Camelot Care (Somerset) Limited

Camelot House

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Camelot House is a nursing home which is able to accommodate up to 90 people in two buildings. Camelot House can accommodate up to 62 people and Camelot Lodge can accommodate up to 28 people. The home specialises in providing nursing care to people who have dementia and other mental health needs. At the time of the inspection there were 73 people using the service.

At the last inspection the service was rated Good.

At this inspection we found the service remained Good.

Why the service is rated Good:

At the inspection of Camelot House in January 2016, we found that risk assessments and risk management plans were not consistently reviewed regularly. The provider wrote to us in May 2016 outlining how they would improve this. During this inspection we found improvements had been made. People at the service felt safe and relatives were mostly positive. There were sufficient staff on duty and recruitment procedures were safe. People received their medicines as prescribed and infection control practice reduced associated risks to people. The equipment and environment was well maintained.

People and their relatives told us they felt that the care received was effective. Care was delivered by staff who had received appropriate training to undertake their role. Staff were also supported through appraisal and supervision. New staff received a comprehensive induction aligned to national standards. The service had appropriate systems to monitor the applications and authorisations for people being lawfully deprived of their liberty. People were supported to eat and drink sufficient amounts and external healthcare professionals were consulted when needed.

People and their relatives said the service was caring and compliments had been received to reflect this. Staff were observed being caring and supportive towards people and knew the needs of the people they cared for. People were supported to have a dignified death in accordance with their wishes.

The service ensured they were responsive through a comprehensive pre-admission procedure. People and their relatives were involved in care reviews and care records were personalised. People were supported with their hobbies and interests and the service gave examples of how they had gone the "Extra mile" to improve the quality of some people's lives. There was a system to ensure complaints would be listened to.

People, their relatives and staff commented positively on the leadership of the service. There were systems to seek the views of people and staff, and additional systems that ensured key messages were communicated. There were governance systems to monitor the health, safety and welfare of people. The service had received accreditation of their good practice from both local and national organisations.

Further information is in the detailed findings below:

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 has improved to Good.	Good
Is the service effective? The service remains Good.	Good
Is the service caring? The service remains Good.	Good
Is the service responsive? The service remains Good.	Good
Is the service well-led? The service remains Good.	Good

Camelot 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was carried out by two adult social care inspectors and a specialist nurse advisor. In addition, an expert-by-experience who had personal experience of using or caring for someone who uses this type of care service was a member of the inspection team. When Camelot House was previously inspected in January 2016, we found that care records were not always regularly reviewed. During this inspection, we found improvements had been made.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. We also reviewed the information that we had about the service including statutory notifications. Notifications are information about specific important events the service is legally required to send to us.

During the inspection we spoke with eight people that lived at the service and five relatives. We also spoke with 13 staff which included the operations manager, registered manager, administrative staff, nurses, care staff and kitchen staff. We looked at a number of records relating to individual care and the management of the service. These included nine care and support plans, staff files and records relating to medication administration and the quality monitoring of the service.

Good

Is the service safe?

Our findings

The service has improved to Good. At the inspection of Camelot House in January 2016, we found that risk assessments and risk management plans were not always reviewed regularly. The provider wrote to us in May 2016 outlining how they would improve this. During this inspection we found improvements had been made.

Risks to people were recorded and reviewed with control measures put into place to mitigate against any assessed risks. We found risk assessments were completed in relation to mobility, skin breakdown and nutrition. Where people had complex clinical needs, comprehensive risk assessments had been completed and review dates had been set to regularly review the risk level. This ensured that responses and interventions were always appropriate to the current level of identified risk and care plans responded to an individual's changing needs. Accidents and incidents were reviewed to establish trends or patterns.

People and relatives we spoke with told us they felt the service was safe. One person, when we asked if they liked living at the service told us, "It's alright, it's a pleasure. Everyone likes you. They are very nice people." We asked a relative if they felt their relative living at the service was safe. They commented, "Absolutely, 100%, they are marvellous. He's made friends with them all." Another relative commented, "I feel confident my husband is well looked after."

Policies and procedures for safeguarding and whistleblowing were accessible for people and staff which provided guidance on how to report concerns. We saw that guidance on reporting concerns by whistleblowing were displayed around the service. Staff we spoke with had an understanding of their responsibilities to keep people safe from abuse or avoidable harm. We saw records that demonstrated referrals had been made when necessary.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. For example, Disclosure and Barring Service (DBS) checks were completed. These were carried out before potential staff are employed to confirm whether applicants had a criminal record or were barred from working with vulnerable people.

Medicines were ordered, stored safely, dispensed and disposed of in accordance with the service policy. The service had a medicines management clinical lead that provided nursing staff with support and information. Medicines were only dispensed by qualified nurses who received medicine management training. We highlighted that during recent case law, it was recorded that people who received their medicines covertly should be subject to a review of this practice after a six month period. The registered manager confirmed these reviews would be undertaken.

The staffing level within the service ensured people's individual needs were met. Staff we spoke with felt staffing levels were safe and we made observations that people received the required level of support. Some people at the service received 'One to One' support from staff. We saw this was factored into the staffing deployment and staff providing this care wore innovative 'One to One' red armbands to ensure they weren't

distracted. Records showed a dependency tool was used to calculate staff levels and call bell response times were audited monthly.

We found staff followed infection control procedures and were seen to use personal protective equipment where necessary. The service was clean and odour free. Hand washing facilities were available in numerous sites. Pictorial illustration of the correct way to wash hands had been placed in staff toilets. People who required a hoist to help move had personal slings, kept in their rooms. The service had recently been congratulated by Public Health services on the way they had dealt with and managed to contain an outbreak of norovirus.

Records demonstrated that dedicated staff employed by the provider checked mobility equipment was serviceable and both the internal and external environment were maintained safely. This ensured equipment was maintained and safe for its intended purpose. Fire alarms and associated equipment were regularly tested.

Good

Is the service effective?

Our findings

People and relatives told us they felt care workers had the relevant skills and experience. People we spoke with did not raise any concerns about the staff at the service and comments we received from relatives were mainly positive. One relative, when asked about the support their relative received commented, "[They are] really good at hoisting, there are always two of them." Another commented, "They have got very good people here. She's happy here."

We found people were offered a varied and nutritious diet, and nutritional risks were managed. Where people had nutritional needs these were assessed and plans were in place to support people with their dietary needs. For example, specialised diets or supplements. Food and fluid intake charts had been completed on a regular basis and included the total intake over a 24 hour period. People were regularly weighed on a monthly basis or more often if they were losing weight.

Advice was sought from external professionals such as a Speech and Language Therapist (SALT) if a person started to experience swallowing difficulties. Catering staff showed us a sample of some people's nutritional sheets. These demonstrated that a person's weight, their results of nutritional risk assessments, diet types, food allergies and required food consistencies such as mashable, pureed or soft were effectively communicated to the catering staff.

Staff were well supported in their role. The provider had an induction process which encompassed the new Care Certificate. This was introduced in April 2015 and is an identified set of standards that health and social care workers should adhere to when performing their roles and supporting people. The provider had a training planner in place for staff together with an appraisal and supervision programme. Records demonstrated the frequency staff received their appraisal and had supervision. Other records we viewed showed staff had received the training they needed to meet the needs of the people using the service. Essential training included moving and assisting, infection control, first aid and safeguarding. Nursing staff also completed clinical training.

Further training was provided where identified. For example, child safeguarding had been introduced following the community link being established with the local school. In addition, staff undertook sensory experience training. This involved staffing being supported by colleagues in mobility equipment, having their teeth brushed or being supported with a meal. This aimed to demonstrate the experiences and sensations people would have when being supported by staff. Staff told us they felt well supported by the training they received.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available. The registered manager kept a record of all DoLS applications made along with copies of authorisations. Some people had legal conditions attached to their DoLS that the service had to

facilitate. Although the service could tell us these conditions had been met, we have advised that maintaining an accurate record would evidence this clearly.

Care records confirmed people had access to external health professionals when required. People we spoke with felt they were well cared for. We saw that where a risk was identified, for example with a person's nutrition or weight loss, the relevant healthcare professional was contacted. If a person became unwell, the person's GP would be called for guidance and would visit if required.

Good

Is the service caring?

Our findings

The service continued to provide a caring service to people. People and their relatives gave us positive feedback about the care and support given by staff at the service. One person commented, "The care is amazing. They are all fantastic." A relative spoken with told us, "I have heard staff talking to him. And not just with [person's name]. I have watched other people who have been very ill and difficult, and they are so patient and kind. Talking, reassurance, trying different things to calm him. They are all pleasant, nothing nasty. They put their arm around, give a cuddle and calm them down."

People's relatives had sent compliments to the service. We reviewed a sample of the compliments. One relative wrote, "I would like to thank all of the staff for taking care of my lovely Mum [person's name] and making us feel that she was safe and happy" Another described staff at the service as, "Incredible people."

We observed supportive, caring and affectionate interactions between staff and people. Staff clearly knew people very well. We noted staff spent quality 'One to One' time with people and each lounge area had a staff member whose role was to be the 'lounge supervisor.' Staff told us that this system prevented people being sat in a lounge with no stimulation or anyone to talk with. There was an unhurried atmosphere, people were given time to try and maintain maximum independence when possible. Staff had a person centred approach and did not appear task orientated.

People were cared for by staff who knew their needs well and understood how people wanted to be supported. All of the staff we spoke with were able to describe in detail how people were supported and we observed this being put into practice. For example, when people displayed behaviour that may be challenging staff understood the person's behaviours and did not cause them any further anxiety or distress when supporting them.

We made an observation at a nursing station when a person told a staff member they were hungry. Staff told the person that lunch would be served shortly, but did ask them what they would like to eat in the meantime, and offered him some choices. During lunch we spent some time observing in the lounge area. We observed staff supporting people with their lunch. The staff were concentrating on caring for people, and were encouraging them by telling them the type of soup they had (one person was blind), talking about and describing the food, and checking it was not too hot. The staff member was heard saying, "Tell me if it's too hot." Interaction between the staff and people was positive, with much laughter.

We saw the records for one person living with advanced dementia showed they became aggressive towards staff and other people at times. This person was prescribed covert medication, up to a maximum of four times a day to help calm them. Supporting records detailed that de-escalation techniques should always be used in the first instance when the person became aggressive and the covert medication should only be administered as a last resort. Medicines records showed the medication had only been given once in the past two weeks. This demonstrated staff understood the person well and proactive support measures had resulted in minimal medicine administration requirement.

The service was accredited by the Gold Standards Framework (GSF) for providing a high standard of end of life care. This is a comprehensive quality assurance system which enables care home service to provide quality care to people nearing the end of their life. The service ensured that advanced care planning for people's end of life care wishes were completed to avoid inappropriate hospital admissions. The service worked closely with the local hospice and relevant GP to ensure the service had sufficient medicines and equipment. This meant people were supported at the end of their lives to have a comfortable and pain free death.

Good

Is the service responsive?

Our findings

People and relatives told us they felt the service provided personalised care and were responsive. One relative told us, "I just come in and sit with him. They don't really need me. I feed him. They are very good, they go out of their way. They gave me a bedroom to stay in. They have been ever so supportive, I don't think I could have coped. There's always people watching out, immediately they are there. They will do anything to protect and look after you." People and their relatives also told us they were involved in care planning and reviews.

People's needs were assessed prior to admission to the service. This ensured the service was confident it could meet the person's assessed needs. Each person had care plans that were tailored to meeting their individual needs, for example in activities, communication and continence. Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. Care plans showed people's life history. Care records had been reviewed where required.

Relatives said they felt involved in the care of their family member on a day to day basis and that the service kept them informed when anything happened. On the day of our inspection, two relatives attended the service for a pre-arranged appointment to review the care plan for a person living at the service. One person we spoke with said, "They have had my family in and talk with them. They are very approachable. You can ask them anything."

Care records communicated how to support people in a personalised way during times of anxiety or distress. For example, one person's record read, "I often become restless or agitated. I am likely to get up and move around, and at times I can walk very fast. My visual spacial awareness can become affected. At times I can require support for my general mobility." This showed individual behaviours were recorded to aid staff in supporting people. Regular reviews being completed ensured information about people's level of need reflected their current situation.

People were supported to maintain hobbies and interests. The activity coordinator we spoke with knew people's preferences and interests. We found planned activities included entertainers coming in to the service, exercises and music. People had access to a minibus so events in the local area and visits to the local garden centre were organised. We also saw the activities staff took time to arrange events on marked occasions, for example the Queen's Coronation and the FA Cup final. People who were able were also supported to vote at the recent general election.

We saw an example of how the service had been responsive to the needs of people and their relatives. Records showed that meetings were held with people. In addition to this, there was a 'You said - We did' board. This was an information board that communicated information from people's relatives about matters that had been raised, and a summary of the action that had been taken by the service. For example, the board showed that people had highlighted they wished to see their GP in a private area, and that this had been arranged. Other changes were garden and parking improvements.

The service was able to demonstrate its responsiveness and how they helped improve the quality of some people's lives. For example, the service arranged a celebration for a person and their wife on their ruby wedding anniversary. The activities staff also support people to use an internet based video calling system to speak with relatives around the world. Additional positive practice included ensuring a person who was a minister at a local church could continue to attend their church. The service also arranged transport for a person's relative who has reduced mobility to ensure they can attend Camelot House and visit their husband frequently.

We found the provider had a process in place for people, their relatives and visitors to complain. People had access to the provider's complaints policy and felt able to complain should they need to. From reviewing the complaints log for 2017, it showed the service had received one complaint which had been responded to by the registered manager in line with current policy. It was noted the current policy information in place for complaints did not contain information on how people could contact the ombudsman should they wish to escalate their complaint.

Good

Is the service well-led?

Our findings

The service had a registered manager. 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 and relatives we spoke with told us the service was well led and that they were involved in the service. We asked some relatives we spoke with if they felt the service was well managed. One said, "Yes. If there's an emergency the bell goes off, all the staff are there instantly. Staff check everybody all the time, looking around." Another relative commented, "The atmosphere is amazing. If I want to know anything I just ring [staff member name], or the nurses."

Staff feedback was positive about their employment. Staff we spoke with told us the management at the service were supportive. Staff commented that in addition to the management at the service they could approach senior staff for advice and guidance. Staff told us that in general the teamwork within the service was very good and this resulted in a positive experience for people. We made observations that supported this. Nursing staff we spoke with told how they received guidance and support with their revalidation. Revalidation is the process nurses must go through to maintain their registration to practice as a nurse with the Nursing and Midwifery Council.

There were effective systems to communicate key messages to staff. The registered manager told us that meetings were held. Staff confirmed this and we saw the supporting minutes that showed meetings were held with registered nurses and other meetings held with care staff. Through speaking with staff, it was also established that key messages were communicated via email to the nursing staff. Key messages were communicated to care staff during handovers or group supervisions. We saw the supporting minutes for the group supervisions that showed matters such as using fluid thickeners, security and records were discussed.

There were governance arrangements in place that ensured risks associated with people's health, care and welfare were monitored. Care records were subject to regular review by senior management. The electronic care planning system ensured people's records were reviewed timely. The service had a 'Resident of the Day' scheme in operation to ensure people were happy with various different aspects of their care and support. The nominated 'Resident of the Day' would be visited by various different departments throughout the service. For example, somebody from maintenance would visit the person to ensure people were happy with their room and a chef prepared the person's chosen meal. The person would also be visited by staff to ensure their care and support needs were met.

There were systems to seek the views of people, their relatives and staff. In addition to this, the views of visiting healthcare professionals was also requested. This helped to monitor the quality of the service provided. Annual surveys were produced by the provider. The results of the most recent surveys were mainly positive. For example, most professionals commented positively on the care planning, medicines and staff competency. Relatives were positive on being made welcomed, the management of the service

and all said care provision was "Excellent." Staff were positive about their training and the support they received.

We saw the service had community links with the local school, and following a visit from a senior member of staff from Camelot House to the school to discuss becoming a "Dementia Friend" some students had joined the scheme. They now attend the service and spent time with people. The service had also joined up with a university to take student nurses on a nine week placement while they studied.

The service had also acted as an example to others by achieving the highest 'Beacon' status from the Gold Standards Framework (GSF) for providing a high standard of end of life care during reaccreditation. In addition to this, the service had been recommended by the GSF as a finalist with six other services nationally in the 2016 'Care Home of the Year' award category. More recently, the service were the winners of the 2017 Care Focus South West 'End of Life Care' awards.