Care Quality Commission

Avens Care Homes Limited

Camplehaye Residential Home

Inspection report

Lamerton
Tavistock
Devon
PL19 8QD
Tel: 01822 612014
Website: www.avenscarehomes.co.uk

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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

We carried out an unannounced comprehensive inspection on 22 and 29 April and 7 May 2015. We had decided to bring forward a planned inspection because of concerns raised with the Care Quality Commission (CQC) about provision of care at the home and because of a change in the management situation.

We last inspected the home in May 2014 and found no breaches in the regulations we looked at.

Camplehaye Residential Home provides accommodation and personal care to a maximum of 44 people. It is not a nursing home. The home specialises in the care of people living with the condition of dementia. There were 37 people resident when we visited.

The home had a registered manager during this inspection. A registered manager is a person who has registered with the Care Quality Commission to manage

Summary of findings

the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager had not been in continuous day to day control of the service since 12 January 2015. There has been an acting manager in their place since 13 March 2015, supported by a provider representative with the provider assuming "day to day" control since that date.

People said they felt safe and looked relaxed with staff who had their welfare at heart. However, some staff had not received training in protecting people from abuse and did not understand their responsibilities. Consequently when a person using the service had hit another this was not reported to the local authority safeguarding team as it should have been.

Risk was not always managed effectively. Records of falls and incidents could not be guaranteed as accurate and there were conflicting risk assessments and care planning, for example, regarding the use of bedrails. Risk assessments had not identified the risk from free standing wardrobes. Unattended spray bottles of cleaning products put people at risk who might not understand the danger from the chemicals.

Evacuation plans were not up to date. There were examples where the provider and staff had already recognised risk and reduced it, such as safety on the stairs but also examples where they had not identified risks.

Medicines were generally well managed. However, two people had not received the sufficient amount of one medicine; their GP was immediately informed when we identified this.

Staff had not received adequate induction, training and supervision of their work. This had been identified and was being addressed prior to the inspection.

People were involved in decisions about their care. The acting manager and the provider representative understood the principles of the Mental Capacity Act 2005 and protected people unable to make decisions about their care. However, at least one person was being deprived of their liberty unlawfully. The provider representative informed the local authority immediately this was identified.

Records at the home could not be guaranteed as accurate or useful. They did not help staff members provide safe and responsive care. They increased the potential for risk.

The home appeared clean and was fresh but there was no cleaning schedule and so the need for cleaning behind furniture had not been identified and there was some old debris.

Some of the issues of concern had been identified by the provider before the inspection and were actively being dealt with. Issues we identified were followed up straight away. However, the auditing and monitoring arrangements established by the provider had not been effective.

Some staff morale was low and they said they felt unsupported.

People said staff responded to their needs in a timely way. Staffing arrangements were flexible where people's needs or circumstance changed. Staff recruitment included checks to be sure the person was suitable to work in a care home environment.

People liked the food, which they said was tasty. People received a nutritious diet and staff understood how to protect people from poor diet or fluids. Any concerns about people's diet were followed up by the service.

Staff were considered to be kind and caring. One of many comments was, "The people who help me are wonderful."

People's privacy and dignity were promoted. Staff readily provided support, a smile and encouragement, especially where people were anxious or upset.

Community nurses had no concerns about the care provided at Camplehaye. People had access to their GP, dental, eye and foot care and were supported to attend hospital and other appointments.

People had many and varied activities available to them, such as gardening, chair exercises and regular discussions about current events. An activities worker ensured people who stayed in their rooms were visited on a regular basis to help reduce any isolation.

Summary of findings

Complaints brought to the provider's attention were investigated and followed up in a timely way. Where they had identified the need for improvement this was put in place.

We found four breaches of Regulations in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The action we have asked the provider to take can be found at the back 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?

Requires improvement

The service was not always safe.

Staff had not followed procedures to protect people from abuse because they did not understand.

Risks were not always adequately managed, such as protecting people from falls, the use of bedrails and access to cleaning chemicals.

Medicine management was not always safe.

The home appeared clean and was fresh but a lack of cleaning routine meant that the need for deeper cleaning was missed.

People were protected through the staffing arrangements, which were flexible to meet their needs.

Recruitment was robust and protected people from staff who might not be suitable to work in a care home environment.

Is the service effective?

Requires improvement

The service was not always effective.

Staff induction, training and supervision were not sufficient to ensure the support and knowledge staff needed for their role. This was being addressed when the inspection started.

One person was being unlawfully deprived of their liberty because staff did not understand their responsibilities and had not followed the necessary procedures.

Staff sought people's consent to care and had actively ensured treatment was not unlawful.

People liked the food and staff understood the importance of adequate diet and fluids. Improved planning and record keeping would improve the arrangements.

Is the service caring?

Good

The service was caring.

People received attention, recognition, smiles and were treated with respect and dignity. It was a happy home for people and they were valued.

There were many thank you cards from families following the death of their loved one. They included: "Love and care through good times and difficult times were a great comfort".

Summary of findings

Is the service responsive?

Requires improvement

The service was not always responsive.

People were involved in the planning of their care but assessment, care planning and records did not always correspond or provide the information staff needed. A new recording system had been purchased but was not yet in use.

People were treated as individuals and supported in person centred way. They were supported to live their lives in a way they wanted. This included a wide variety of activities available to them.

Complaints had been used as a way to improve the service; fully investigated and any actions had been identified and followed up.

Is the service well-led?

Requires improvement

The service had not been well led.

Company policies, intended to promote an effective and safe service, had not been followed and the provider had not known.

Some staff morale was not high. Staff did not always know who to take concerns to and had not felt supported.

People's views were sought through meetings, care planning and a yearly staff survey. People and the families were happy with the service.

The home was undergoing in-depth audit and where concerns were identified they were being followed up. There was a programme of improvement.

Camplehaye Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 22 and 29 April and 7 May 2015. The first visit was unannounced and the following two visits were announced so that we could be sure a representative of the provider was available. The inspection involved two inspectors.

Prior to the visits we had been informed of management changes at the home. We reviewed information we had about the service such as previous inspection reports and notifications sent to us. A notification is information about important events which the service is required to send us by law. We also looked at additional information we had requested from the registered manager. This enabled us to ensure we were addressing any potential areas of concern.

A number of people living at the service were unable to communicate their experience of living at the home in detail as they were living with dementia. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people, who could not talk with us.

We met most of the people living at the home and received feedback from nine people using the service and three relatives. We spoke with 16 staff, which included care and support staff, the acting manager, a provider representative and the provider. We looked in detail at the care provided to seven people, which included looking at their care records. We looked at three staff recruitment records and at staff training and supervision records. We also looked at a range of quality monitoring information. We asked a member of the community nursing team their opinion of the care provided.

Requires improvement

Is the service safe?

Our findings

People were not fully protected from abuse. Some staff were unsure about what might constitute abuse but all said they would recognise where concerns needed reporting. Some staff had received training in the safeguarding of adults during their employment at Camplehaye but some had not or it was "a couple of years ago." Staff knew to report any concerns they might have to the registered manager or provider but two of the four staff we asked were unaware they could alert concerns externally such as the local authority, police and the Care Quality Commission (CQC). One said, "I don't know who is higher (than the provider)". A second said, "I would tell the perpetrator not to do it". Two of the four were unaware of safeguarding or whistle blowing policies at the home. The policies were within the staff handbook which was in the office and available to them.

The safeguarding and whistle blowing policies set out types of abuse, how to recognise abuse and the steps which should be followed to safeguard vulnerable adults, such as working in partnership with the local authority. Records showed that one person using the service had hit another individual but the local authority had not been informed as it must as part of that person's protection. When we informed the provider representative he made an immediate safeguarding referral. We saw no information which suggested there had been other unreported concerns or allegations of abuse and the provider representative did an immediate review and said they found the same.

The provider had not ensured systems and processes were in place to protect people from abuse. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

One person, asked if they felt safe, said they felt safe with the staff and their property was looked after and not mishandled. They looked comfortable with staff that entered the room, exchanging conversation with them. Another person said if they had any concerns they would tell whoever was senior to the person committing the offence.

It was not clear how well risk was managed at the home, mainly due to the standard of record keeping. For example, people's care files included risk assessment forms for the use of bedrails but in three we looked at these had not been completed or used appropriately. For one person their file said they did not require a bedrail yet bed rails were in use at the time of the visit. For a second person the risk of bed rail use was "high risk – do not use bedrails" yet they were in use.

The registered manager had notified the Care Quality Commission of serious injuries, of which there were only few, and the community nurses had no concerns, which indicates risks were mitigated by staff.

Accident report forms did not always correspond to a person's daily records which meant it was difficult to identify how many incidents/accidents a person had and whether they had been investigated to reduce risk. Accident report forms included where accidents happened but not always the time. In one case an accident record lacked the information that the floor was wet when a person fell and sustained a fracture. This information was included in the person's daily record. We informed the environmental health agency, to which the original accident had been reported, and the coroner of the additional information.

Body maps were in use but had not always been used according to the provider's policy because more than one observation was recorded on the forms, which was confusing in some cases. The provider representative said, "(Staff) have taken action, but it is about consistency." They said that from March 2015 any body map completed had been taken to the office, where it was signed off and information transferred to the person's care plan.

Personal evacuation plans were not accurate so as to provide information for emergency services should an emergency occur, such as a fire. The provider representative said, "The system is there but it is not being used." One evacuation plan related to the previous occupant of the room and so might not reflect the current occupant's needs in an emergency. A fire risk assessment dated March 2015 had been carried out by a fire safety company with no issues identified.

Some staff may have exposed some people to risk. For example, there were unattended spray bottles of cleaning products and people walking by who might not understand danger associated with the chemicals. We immediately fed this back to the provider representative. In other areas staff were aware of potential risk and managed these well. For

example, Staff ensured footplates were in place on wheelchairs before moving people. One person had a room on the ground floor for their safety as they walked about independently. A care worker sought help from a second care worker to help a person safely into their family member's car.

The premises and equipment was under regular review. Two maintenance staff said they were "always on call". A maintenance book was used for the record of any maintenance issue and signed off when the issue had been addressed. Records showed regular checks for safety. These included lighting, fire doors, and equipment and water temperatures. They said they risk assessed every bedroom. Risk assessments for each person's room were in place but did not identify every risk. For example, there were many rooms with freestanding wardrobes which could topple if pulled upon, for example, should a person fall and try to get up. The provider said this would be addressed immediately.

The occupant of one room had a history of falls. Their carpet was worn and uneven for our first visit but arrangements were already in place for its removal as previously arranged. When we returned for a second day, the carpet was being replaced. The acting manager told us staff had previously reported the issue and the provider had taken action as soon as they were informed.

The maintenance staff were unaware of any general risk assessments. However, there were risk assessments for shared areas of the home although some had not been

reviewed within the timescale the provider had set. Following an accident in the vicinity of the stairs this area had been risk assessed. The provider said they believed expert advice had been sought about this at the time, but they were not sure. Alterations to the area had included changing the height of the hand rail and a gate as a visual deterrent at the bottom of the stairs. They said there had been a significant reduction in the use of the stairs since the changes had been made and so safety was improved.

Two staff who had received medicines training undertook the ordering of medicines. Measures were in place to help prevent or identify errors arising in the ordering process, such as prescribing errors. Staff had recorded quantities and signed medicines received, including those received outside of the four-weekly ordering cycle (such as courses of antibiotics). The acting manager told us the ordering process included an audit of existing stocks so that the service did not order more medicines than were needed for the coming month. 'Carried forward' totals were recorded so that an accurate record of medicines within the home was kept.

Medicines were stored securely. There were appropriate trolleys for administration, one on each floor, which we saw were locked and secured when not in use. Medicines cupboards, including one meeting requirements for medicines requiring specialist storage, were kept locked when staff were not present. A fridge solely for medicines was kept in a locked room and its temperature checked daily. The medicines storage room felt cool during our visit but its temperatures was not checked such as to ensure all medicines were stored at temperatures indicated by manufacturers.

Some safety measures were in place including people's photograph and a signature list so that it was possible to identify which staff had administered any medicines. The acting manager told us people's allergies would also be printed on the MAR in future, for clarity. The service had just provided this information to the pharmacy. Staff described safe practices such as checking the medicine record each time before removing medicines from their packaging, checking the person's identity before giving medicines, and signing the record after attending to each person and only after they had taken the medicine.

Where individuals were prescribed medicines for use 'as required' there were guidelines for the giving of these with their medicine record. For example, for what conditions prescribed pain-relief was intended. This promoted consistency in their use, especially when people living with dementia might have difficulty requesting medicines they wanted or needed.

Directions on medicine charts were not always sufficient. In one example eye drops were to be applied to the person's 'affected eye(s)'. There was no indication of which eyes were to be treated, and neither the acting manager nor deputy manager knew.

Two staff had signed handwritten directions and alterations to printed directions on medicine records. However, there was no signature or date recorded where a hand-written entry stated a medicine had been stopped, to show who was involved in this decision and when.

Requires improvement

Is the service safe?

Medicines were not always administered in line with the prescriber's directions. Senior staff had identified the topical medicines charts were not being used appropriately so as a result it was not always clear what action staff had taken. Charts included the product, where it was to be applied (although with no body maps used to clarify this) and usually indicated why/what it was for though not consistently. For example, soreness of one person's sacrum had worsened and the frequency of application was not always stated, creating a risk of over or under use.

Two people were prescribed a medicine, doses of which can vary over time depending on the results of blood tests. There were faxed details of their current regime to ensure clarity for staff. Staff signatures and other records indicated staff had administered the medicine as directed. However, there were more tablets than there should have been. This indicated both people had not been given their medication as prescribed. This was fed back to the acting manager immediately for them to follow up with the people's GP for their safety. One of these person's care plan included foods that interact with their medicine. The kitchen staff told us they knew about people's allergies, but it was not recorded or available in writing in the kitchen and some of their knowledge about allergies was incorrect. This increased the risk that some people might be given foods that interacted adversely with medication they took, and be deprived of foods they could eat safely.

The prescribed medicines/products were not always available for people. The acting manager described difficulties due to a fault in a new system being used by the GP surgery and pharmacy which was impacting on the home. Prescriptions which had been affected included dietary supplements. One person had not been given them for over five days as a prescription was awaited for them. Another person had not been given one prescribed medication in the current medicines month, with the chart showing no stock had been supplied. The acting manager told us this medicine was taken intermittently and she thought it was currently stopped, though this was not reflected on the record. When she phoned the surgery to check, they advised it should be taken currently.

Staff did not have easy access to information about the medicines people were currently prescribed. We queried with the acting manager and a deputy manager what a couple of medicines were prescribed for, however neither was aware. One unsuccessfully referred to a book on medicines which was printed in 2001, which could not be guaranteed to contain up to date information. The acting manager told us they sometimes received patient information leaflets about people's current medicines although these were not found.

The supplying pharmacy collected unwanted medicines for proper disposal. Such items were recorded in a duplicate book (which the supplying pharmacy currently had), so that the service and the pharmacy could both keep records of these items. If anyone refused a medicine offered to them, there was a system in place for enabling their return for disposal.

The acting manager told us that the supplying pharmacy had carried out an inspection in recent months (Dec/Jan) but their written report was still awaited – she had pursued this. Action had been taken already in response to some of their findings, such as improving the system for recording fridge temperatures. The acting manager said that staff were to receive refresher training on medicines in June 2015, from the supplying pharmacy.

The provider had not ensured safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

Communal areas of the home and people's rooms were clean with no unpleasant odours. Staff had access to appropriate cleaning materials and equipment. Staff had access to personal protective equipment (PPE's) such as gloves and aprons. They had followed additional cleaning measures when one person was unwell to protect other people from any infection risk. However, some bedrooms had debris behind furniture. This included a candle from a birthday cake from three months before and biscuit and wrappings under a bed. One person's family said they found debris which had been there since the previous week. Cleaning staff said they did not follow a cleaning schedule or plan and the provider representative told them this would be put in place.

Staff took time to engage with people as they met them around the home. All staff appeared to be working in a calm and organised manner. One person said staff did not rush when they assisted them. Another person said call bells were responded to within "only a minute or so." A third person said it was "not long" if they called for staff.

The acting manager and provider confirmed that staffing levels would be adjusted according to people's needs. For

Requires improvement

Is the service safe?

example, additional staff were arranged when a person required an escort to hospital. The acting manager said that night staff had no other duties other than providing care to people. For example, they were not expected to do any laundry or food preparation. The staff rota showed that any staffing shortfall was met if possible.

There were recruitment and selection processes in place. Staff files for the most recently recruited staff included completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers, health screening and Disclosure and Barring Service (DBS) checks completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated that appropriate checks were undertaken before staff began work with people using the service.

Requires improvement

Is the service effective?

Our findings

Prior to our inspection the provider had identified through audit that staff training was not in line with their policy and some staff might not be equipped to provide a safe and effective service. As further confirmation of this two care workers said they received moving and handling and fire safety training "and nothing else" when they were new to the home. They confirmed they 'shadowed' another worker for three shifts and then worked alongside another worker where those people required two staff working together to meet their needs.

Staff had not received an induction based on the nationally recognised induction standards or which followed the provider induction process. An induction check list was in use which provided a brief introduction to Camplehaye Residential Home. However, the provider representative was aware of the Care Certificate which became a requirement on 1 April 2015. The provider informed us, "We are currently reviewing all staff induction paperwork and any shortfalls are/have been identified and we will complete any process which is outstanding to ensure our staff team have undertaken a comprehensive induction".

There was a training matrix but it was not up to date. Staff training certificates were being used by the provider representative to work out what training had been completed and what was needed. Arrangements were being made during our visits to meet currently unmet training needs and care workers were receiving advice and support from the acting and deputy managers. On-line training was being arranged as an interim staff training tool but this was to be supplemented by 'hands on' training as soon as this could be arranged. There was fire safety training taking place during our visit.

Each care worker had started a learning programme in dementia. However, many areas of important learning had not been covered with the existing staff, for example, cleaning staff had not received training in infection control or the safe handling of chemicals. One staff member, who did not provide care to people but had been at the home since 2009, had only ever received training in fire safety.

There was a notice advising staff that manual handling training would be taking place. The acting manager told us one session had taken place, with another due to be held.

There was information on Lewy body dementia displayed in an area used by staff, and information on pressure ulcers in the medical room. District nurses provided some guidance for staff.

People liked the staff and felt they received good care. Their comments included, "So far I'm well looked after"; "The people who help me are wonderful" and "The treatment of the patients is first class."

Supervision provides an opportunity for staff to discuss work and training issues with their manager. It also provides the manager with an opportunity to feedback to staff issues around their performance. Staff supervision at Camplehaye was inconsistent and considered by staff to be of limited value. Some staff had received no supervision.

One staff member said they were unable to complete their probation period within the timescale but was not informed why that was. The registered provider said it was clearly demonstrated that they had met with the registered manager on two occasions, which was confirmed by formal letters regarding the extension. One staff member described their only supervision saying, "It lasted five minutes and was between other tasks. I didn't get to put my point across." Another staff said, "The first was five minutes and the second was 10 minutes long. The support is just not there." The provider representative said this shortfall had recently been identified and was being addressed.

The provider was not ensuring staff were receiving appropriate support, training, professional development and appraisal to enable them to carry out their duties. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The Mental Capacity Act (MCA) 2005 provides the 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 is made involving people who know the person well and other professionals, where relevant. Deprivation of Liberty Safeguards (DoLs) provide legal protection for those vulnerable people who are, or may become, deprived of their liberty.

Some staff had a limited understanding of the MCA and DoLS and how they applied this in practice. There was a procedure for assessing people's capacity to make decisions.

Requires improvement

Is the service effective?

The provider had identified that some people's mental capacity assessments were not completed in line with the procedure and that paper work related to mental capacity and best interest decisions would take some time to get into order. However, daily care records and monitoring charts showed people's decisions were listened to, such as regarding the time they went to bed or whether they had a shave. Staff returned later to offer support again if people did not agree to care or declined assistance.

Some arrangements were in place and in use to protect people's legal rights in line with MCA and DoLS. For example, that people had a right to refuse their medication, and that a GP should be involved if there were concerns about the person's capacity to make decisions about their medicines. One person was given their medicines covertly. A letter from their GP indicating a best interest decision had been made about this. The acting manager had protected one person who they believed was unable to consent to a medical procedure by ensuring their capacity to make the decision was assessed in accordance with the principles of the MCA.

Care records did include consideration of individuals' ability to consent to live at the home although no assessments were found of the individuals' capacity to make such a decision themselves. There were capacity assessments in relation to consent to receiving personal care from staff and for the use of bed rails, which had been signed by the person where it was recorded that they had capacity to consent to such care. These people had also signed their care plan, and subsequent care plan reviews in some cases, indicating their involvement. However, in one case where the outcome was that the person did not have capacity to make a decision, records showed consent had been sought from their relative. There was nothing in the care file records to indicate the relative had the legal authority to make decisions on the person's behalf, such as through a lasting power of attorney.

One person was identified during the inspection who was being deprived of their liberty unlawfully. A senior staff member explained in detail how one person had not wanted to come to the home and how they continually wanted to go out. They said, "I explain that if the weather is fine I can let you out." That person's records made clear the person's desire to leave. For example, one entry stated, 'Bags packed again last night, ready to go!' but they had been kept at the home. There had been no application for the person's liberty to be removed, as there must. When we informed the provider representative about this they started that process immediately and also checked to confirm no other immediate applications were required. They found additional applications were required and made two other applications immediately following the inspection visits.

The home had not made any applications to deprive people of their liberty following a Supreme Court judgement on 19 March 2014 which had widened and clarified the definition of deprivation of liberty. The acting manager and provider representative were aware of the judgement and had recognised this should have been done.

The provider had not ensured systems and processes were being used to protect people from deprivation of their liberty. This is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People said, "Good food"; "Good" and "I like the food." There were jugs and cups in each bedroom. When staff asked one person if they were drinking enough, the person replied "No" explaining this was because the drink was not in front of them. This was the case. The person's intake chart indicated staff did not attend at regular intervals to support the person to drink. Another person's intake chart indicated that drinks were not given during the night although the person had their position changed every two hours by staff providing their care. Hot drinks were offered to people throughout the day.

There was a calm organised atmosphere at mealtimes, with staff sitting with some individuals to support them to eat. Staff were observed taking meal trays around the home, with plate covers used and condiments included. People in the dining room chose desserts from a trolley brought in when the main course was finished.

Sandwiches were prepared daily for night staff to offer to people with their bedtime drink or overnight. They told us all the sandwiches prepared for the night before our visit had all gone. People could have a cooked breakfast every day and could have what cooked breakfast they wanted (a 'full' breakfast with mushrooms and hash browns to an

Is the service effective?

omelette). One person had eaten cereal and toast then told the kitchen staff they had not had any breakfast. The cook offered them a cooked breakfast, which the person agreed to and ate.

The main cook planned the menus on a weekly basis and did most of the ordering, with the other cooks able to order other items if they needed them. This included fruit and vegetables, which could be ordered daily. The menu was varied and the cook said she was aware of people's preferences.

Pureed meals were served as separate components (that is, the meat, potatoes and vegetables presented separately and not mixed together). The cook added that gravy was then put on top, or a parsley sauce was used if it was pureed poached fish. When we queried that gravy was always added, the cook replied "Yes, they're all okay with gravy." When we named a person who had told us they did not and never had liked gravy, the cook replied/exclaimed "(The person) has always liked gravy; it could be his taste buds", querying if his condition had changed. That person's weight was a concern and so their dietary intake was important for their well-being.

Where people did not like or want the planned meal, the cook told us the person chose an alternative at the mealtime and it was made for them if staff had not told the cook in advance. The alternative meal was not recorded. This meant an opportunity was missed for identifying what an individual enjoyed eating, which is important particularly when supporting people living with dementia. The acting manager explained the means by which she knew people were receiving an adequate diet. This included feedback at hand over, which we observed taking place.

Staff were not given any guidance on what amount of intake to aim for though they reported at handovers what people had to drink and it was written in their daily notes. One staff member felt that not much action was taken in response to staff observations about low fluid intake or output. Another felt staff were listened to. They said a GP or district nurse would be informed if a person's intake was low and there was some recorded evidence of this. A district nurse said they had no concerns about food or fluids and charts were in place where there were concerns, but sometimes not completed as well as they could be.

Some adaptation of the home environment promoted people's independence. Some bright pictorial signage helped people find their way around, for example, identifying rooms such as toilets, the office and bedrooms. The daily menu was in picture form for the same reason. Some doors were of a bold colour, distinguishing them from adjacent walls. Each part of the interior or the home included hand rails. However, in some parts the rails were only positioned on one side of the corridor. This meant that should a person suffer from stroke and one sided paralysis they would be unable to walk in one direction using the rail. Many people were seen to walk independently around the home.

People benefitted from large enclosed and well-kept garden areas. One person said how they enjoyed visiting the garden and many people's rooms overlooked the area, some with patio doors.

People liked the staff and felt they received good care. Their comments included, "So far I'm well looked after"; "The people who help me are wonderful" and "The treatment of the patients is first class."

Staff involved health care professionals for advice, for example, afternoon bed rest for pressure relief and where staff were concerned about a person not sleeping. Behaviour charts showed staff now offered that person assistance at 10pm, returning later if the person did not want to go to bed then as they had been advised. Staff reminded one person they had a hospital appointment later in the day. Nearer the time, they ensured the person was ready to go out.

People had sight or eye health checks. Senior staff told us the visiting optician had recently begun to label any new spectacles provided, with the individual's name, so that staff could easily identify the owner. The care records of one person included they should be offered chiropody every six weeks. The acting manager said the visit would be written in daily care notes, possibly by the chiropodist themselves. This could not be found at the time but the provider said they were confident the treatment had been provided. Senior staff told us they would act if staff reported issues with a person's nails, contacting a GP if a health problem was noted for example.

Good

Is the service caring?

Our findings

People described the staff as caring and polite. One person said, “The staff ask, they are not bossy.” Another person said, “The people who help me are wonderful.”

The language heard and was recorded in care records was generally appropriate and not disrespectful. However, staff were heard using the term ‘the feeds’ referring to people needing assistance with eating and some staff used the term “darling” rather than addressing the person by their individual name.

We had been informed prior to the inspection that people did not have enough continence products available to them which meant they may have the indignity of being wet and would be at increased risk of skin damage. We were also told that staff would borrow pads from one person to use for another person. During hand over between staff they reported, ‘quite wet’ in the morning for two people. The reporting staff member also commented the incontinence sheet used were not very adequate. The provider representative said that the ordering of the products may well have lapsed but the home always kept additional stock which was available for staff to access and so people’s dignity was not compromised. The provider said the issue was that continence assessments had been carried out on additional people at the home and staff were waiting to hear to the outcome from those assessments. By the beginning of the inspection people’s continence needs were being reviewed by community nurses at staff’s request.

Staff knocked on people’s bedroom doors before entering, greeting the person as they went in and explaining they were leaving when they did so. Staff assisted one person to a dining table and asked if they were “okay” and waited for the person to answer before leaving them. Maintenance workers said, “You knock on the door and tell them what you are doing” to ensure people had the privacy they wanted. When a community nurse came to see someone and found them in the lounge, we heard the activity staff ask if the nurse wished to see them somewhere more private.

A sign reminded staff to keep a door closed to protect people’s personal information kept in the room beyond. Staff were careful to ensure this. Handover was held in the dining room, but away from the door and with discussions taking place quietly.

Staff took their time to engage with people, making eye to eye contact and gestures of friendliness. For example, one person smiled and laughed when they saw the acting manager, who then put their arm around the person and asked if they wanted to move to the lounge. Another staff member explained to a person that their daughter was visiting and then explained which medicine they were giving them. Another staff member greeted everybody in the lounge and invited a person passing through to join in the activities. The activities worker attended each person’s birthday event regardless of which day of the week it occurred.

A district nurse said they had “no issues” about the end of life care provided at Camplehaye. Some staff members were undertaking the “Six steps” palliative care training provided through a hospice. There were many thank you cards from people’s family thanking the staff for the end of life care they provided. Their comments included:

- “The care, patience and kindness you have shown her and my family has been amazing”
- “She was so well looked after”
- “Love and care through good times and difficult times were a great comfort”
- “Thank you for the care and love”
- “Thank you for your care and kindness”
- “Wonderful care and attention”

Requires improvement

Is the service responsive?

Our findings

One person said, “Timing, attitude to individuals. They give all their attention. The treatment of the patients is first class.” One person’s family gave an examples of when they had a concern adding how quickly this was dealt with; “They were as good as gold and got it sorted.”

At a staff handover meeting held before lunch care staff passed information to the senior carer about care they had provided that morning to each person and observations of the person. The senior carer also sought information from staff. Staff who worked 12 hour day shifts told us they received a handover at the start of their shift, and then took part in handovers again halfway through the shift and at the end of their shift to pass on or share information. This aided the monitoring of care so it could be adjusted in a timely way if a person’s needs changed or planned care was not sufficient. Staff reported on information including: personal care given and care declined; creams applied, and skin problems.

Staff were responsive when people needed reassurance. One person, who walked about a lot, was often in the kitchen door and sometimes in a distressed state. Kitchen staff addressed them by name and asked if they would like a cup of tea and a snack, which the person accepted and became more cheerful. People were never ignored.

A district nurse said that some people who needed to spend a lot of time cared for in bed, were repositioned regularly. She said she had no concerns about their care.

Care plans are a tool used to inform and direct staff about people's health and social care needs. Each person at Camplehaye had a care plan. The acting manager said that care plan reviews always included the person themselves and people had signed to confirm they agreed the plan where they were able. Otherwise people’s families were asked to contribute.

Care plans did not always provide the information needed for staff to deliver the care. Care staff appeared to know people’s needs in line with care records but they did not always describe how to meet their needs in line with the care plan. For example, one staff member knew one person could “feel shaky” and was at risk of falling. They explained they encouraged the person to sit down, on a chair kept outside their room so they could sit down quickly, but this information was not included in their care plan. The person’s whereabouts was to be monitored at all times. The staff member said an alarm mat was not used in the person’s room, although the care plan included the use of one. There were other examples.

A district nurse said, “People are always clean.” However, care plans recorded if people preferred a bath or shower and how often but daily care notes did not show they received such support at their preferred frequency.

There were daily activities held at the home; an exercise session, singing and bingo were held in the lounge during our visits. A district nurse felt the home did well with regard to activities for people. When we were with one person in their room, the activities staff came in to speak with them. They explained they were on their rounds, catching up with people who were in their bedrooms. They asked the person, who was now cared for in bed, if they still wanted to read, but the person indicated they did not. The staff then offered to come back later to discuss the forthcoming election, in which the person expressed an interest.

People engaged in group discussions led by the activity staff, on current topics, such as the forthcoming royal birth. However, prior to the arrival of the activities worker the television was on although none of the ten people present appeared to be watching. Staff did not notice this.

Information in care files briefly stated people’s interests or hobbies, such as likes ‘Sport – likes to watch rugby on TV’. Plans included that people were to be encouraged to join activities provided to prevent their isolation, without reference to this information. One person said they were very interested in gardening and their gardening tools were kept near them in their room.

Daily care records infrequently included what activities people were offered or had enjoyed in their spare time. The activities staff kept records of what activities had taken place, naming those who received one-to-one support such as for nail care or outings. Those attending group activities and anyone who had declined to attend or participate were not named. It was therefore not evident if everyone was being given the same opportunity for recreation or stimulating support they enjoyed. The provider representative said there was an individual record form that should be used with care plans, by staff, to record how recreational needs were met, and he presumed staff were unaware of it as it was not being used.

Requires improvement

Is the service responsive?

A wide variety of recreational activities had taken place recently, including: crosswords, a large version of snakes and ladders, quizzes, craftwork, sing-alongs, light exercises to music (which we saw take place with a large group), poetry, baking and nail care. Some people had been on outings, such as to a pub. One person said how much they enjoyed the arm chair exercises and the arts and crafts. The provider representative said the home had participated in a council project for people living with dementia, with resulting craftwork currently displayed in a local library.

We saw people's birthdays were remembered and celebrated, with a home-baked cake.

Faith needs were recorded in their care records and ministers of religion visited regularly, so that people could attend services and celebrate occasions in the Christian calendar such as harvest time or Easter if they wished. The acting manager was not sure whether there was anyone of another faith living at the home.

A complaints policy was displayed in the entrance to the home and available to people through the home's information for people. People said they had no complaints to make.

Formal complaints were investigated in detail and the complainant was provided with the evidence and an outcome within the timescale stated in the policy. Any identified actions were followed through. An example included meeting with senior staff and additional medicine training. The provider representative said it was company policy to use a complaints book from which complaints brought to the attention of the registered manager could be audited. However, they were unable to find the book.

Requires improvement

Is the service well-led?

Our findings

People who were able to comment spoke favourably of the home. Their comments included, "They look after me very well"; "A very high standard" and "I quite like the place." We received this endorsement of the home in March 2015: "It's just a wonderful place to be in; all mum's need catered for; staff are just great. Can't fault the service at all." People unable to comment about the service looked well cared for and contented.

Each month the registered manager was expected by the provider to submit a detailed internal audit of the service. The audit was the means routinely used by the provider to monitor the quality of the service on an on-going basis. In addition there were monthly manager meetings and a daily provider visit to the home although no records of those provider visits.

The registered manager was not in day to day control of the home at the time of this inspection. There was an acting manager in place.

In October 2014 a number of issues were identified by an external financial auditor that warranted further investigation by the provider themselves. Further information then came to light relating to non-financial issues. The provider representative is a registered manager at another of the provider services. The provider instructed them to conduct an in-depth review of the January 2014 internal audit and they found it was not an accurate account. For example, there were care file inaccuracies/ items missing and incomplete staff training records. Following that audit review the provider representative continued their investigation into the service provided at the home at that time.

This inspection started during the provider's investigation into how the service was being run. The provider representative said, "There may still be elements we have not found out." We identified some of those elements during this inspection, for example, a person being deprived of their liberty unlawfully. Concerns we identified were dealt with immediately we fed them back.

Staff did not feel valued or supported at the time of the inspection. One staff member said, "I'm not very trained in this place. I have learned as I've gone along. I'm not sure who to talk to." Another staff said "The support is just not there." Training, supervision and staff support had been identified as requiring immediate attention and the situation was being dealt with, for example, identifying where training had lapsed. Staff meetings were held. The provider representative said they should have been monthly but they were being held three monthly. The previous meeting, chaired by the registered manager, had been December 2014.

Written information for staff was sometimes confusing and inconsistent. For example, the acting manager told us people were asked on admission if they wished to self-administer their medicines but it was the policy not to encourage this in case 'people overdosed'. The service's medicines policy included that people were to be encouraged to self-administer if this was safe, and so a contradiction.

The provider had purchased a new system for recording at the home and was planning its installation prior to this inspection. People were put at risk by the current record management. For example, medicine charts had not been signed as indicated in care records. An assessment of the risk to one person of skin damage showed he was at 'high risk' but this was not reflected in his care plan. A 'Skin intact' prompt had been selected in the care plan, where there was also a 'Skin at risk' option. There was no reference to preventative aids, only 'staff to apply cream'. There were no observations in recent daily care notes about the person's skin safety.

The records relating to a serious accident differed in their account of what actually happened, leaving a possible hazard not dealt with and incorrect information provided to agencies involved. The provider decided to put the new recording system on hold until the current information was accurate and fit to be transferred.

We could not be sure that the Care Quality Commission (CQC) had been notified of all serious events as required. For example, one person's records described them being hit by another person but the CQC had received no notification of this, as they should. The record of a serious fall did not include the full detail of the fall as described in the care record.

The provider did not have effective systems to assess and monitor the quality and safety of the service provided at the home and were not ensuring accurate records were kept in relation to people at the home.

Requires improvement

Is the service well-led?

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

People's views were sought and responded to. There was a yearly feedback survey due again this April 2015. The 2014 survey asked questions including: activities at the home, the overall quality of the service, accommodation and privacy and dignity. Most results were positive but not all, for example, regarding activities. The activities people had requested were now being provided, for example, more physical activities which people had told us they enjoyed.

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 **Regulation 12 (2) (a) (b) (d) (g)** **The provider had not ensured safe care and treatment.**

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 **Regulation 13 (1) (2) (3) (5)** **The provider had not ensured systems and processes were in place to protect people from abuse, including unlawful deprivation of liberty.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 (2) (a) (b)** **The provider was not ensuring staff were receiving appropriate support, training, professional development and appraisal to enable them to carry out their duties.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) The provider did not have effective systems to assess and monitor the quality and safety of the service provided at the home and were not ensuring accurate records were kept in relation to people at the home.

The enforcement action we took:
We have served a warning notice to be met by 31 July 2015.