Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Cams Ridge

7 Charlemont Drive, Cams Hill, Fareham, PO16 8RT

Tel: 01329238156

Date of Inspection: 10 July 2014

Date of Publication: August 2014

We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Meeting nutritional needs	✔ Met this standard
Management of medicines	✖ Action needed
Staffing	✔ Met this standard
Assessing and monitoring the quality of service provision	✔ Met this standard

Details about this location

Registered Provider	Adiemus Care Limited
Registered Manager	Miss Zoe Cummins
Overview of the service	Cams Ridge is a nursing home which provides accommodation and care for up to 46 people, who have a range of nursing needs.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 10 July 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and were accompanied by a specialist advisor.

What people told us and what we found

Thirty three people were using the service on the day of our inspection. We looked at five outcomes during our visit and looked at people's care and welfare, food and nutrition, medication, staffing and quality assurance. We spoke with four people who used the service, three visitors, eight staff and the manager. We used the information to answer the five questions we always ask;

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

This is a summary of what we found-

Is the service safe?
We found that some aspects of the service were not safe because people's assessments and care plans were not detailed enough to ensure their needs were met and the storage of some medical items could put people at risk. We have set compliance actions for the provider to tell us what they are going to do to improve these areas. However, people were cared for by staff who were knowledgeable about their needs and had the skills to provide the support people required.

People who use services would only be deprived of their liberty when this had been authorised by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards. At the time of the inspection, the safeguards were not needed to protect anyone.

Is the service effective?
People told us that they were happy with the care they received and felt their needs had

been met. One person said, "Yes, I don't mind it here". Another person said the home was, "great" and explained staff helped them if they wanted help but did not "push themselves" on them, if they could attend to their own needs. Other quotes included, "I cannot fault it… the care is outstanding", "I am very happy here…the staff are kind". It was clear from what we saw and from speaking with staff that they understood people's care and support needs, which they knew well.

Is the service caring?
We spoke with one person about whether they felt cared about and they confirmed they did. Visitors told us they were happy with the way their relatives were looked after and cared for. One said it was a, "very nice home" and another one said the home was "brilliant" with "very good care".

We observed staff as they supported people around the home and saw they responded to people in a caring way. Staff knew people's needs and cared that they worked in a way which met those needs. Staff spoke about people in a caring way.

Is the service responsive?
People's needs were assessed before they moved into the home. Records confirmed people's preferences were noted and formed part of the care plan. Staff responded to changes in people's health in order to meet their needs.

Is the service well-led?
People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Each month, the provider sent a survey to people who use the service, their friends and families or visiting professionals.

The provider had a system of audit in place. An external company undertook health and safety and fire audits once a year. The provider's compliance officer visited once a month to assess the quality of the service and monitor any improvement needed. Action plans were put in place where they were warranted and the manager followed them up. A senior member of the leadership team ensured the actions had been completed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 22 August 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People's needs were assessed and care plans were in place but these were not person centred and not always up to date. There were arrangements in place to deal with foreseeable emergencies.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with four people who used the service. One person said, "Yes, I don't mind it here". Another person said the home was, "great" and explained staff helped them if they wanted help but did not "push themselves" on them, if they could attend to their own needs. Other quotes included, "I cannot fault it…the care is outstanding", "I am very happy here…the staff are kind". Visitors told us they were happy with the way their relative was looked after and cared for. One said it was a, "very nice home" and another one said the home was "brilliant" with "very good care".

We saw people had a completed pre-admission assessment in their records prior to moving into the home, which was then used to create care plans. Staff were able to describe how they supported people to meet their needs, wishes and preferences. However, people who used the service had complex needs and the assessment and care planning paperwork consisted of tick boxes which meant there was a lack of person-centred detail. For one person, the tick box assessment showed they were disoriented to time and place, but their understanding was good although with poor short term memory. It did not indicate how this had been assessed and what sort of things they may be able to understand.

The care plan format was not written in a person centred way. We saw statements which said, "I would like AO1 with washing and dressing and personal grooming daily". The plan did not show what support the person needed or how they liked to be supported. We saw another person's care plan which stated the person needed the assistance of two staff, was "totally dependent" for all needs, needed assistance to wash and shower, was "co-operative", needed assistance with top and bottom clothing and footwear. The tick boxes did not refer to how this assistance was to be provided. However, we spoke with staff who

were able to tell us how they provided care to people in great detail, which was considerate of peoples' wishes and preferences and in line with their care needs.

Some language used in the care plans and assessments did not respect people. One example was, "[name of person using the service] can be non-compliant at times". Another example was, "Tendency to wander", with tick box options to answer the question. Care plans were not all updated or accurate, for example, one person's ability to stand had deteriorated to a level where they needing a hoist for transferring. Staff told us the person needed a hoist so the person could have been at risk by new or agency staff following the care plan and trying to assist the person to stand. Another example stated the person should have had their oxygen levels taken four times a day. Records showed this did not happen and staff said they did not conduct the tests. The manager told us the care plan needed to be changed as the tests were not needed any more. This meant people were at risk of getting inappropriate care as the care plans were not up to date with their needs.

Care plans did not evidence whether people or their representatives were involved in the care planning process, as they were not signed and there was no record of conversations held. The manager said they did sit with people, where appropriate and discussed their care needs. We spoke with one person who was not aware of their care plan but did say, "Staff know what to do to help me".

The home did not have a specific framework for planning care to meet people's' needs at the end of life. We saw the care plan in use was a "respite support plan", which was used for people staying at the home for a short period of time before going back to their homes in the community. Although staff had tried to complete this to show how care was to be provided, there was not any detail about how to manage the person's pain or how their relatives had been involved in the care planning. This meant people may be at risk of not having their care needs met at end of life.

The home had an emergency call bell system in place and people's call bells were accessible to them in their bedrooms. One person who used the service told us they could have a call bell pendant when sitting in the lounge and did use one when they went into the garden. We saw some people were using the pendants. One person told us, "Staff come quickly when I press the alarm". This meant people could alert staff when they needed support.

We looked at the pressure area risk assessments for three people and found they had been completed and updated each month. The daily monitoring charts showed people received support to change their position to relieve pressure from areas of skin at risk. Pressure relieving mattresses were in place and were checked regularly to ensure that were set correctly. One person had sustained a minor injury and a care plan had been put in place, a body map completed and the wound had been dressed. This meant staff were aware of the importance of maintaining people's skin in a healthy condition.

People who use services were only deprived of their liberty when this had been authorised by the Court of Protection, or by a Supervisory Body under the Deprivation of Liberty Safeguards. The safeguards were not currently in use for anyone living in the home but the manager was aware of how to use them and staff had received training.

There were arrangements in place to deal with foreseeable emergencies. Staff received fire safety training as part of their induction and attended a fire safety course every six months. We spoke with two staff about evacuation procedures and they told us what

action they would take, which the manager confirmed was correct. The provider had systems in place to support the management of an emergency situation, such as the use of mini-buses to move people out of the home if necessary.

Meeting nutritional needs ✓ Met this standard

Food and drink should meet people's individual dietary needs

Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration. People were given a choice of food and drink and were supported to eat where necessary.

Reasons for our judgement

People were provided with a choice of suitable and nutritious food and drink. People who used the service said they were offered a choice of food and confirmed they had plenty of drinks. Throughout the day we saw people had drinks within their reach and were offered a choice of tea, coffee and squash. At lunchtime, people were offered hot or cold drinks with a range of different fruit juices they could choose from. People had been given a choice for lunch and we saw staff responding well to a person who was unclear about their choice and was wanting something different. People could invite their visitors to eat with them if they wished.

The provider undertook a menu satisfaction survey earlier this year which showed people were happy with the food. The results showed people were not aware of the availability of snacks during the day and an action plan was put in place.

People were supported to be able to eat and drink sufficient amounts to meet their needs. We saw staff supporting people to eat in the dining room and saw staff sitting next to a person and explaining what they were doing. We also saw equipment such as plate guards were provided which meant people could continue to eat independently. Where people stayed in bed and needed assistance to eat, we saw they were supported sensitively. They were helped to sit in an upright position so they could swallow safely. People's food and fluid intake was recorded and monitored to ensure they had enough to meet their needs.

Some people had specific nutritional needs, such as special diets or the need for pureed food and we saw people were served their meal accordingly. People who were at risk of choking had been seen by a speech and language therapist and guidance had been put in place. There was guidance in place for people who needed their drinks to be thickened and staff told us how much thickener each person needed. One person was identified as needing a restricted fluid intake due to their physical health. Their records stated staff must always ask the nurse in charge before they gave the person a drink. We spoke with staff who confirmed they did this as they were aware of the importance of the person's needs. This meant the person's needs were met, reducing the risk to their health.

We spoke with the chef who told us about people's individual diets and explained how they

fortified foods to add extra nutrition to meals. They were aware of the needs of people with diabetes and gluten intolerance. This meant people received a diet which met their individual needs.

Management of medicines ✖ Action needed

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was not meeting this standard.

People received their medication as prescribed but not all medical items were stored securely.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with two people who used the service, about medication. They both confirmed they got their medication at the right time.

Medicines were prescribed and given to people appropriately. We observed a member of staff administering medication to people using the service. Staff took medication to one person at a time and signed the Medication Administration Record to confirm the person had taken it. We saw one person was given their medication and left to take it unsupervised by staff. A nurse explained the person was able to make a decision about when they would like to take it. However, the nurse was signing to say it had been taken, but had not observed this. There was not a risk assessment and care plan around how this could be managed safely to ensure the person could remain independent.

Medicines were kept safely and securely. Some medication needed to be stored in a fridge and we found the temperature of the room and the fridge was recorded each day, and were within the necessary range. However, items including an assortment of dressings, needles and syringes and a 'sharps' box for used needles, which were potentially dangerous, were stored in the treatment room which did not have a lock on the door. We brought the risks of this to the manager's attention who agreed to consider it further with regard to people living at the home.

Appropriate arrangements were in place in relation to the recording of medicine. Controlled drugs were recorded in a book and two staff signatures showed the medication was checked and audited correctly. Administration records were completed accurately and included information such as topical creams, allergies and where the amount of medication was variable, the actual amount given was recorded. There was a list of signatures of staff administering medicines which could be checked against initials on the record charts should there be any queries about the administration of a medication.

We looked at records for two people for paracetamol prescribed as 'when needed', (PRN) and found the records did not match the stock. One person's record showed there were 16

unaccounted for, the other person's record showed there were eight more than there should have been. This meant there was not an effective system in place to ensure the PRN medication was managed safely.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were determined by people's assessed needs.

Reasons for our judgement

There were enough qualified, skilled and experienced staff to meet people's needs. The manager explained how staffing levels had been decided, based on dependency levels of people. Currently the manager designed the rota with three nurses on duty between 7am and 8pm, dropping to one or two overnight. There were also eight care staff on duty during the day and three or four at night. The care team was supported by chefs, kitchen assistants, hostesses, maintenance staff, activities co-ordinators, housekeeping and administration staff. This meant people were supported and cared for by staff with clearly defined roles.

The manager told us how they met staffing needs when there was staff sickness and other gaps in the rota. Overtime was offered to staff, which was their choice to accept or not and agencies were used. The manager told us they used the same agency staff, where possible, to ensure consistency. We were shown a folder which showed the manager had ensured the agency staff were appropriately checked and trained. The manager said they used between 33 and 77 hours of agency nurses each week and consequently ensured there were two nurses at night to ensure there was not one nurse who was less familiar with the home, working alone. Day agency care staff were paired with one of the home's own care staff and new agency nurses were offered the opportunity to visit the home before the day they were due to work. We spoke with a regular agency worker who told us they received a detailed hand over each time they worked at the home and staff provided them with a summary of peoples' needs. This meant agency staff were supported in their roles.

Staff told us that they had opportunities to attend training relevant to their role. A registered nurse told us about the training they had received to update clinical skills relevant to their role and the needs of people living in the home. One care worker told us they acted as a "mentor" to all new staff and worked with them until they were assessed as competent to work unsupervised. This meant people were supported by staff who had the necessary skills.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive. People's views were sought and action plans put in place if necessary to improve the service.

Reasons for our judgement

People who use the service, their representatives and staff were asked for their views about their care and treatment and they were acted on. Each month, the provider sent a survey to people who use the service, their friends and families or visiting professionals. The survey had a different focus each month. Recent surveys to people who use the service had included topics such as food and cleanliness. The results were then collated and analysed, with an action plan put in place to address any areas of improvement.

The provider had a system of audit in place. An external company undertook health and safety and fire audits once a year. The provider's compliance officer visited once a month to assess the quality of the service and monitor any improvement needed. Action plans were put in place where they were warranted and the manager followed them up. A senior member of the leadership team ensured the actions had been completed.

The manager undertook a range of audits on a regular basis, including accidents and incidents; falls; pressure sores; complaints and training. This system of review had identified an issue with hoist slings, which was being monitored.

The manager reviewed the call bell records to see how long staff took to answer the bells when they rang. They said if there was an entry which appeared exceptional, they traced it back through the system and found the reason for it, such as staff dealing with an unexpected emergency. We sampled the records and found most call bells were answered within one to five minutes.

The manager said there had not been any complaints about the service. We asked one person and two visitors if they knew how to complain and they thought they would speak to the manager.

There was evidence that learning from incidents took place and appropriate changes were implemented. The manager said they had been undertaking spot checks at night, as part of the quality assurance process. These visits had been put in place following an issue

identified in another care home, which the manager wanted to ensure was not happening at Cams Ridge. The manager told us of another example, whereby there had been a power cut in the neighbourhood, which meant plans had to be put in place to ensure people's needs could still be met. The situation was rectified within a timeframe which meant people did not need to leave the home. The provider subsequently agreed to install a generator, in case this should happen again.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: The registered person was not taking proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe. Regulation 9 (1)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010** **Management of medicines**
	How the regulation was not being met: The registered person was not protecting service users against the risks associated with the unsafe management of medicines. Regulation 13.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 22 August 2014.

CQC should be informed when compliance actions are complete.

This section is primarily information for the provider

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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