed fire detection and fighting equipment was regularly checked. The manager was in the process of organising an emergency grab bag containing equipment such as a mobile phone, torch and equipment to keep people warm if they needed to evacuate the home. 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.

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.

Requires Improvement

Is the service effective?

Our findings

Following the previous inspection in December 2015 we found improvements were needed to ensure people's legal rights to make decisions were assured and the Mental Capacity Act 2005 (MCA) was fully implemented. We made a requirement telling the provider they must make improvements. At this inspection we found improvements had been made; however, some further work was required to ensure this was embedded in practice and used on all occasions when required.

The MCA provides a legal framework to making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Where people had been assessed as lacking capacity to make specific decisions, some best interest decisions about their care had been made and documented, following consultation with family members and other professionals, where relevant. For example, an assessment of a person's ability to understand and consent to medicines had been followed by a best interest decision for the person to receive their essential medicines covertly [hidden within small amounts of food or drinks]. This was clearly documented with guidelines to make sure this was achieved safely, was in the person's best interest and had followed consultation with family members and the GP. However, for some other decisions, such as the use of specialist equipment to reduce the risks of falls or breakdown in skin integrity, assessments of the person's ability to make the decision and subsequent decision being made on their behalf had not been formally recorded. The manager agreed this was an area they needed to develop to demonstrate full compliance with the MCA.

People told us they received the personal care they required in a way that met their preferences. One person told us, "They [care staff] do tell me what they are going to do. They don't make me do anything that I don't want to do". Staff respected people's rights to make choices. For example, one person was cared for in bed as they had found it uncomfortable sitting in a recliner chair and had therefore not wanted to get out of bed. Care plans included information about people's ability to make decisions and support they may need to do this. For example, one care plan reminded staff that a person could make choices but needed to be given clear and simple explanations. Care files also included guidance for staff as to the actions they should take if people refused care or medicines. This guided staff to explain to the person why the medicine was required, to record any refusals and if this continued to inform the person's GP.

Staff had received training in the MCA and told us how they offered choices and sought consent before providing care and were clear about the need to seek verbal consent before providing care or support. We heard care and other staff seeking verbal consent from people throughout our inspection. We also heard care staff inform the manager that a person had not wanted their bath earlier so they were returning to support them later in the morning. One care staff member said, "We ask them. If they said no, we don't do it but try later. We would document and review or try a different staff member." Care plans included information as to how individual people should be supported to make choices and decisions people could

make for themselves. For example, one stated a person should be shown choices of clothing from which they would then be able to make a choice.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). 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 was being met. The manager was in the process of applying for a DoLS for a person who had been admitted a short time before the inspection. They told us the delay was to enable them to discuss this with the person's family. Otherwise, we found the provider was following the necessary requirements and DoLS applications had been made with the local authority where necessary. There was a system in place to ensure that these were reapplied for when necessary and that any individual conditions relating to the DoLS were known and met.

People received the personal care they required. A visitor told us they were happy with the way their relative's personal care needs were met. They said "They always look cared for, clean and hair bushed etc". The relative also confirmed that health professionals were contacted when required. Staff recorded the personal care they provided to people including if people had declined offered care such as a bath. These records showed people were supported to meet their personal and other care needs. The manager stated they reviewed records of care to monitor that people were receiving the care they required.

People's general health was monitored and they were referred to doctors and other healthcare professionals when required. One relative told us "They [care staff] did arrange for the doctor to see her recently as she had an infection". Another visitor said "The staff would arrange for a doctor and, if they needed to do that, they would let me know straight away". A person told us "They [care staff] would arrange the doctor for me". A health professional told us they were consulted appropriately and felt Cameron House met people's mental and physical health needs well. Care staff described how they supported people which reflected the information in people's care plans and risk assessments. People were seen regularly by doctors, opticians and chiropodists as required.

Cameron House had equipment suited to the needs of people living there although it did not have adequate numbers of slide sheets. These are used when assisting people to reposition safely in bed. Care staff told us that there were three people who required these although the home only had two, so these were being shared between people. This creates a risk to people from sharing equipment and may mean equipment was not readily available to staff when they required it. The manager stated they had been unaware of this and ordered additional slide sheets as soon as this was brought to their attention. These were received prior to the second day of the inspection. We spoke with two visiting healthcare professionals who were complimentary about the home. They said they were consulted appropriately and in a timely way and felt people's healthcare needs were met. A social care professional told us the manager was aware of the level of care the home could provide and did not accept new people whose needs they were unlikely to be able to meet.

People's nutrition and hydration needs were met by staff who had time to support them to eat, when necessary. One person told us "The food here is good. I enjoy it". A visitor said, "The food always looks nice. They get plenty of refreshments". Another visitor also told us how their relative was eating "much better here" and added that their relative had gained some weight since moving to the home. The provider had taken note of best practice guidance for people living with dementia as we saw that drinks were served in coloured mugs and food on coloured plates which would help people notice these and so prompt them to eat and drink more.

The manager told us they were in the process of building up a photograph collection of the various meals to help people make choices about what they would like. Staff told us they could provide people with food at any time this was requested or required. Records showed people were provided with food when they wanted it; for example, we saw two very active people being given additional snacks mid-morning and during the afternoon. Staff were aware of people's dietary needs and preferences. Staff told us they had all the information they needed and were aware of people's individual needs. People's needs and preferences were also recorded in their care plans. The manager told us one person liked a specific brand of breakfast cereal. We saw that this was available in the food store and the person's records showed they received this. People received varied meals including a choice of fresh food and drinks.

People received the appropriate amount of support and encouragement to eat and drink. Some people were being fully supported to eat and this was done in a kind, unhurried way. The staff members providing the support were talking with the people, encouraging them and asking them if they were ready for more. Staff were attentive to people and noted when people required support. We heard staff members asking people if they would like any assistance with their meals and one to one support was provided where required. We saw staff sat with one person and encouraged them to eat. When the person did not eat the staff member assisted the person and then further encouraged the person to eat independently. When necessary, staff recorded the amount of drinks people had received. However, staff were not adding these up daily which would mean that it may not be identified promptly that people were not receiving enough to drink. The manager said they would ensure night staff completed this in future.

People were cared for by staff who had received appropriate training. Training was provided by some in house computer training and via external trainers. A care staff member told us, "We get lots of training". Staff confirmed they were provided with a range of relevant training. They told us that all staff, including those not working directly in care, undertook training to help them understand the needs of people living at the home such as dementia awareness. They told us this helped them understand the needs of people. New care staff completed an induction which covered a range of training including the Care Certificate. This is awarded to care staff who complete a learning programme designed to enable them to provide safe and compassionate care for people. Most care staff had obtained or were undertaking a care qualification. The manager monitored staff training and had systems in place to identify when staff were due for refresher training which was then booked.

Staff were supported in their work through the use of one to one supervision and received an annual appraisal. Supervision and appraisal are processes which offer support, assurances and learning to help staff development. Supervisions included specific observations completed by the manager, such as use of moving and handling equipment or administration of medicines, and an opportunity to discuss any issues privately with the staff member. Staff told us supervisions were carried out regularly and enabled them to discuss any training needs or concerns they had. One staff member told us, "I feel supported. I always feel I can go to the manager and tell them if I have any problems."

Since the previous inspection, in December 2015, parts of the home had been redecorated and hand rails provided in downstairs hallways. The manager was aware of best practice guidance on environments which were both safe and provided opportunities for people to explore and encouraged memories. They told us they had further plans to develop the environment to more fully support people living with dementia such as developing a sensory/activities room in the conservatory. Cameron House was easy to navigate around and the manager was introducing new signs to help people further when moving around the home. The home was suitable to meet the physical care needs of people with corridors, doorways and bedrooms large enough for the use of any specialist equipment required. A stair lift was available to the first floor bedrooms and the manager said they were always mindful of which room was available when considering if a new

person should move to Cameron House. Individual bedrooms had been personalised to meet the preferences of the person living there. People were able to bring in items of their own, including furniture, to make their rooms feel homely and familiar. People were able to access fresh air in the home's rear garden if they wanted to do so. The manager told us they also had plans to provide a sensory garden suitable for the people living at Cameron House.

Good

Is the service caring?

Our findings

People were consistently positive about the way staff treated them saying that all the staff were kind, caring and affectionate. One person said, "The staff here are nice, they are nice to me". When asked if they thought the staff were caring another person said, "They are". Relatives also felt staff were caring. One said "All the staff do seem very caring, not only of [name relative] but also for us". Another visitor said "The staff are friendly and I'm always made to feel very welcome".

We observed staff over the course of our inspection and found staff were caring and kind. Staff spoke to people in a respectful but friendly manner and people responded in a similar way. Staff had a good awareness of people's needs and there was a great deal of warmth evident between staff and people. Staff responded to people in a caring way that also protected their dignity. For example, one person had rearranged an item of clothing and was not fully covered. Staff noticed and, as the person would not allow them to rearrange the clothing, used a blanket to protect the person's dignity. We observed staff supporting people with their meals in ways that were kind and patient. Staff did not rush people; they spoke with them about the food and asked them if they were enjoying it. Staff were kind and compassionate; for example, we observed staff made sure people had a drink with them most of the day, and when their drinks needed refreshing or topping up, staff offered an alternative. Staff interacted in a friendly way and people seemed happy and were laughing with staff. People were supported in an unhurried way and staff kept them informed of what they were doing.

Staff had built up positive relationships with people. Staff spoke positively about their work and about people warmly. One staff member told us, "I love working here. I've not done care work before but I really enjoy it." They added that they liked going home knowing they had made a difference to people's lives. Other comments from staff included "I enjoy working here. The atmosphere is nice and really caring and residents always seem happy."

People were relaxed and comfortable in the company of staff. All the interactions we observed between people and staff were positive and friendly. We saw staff kneeling down to people's eye level to communicate with them. Staff gave people time to process information and choices were offered. Staff showed respect for people by addressing them using their preferred name and maintaining eye contact. Although busy, staff did not rush people when supporting them. We heard good-natured banter between people and staff showing they knew people well. Staff demonstrated a knowledge of people as individuals and knew their personal likes and dislikes. For example, staff knew one person felt the cold so assisted the person to place a blanket round their shoulders and on their knees.

People's dignity was protected during the provision of care. One person told us, "They [care staff] do remember to shut the door and curtains". A relative said of care staff, "They do respect [relative's name] and they certainly look after her dignity". From conversations with staff and observations of the interactions between them and people it was clear that staff understood the importance of promoting people's dignity. Staff told us that privacy and dignity was adhered to and we observed care was offered discretely in order to maintain personal dignity. One staff member told us, "I shut the curtains and make sure the doors are shut.

We always keep the person covered as much as possible if we are providing personal care". Another staff member said, "We make sure doors are closed when providing personal care, and I make sure I ask them if it's okay". People's privacy was protected by ensuring all aspects of personal care were provided in their own rooms. One bedroom was shared by two people and we saw a privacy screen was available in the room which was organised to provide two distinct areas, one for each person. The manager said that people were always informed prior to admission if they were to be accommodated in the shared room.

People were supported without restricting their independence. The manager told us they had supported a person to move from an upstairs bedroom to make it easier and safer for the person to access their bedroom independently. At lunch time we saw staff encouraging a person to eat independently and another person was offered a spoon instead of a knife and fork to make it easier for them to eat independently. Where people were able to use the stairs we saw they were supported to do so. For example, we saw one person was supported to walk down the short upper flight of stairs (about four steps) and then assisted to use the chair lift down the main flight of stairs to the ground floor.

Care was individual and centred on each person. People received care and support from staff who knew and understood their history, likes, preferences and needs. When people moved to the home, they and their families (where appropriate) were involved in assessing, planning and agreeing the care and support they received. One visitor said, "The manager came to visit us before [name of relative] moved here. They asked us lots of questions about health but also about them generally". Another visitor told us they had been involved in discussions about care planning and how their relative would be cared for.

Staff knew about people and what was important to them and people were supported to maintain friendships and important relationships. One staff member said, "We know everyone well. Their care plans have information which tells us about them". Another staff member told us, "We've all got really nice friendships with the residents". We saw staff talking with a person and they knew the person's relatives by name and that the person liked dogs. Staff were able to tell us about another person's previous occupation and things they were interested in. Care staff described how they formed caring relationships with people and said, "We chat to people, talk to them about their family". There were no restrictions on visiting and visitors and relatives were made welcome. One visitor told us they were always offered a drink when they visited and we saw this was the case. The manager told us visitors could also join people for meals if they wished to do so. They told us how a relative they knew would be on their own on Christmas day had been invited to join their loved one for Christmas lunch. Where people had religious or cultural preferences these were known and met. Care plans contained information about people's religious needs and how these should be met. The manager was aware of how to contact religious leaders of various faiths if required.

Good

Is the service responsive?

Our findings

Following the previous inspection in December 2015 we found improvements were needed to ensure that care was provided in a safe way and all necessary actions were taken after an accident or injury to reduce the risk of this reoccurring. We made a requirement telling the provider they must make improvements. At this inspection we found improvements had been made and systems were in place to protect people.

When untoward incidents or accidents occurred, procedures were in place to ensure people received all the necessary care. Incidents and accidents were recorded. Forms showed that, where necessary, action was taken to monitor the person for any signs of deterioration. Action was taken to reduce the risk of repeat incidents such as through the use of movement alert equipment for a person who was at risk of falling. The manager had also requested the GP to refer the person to the falls clinic to consider actions that could be taken to prevent further falls. Should people require to be transferred to other care settings, such as hospital, the manager stated that a member of staff would always accompany the person. They explained this was to ensure essential information was provided to hospital staff and support the person in the unfamiliar environment. The manager said that copies of care plans and medicines information would be taken to the hospital by staff. This meant the person was supported and individual information which would be helpful to others who may be required to provide care could be passed on.

Following the previous inspection in December 2015 we recommended that the provider increased the variety and amount of activities provided to ensure people received the mental and physical stimulation they required. At this inspection we saw staff had more time to spend with people providing individual activities. We saw staff playing table games, working with people to complete jigsaw puzzles, discussing articles in the local paper and undertaking nail pampering sessions. One person told us they did not join activities but staff provided them with magazines which they enjoyed. We saw they were reading a magazine when we visited them in their bedroom. Another person's care plan stated they liked listening to the radio and this was playing suitable music when we visited them in their bedroom. On another occasion we saw staff talking to a person as they were selecting a radio station and asking the person "Is this music okay?" In addition to activities provided by staff an external music entertainer visited the home each fortnight. Another external activities provider also visited the home weekly providing a range of small group and individual activities. The manager had identified that there was a need for further activities and told us about plans to develop a sensory/activities room.

People experienced care that was personalised and care plans contained information specific to each person. For example, one person's care plan detailed that they enjoyed listening to the radio. When we visited them in their bedroom their radio was playing and the person confirmed they were enjoying the music. The person was also able to confirm that they were receiving care as detailed in other sections of their care plan. Assessments were undertaken to identify people's individual care and support needs, following which care plans were developed, outlining how these needs were to be met. Care plans provided information about how people wished to receive care and support and were comprehensive and detailed, including people's physical and mental health needs.

People's daily records of care showed care was being provided in accordance with people's needs. 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. Each month named keyworkers reviewed the person's records for the month and wrote a monthly summary which included, for example, any medication changes or contact from health professionals. A keyworker is a member of staff who is responsible for working with certain people, taking responsibility for planning that person's care and liaising with family members. One staff member told us, "I'm a keyworker which involves me writing a report about their previous month and if they needed toiletries or clothes I would get them for them or ask their relatives to get them". The manager reviewed care plans and risk assessments monthly or when people's needs changed. Records of care demonstrated that people received appropriate care and staff responded effectively when their needs changed.

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, for example, if the person had eaten and drunk well and if they had received personal care. Visiting health care professionals told us staff noted changes in people's needs and contacted them appropriately. They gave an example of when they had been visiting one person and staff had asked them to check another person's skin integrity. We saw for another person staff had requested health professional's advice and additional topical creams had been prescribed and were being used. There were systems in place to respond to changes in people's prescribed medicines. The manager told us that they were able to obtain medicines promptly by collecting these from out of hours pharmacies meaning there would not be a delay in the person commencing treatment.

People's views about the service they received at Cameron House were sought by the manager. Each month the manager met individually with people or, where more appropriate, with relatives and discussed their views about the service they were receiving. The manager said they would also ask people what they thought about any new staff or seek their views about meals or other changes at the home.

People, their relatives and friends were encouraged to provide feedback and were supported to raise complaints if they were dissatisfied with the service they received. People and visitors said they would make any complaints to the manager or senior staff. One person said "Oh yes I would say something". A visitor told us, "I've never needed to make a complaint but would see [name of manager] if I needed to". No one we spoke with had ever had cause to formally complain. The manager told us people and relatives were informed about the complaints procedure when they undertook a pre-admission assessment and written guidance was also provided within the 'service user's guide' given to people or relatives. No complaints had been received since the previous inspection; however there were systems in place to deal with complaints if these occurred.

Requires Improvement

Is the service well-led?

Our findings

Following the previous inspection in December 2015 we found improvements were needed as the provider had failed to ensure that CQC were notified of all incidents as required by law. We made a requirement telling the provider they must make improvements. Since that inspection we have received notifications about a variety of incidents. The manager was able to explain what they needed to notify CQC about and records viewed showed that we had been notified when necessary.

Providers are required by law to follow a duty of candour. This means that following an unexpected or unintended incident that occurred in respect of a person the registered person must provide an explanation and an apology to the person or their representative, both verbally and in writing. Where incidents between people, or falls resulting in an injury, had occurred the manager told us they had not provided a written explanation of the event to the person or their relatives although they had spoken with them about the incident. A member of the provider's management team showed us a new policy in relation to duty of candour which they were writing.

The failure to ensure that people or their representatives were provided with written apology and explanation following incidents and accidents is a breach of regulation 20 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required to display the most recent quality rating that CQC has awarded to the service. This should be displayed in a conspicuous place which is accessible to service users. When we arrived at the start of the inspection the rating awarded following the inspection in December 2015 was not on display. The manager stated they had been unaware of the need to display this. They took immediate action to copy the ratings from the December 2015 report and place these in a conspicuous area in the home's front entrance hall.

There was a registered manager for the home; however, whilst they retained oversight and responsibility for the service they were not in day to day charge of the home as they were managing another homed owned by the provider. 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. A new manager for Cameron House had been appointed and was in the process of registering with CQC to become the registered manager. They told us they were able to make day to day decisions about the home without consulting the provider. For example, they had access to funds to make local and online purchases, when required, such as the slide sheets ordered during the inspection.

People, relatives and staff all felt Cameron House was well-led. A visitor said, "[Name of manager] is very good, she will always sort anything out". Another visitor said "I do believe this place is well managed". A staff member said of the manager, "She is lovely, you can go to her and she will sort anything out." Another staff member said the manager would "help [care staff] if needed". Visiting health professionals said they had no

concerns about Cameron House or the way it was run. Every person and visitor we spoke with stated they would recommend the home to others. One visitor said, "I have already recommended it". Health and social care professionals were positive about the way Cameron House was managed and felt that it was well led. They also said they would recommend the service.

People were cared for by staff who were well motivated. They praised the manager who they described as "approachable" and said they were encouraged to raise any issues or concerns. The manager told us they undertook some care shifts, including night duties, which they felt helped them understand the pressures felt by staff and enabled them to directly monitor the quality of care provided. Staff understood their roles and worked well as a team. For example, administration staff usually based at the provider's other nearby home attended Cameron House during the inspection to enable a care staff member to attend the funeral service for a person who had recently died at the home.

Staff told us there were staff meetings. One staff member told us, "Staff meetings are held quite regularly and we always get asked at the end for any ideas or if we have any concerns". We saw the minutes of the most recent staff meeting were available for staff to read. This meant any staff unable to attend would be aware of what had been discussed.

There was an open culture within the home. Visitors were welcomed, there were good working relationships with external professionals. Relatives told us the manager and other staff were "approachable" and "caring". Relatives felt able to raise issues and were confident these would be sorted out. The home had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were informed about this and other staffing policies in a handbook provided to all staff. Staff felt able to make suggestions to the management team for the benefit of people. One staff member told us, "I feel the manager operates an open office and I could go to her anytime about anything."

The manager described the home's values as being to provide "a warm, loving homely environment where people's needs and best interests are met". They added that their goal was for people to be happy and to feel that Cameron House was their home. One care staff member described the home's values and purpose as being to "make the best possible quality of life [for people], to provide comfortable, person centred care". Another staff member said the home's values were "to treat people as human beings, how I would want to be treated". All staff members said they would be happy for a member of their own family to receive care at Cameron House.

The manager told us they ensured the quality of the service provided by talking to people, relatives and staff. More formal quality assurance systems were also in place, including seeking the views of people about the service they received. Surveys had been sent to visitors and external professionals. The surveys could be completed anonymously and those already completed showed everyone was happy with the service provided at Cameron House. The provider visited the home most weeks and undertook a formal monthly monitoring visit. The manager was provided with a report following these monitoring visits which would detail any actions required. We saw these were comprehensive and covered all aspects of the home from the environment to meals and included talking to people, visitors and staff. Auditing of all aspects of the service, including care planning, medicines, infection control and staff training was conducted regularly. The formalised quality assurance system also included systems to monitor other areas, such as accidents or incidents and people's valuables. The manager also conducted unannounced spot checks during the night to monitor whether staff were delivering care to an appropriate standard.

The manager told us they kept up to date with current best practice and was keen to develop the service for

the benefit of people. For example, they were taking pictures of staff to be used on a notice board to inform people which staff were on duty each day. When we identified areas which could be improved the manager was receptive to these and where necessary took immediate action. This showed they were willing to listen to others opinions and views about the service. The manager completed the Provider Information Return (PIR) to a good standard. 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.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The registered person has failed to ensure that people or their representatives were provided with a written apology and explanation following incidents and accidents. Regulation 20 (3)