

SHC Clemsfold Group Limited

Clemsfold House

Inspection report

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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?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This was an unannounced inspection which took place on 7 and 8 November 2017.

Clemsfold House is a residential care home. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Clemsfold House is registered to accommodate a maximum of 48 people. At this inspection the registered manager told us that they would only provide accommodation to a maximum of 31 people due to part of the building not being in use and changing the rooms to single occupancy. The provider had not taken action to ensure that their registration information reflected the service they provided. This had not been identified by the quality monitoring systems in place. The registered manager told us that all but one person was living with dementia or impaired memory.

We carried out an unannounced comprehensive inspection of this service on 15 and 18 November 2016 where it was awarded an overall rating of 'Good' and rated as 'Good' in all domains.

The home was not due for another comprehensive inspection however the registered manager notified us of two events that had occurred. One of these related to a person who fell and required hospital admission for treatment. The information supplied led us to review our inspection plans and we decided to bring this comprehensive inspection forward.

Since our last inspection of Clemsfold House, services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. Clemsfold House had been the subject of one safeguarding concern about a person sustaining a serious injury following a fall. Our inspection did not examine specific incidents and safeguarding allegations which have formed part of these investigations. However, we used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Since May 2017, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

During our inspection the registered manager was present. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Quality assurance processes were in place that included regular audits of the service by the registered manager and representatives of the provider. These had not identified the failings we found at this inspection. Within the quality audits that had taken place it had been identified that mental capacity assessments for people were not decision specific. It was recorded that this had been acted upon and addressed. However, four people's assessments that we looked at were still not decision specific. Prior to

the inspection the registered manager had notified us of events including potential safeguarding matters in line with her legal responsibilities. However, at the inspection, despite people telling us that they felt safe, we identified two instances where a service user who lived at the home had assaulted other service users.. These had not been reported to the local authority safeguarding team. This would have enabled an independent investigation of the incidents to ensure people living at the home were cared for safely. This had not been identified within the quality monitoring systems in place at the home.

People's records were not always accurate and in parts contained conflicting information. As a result, there was a risk that people would receive care that was not appropriate or in line with their needs and wishes. Again, this had not been identified within the quality monitoring systems in place at the home.

There was a system for reviewing accidents and incidents to prevent or minimise re-occurrence and to learn from mistakes. The registered manager had sought advice from a GP when people fell and reviewed their risk assessments and care plans, but referrals to other relevant specialists had not taken place in line with the provider's policy. As a result, full and robust action had not been taken to reduce the risks associated with falls.

The provider had shared learning from safeguarding situations at other homes they operated and the registered manager had used this to review aspects of service provision at Clemsfold House. However, the evidence at this inspection confirmed that the provider had not fully embedded or sustained learning as a result of feedback and situations that had occurred at other locations they operated.

There were sufficient numbers of staff on duty to meet people's needs. Training had been provided to staff that included equality and diversity and dementia awareness. But at times there was limited interaction with people who lived with dementia as staff focused on tasks and missed opportunities to involve or communicate with people. There were dedicated activity staff employed and an activity programme in place but care staff at times did not provide stimulation for people they were supporting. Efforts had been made to make the environment homely and suitable for people but there were aspects that would benefit from further attention. We have recommended further development based on current best practice guidance for people living with dementia.

Equality, diversity and Human Rights (EDHR) featured as core principles within the provider's policies, procedures and mission statement. The registered manager and staff demonstrated understanding of these. Some information had been provided in suitable formats for people in order that they could communicate and be involved in making decisions about their care. Development of this would enhance people's rights further. We identified that the service had not consistently applied the Mental Capacity Act 2005 Code of Practice in order to ensure that people's rights to consent and decision-making were protected.

People said that they enjoyed the meals that were provided. However, some people did not receive consistent personalised support to eat their meals.

People said that they were happy with the support they received to manage specific health needs. There were clear lines of communication with GP's and district nurses who visited the home that helped to ensure people's health needs were responded to. People's nutritional and dietary needs were met. Medicines were managed safely and effective infection control measures were in place.

Staff said that they were fully supported and everyone spoke highly of the registered manager. The registered manager demonstrated an open and honest demeanour and it was apparent that she had a high visible presence in the home. People said that they were treated with kindness by staff who understood their needs and respected their privacy. There were systems in place to support people to raise concerns.

Relatives said that they were made welcome whenever they visited.

There were regular meetings between representatives of the provider and the various departments within the organisation in order information could be shared and the provider could retain oversight of the company. The provider had made a public commitment to work with outside agencies with the aim of improving service delivery.

At this inspection, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Aspects of the service were not safe.

Systems, processes and practices did not always safeguard people from abuse.

Risks to people were assessed in order to keep them safe but falls prevention procedures were not followed in full.

Systems were in place so that lessons were learned and improvements made when things went wrong. These needed to be embedded further to promote safe care.

A dependency assessment tool was used to decide safe staffing levels. The deployment of staff would benefit from review to promote personalised care.

Safe medicines processes and procedures were followed.

People were protected from infection due to safe control measures.

Requires Improvement ●

Is the service effective?

Aspects of the service were not effective.

People's needs and choices were assessed and care, treatment and support delivered. Further development of personalised dementia care based on current best practice guidance would enhance people's lives.

Efforts had been made to ensure people's individual needs were met by the adaptation, design and decoration of premises. Further development of this would promote personalised care.

Consent to care and treatment was not always sought in line with legislation and guidance. Understanding and adherence to the Mental Capacity Act Code of Practice was not consistently applied to protect people's rights.

Systems were in place to ensure staff had the skills, knowledge and experience to deliver effective care and support.

Requires Improvement ●

People were supported to eat and drink enough to maintain a balanced diet.

Systems were in place to help staff within and across different organisations work together to deliver effective care.

People were supported to live healthier lives and had access to healthcare services and on-going healthcare support.

Is the service caring?

Aspects of the service were not caring.

People said that they were treated with kindness, respect and compassion. However, staff practice was not consistent and at times task focused.

People were supported to express their views and be involved in making decisions about their care, support and treatment as far as possible.

People's privacy, dignity and independence were respected and promoted.

Requires Improvement ●

Is the service responsive?

Aspects of the service were not responsive.

People did not always receive care that was responsive to their individual needs.

People said that their concerns and complaints were listened and responded to.

Procedures were in place to ensure people were supported at the end of their life to have a comfortable, dignified and pain-free death.

Requires Improvement ●

Is the service well-led?

Aspects of the service were not well led.

The governance framework had not ensured that quality performance, risks and regulatory requirements were understood and managed.

Systems were in place to support continuous learning, improvement and to ensure sustainability. However, these were not fully embedded.

Requires Improvement ●

The provider had policies and procedures, vision and mission statements and a strategy to deliver high-quality care and support, and promote a positive culture that was person-centred, open, inclusive and empowering.

Systems were in place to support engagement with people who use the service, the public and staff.

The provider has been working with other agencies with the aim of improving service delivery.

Clemsfold House

Detailed findings

Background to this inspection

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

The inspection was prompted in part by notification of two incidents. One in which a person using the service died and a second where a person sustained a serious injury as a result of a fall. The information shared with CQC about the incidents indicated potential concerns about the management of risk of falls. This inspection examined those risks. These events were brought to the attention of the Police and West Sussex County Council (WSCC). Whilst we were at the inspection the registered manager received information from WSCC and was informed that no further action was being taken by the police or the local authority regarding the death which was not deemed to be suspicious.

The inspection plan was informed, in part, by partner agencies notifying CQC of a safeguarding concern about this location related to a person who sustained a serious injury following a fall. A number of safeguarding and quality concerns in relation to the provider, Sussex Health Care, are the subject of a police investigation and safeguarding enquiries although only one safeguarding concern related to Clemsfold House and has since been closed. As a result this inspection did not examine the circumstances of the specific allegations made about the registered provider. However, the information of concern shared with the indicated potential concerns about management of falls and response to incidents. Therefore we examined those risks in detail as part of this inspection.

This inspection took place on 7 and 8 November 2017 and was unannounced. The inspection team consisted of two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise included dementia care.

Prior to the inspection we reviewed the information we held about the home. This included information from other agencies and statutory notifications sent to us by the registered manager about events that had occurred at the service. A notification is information about important events which the provider is required

to tell us about by law. We used all this information to decide which areas to focus on during our inspection. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home, three visitors, the registered manager, the area manager, three care staff, an activity person and the chef.

The majority of people who lived at the home could not tell us directly about their views of the service they received due to their advanced conditions and communication difficulties. In order to obtain their views and experiences we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon. We also observed a member of staff giving people their medicines.

We reviewed a range of records about people's care and how the home was managed. These included four people's care records and medicine records. We also looked at four permanent staff training, support and employment records, two agency staff profiles, audits, minutes of meetings with people and staff, menus, policies and procedures and accident and incident reports. We also requested additional information after our visit to the home and this was supplied. We also contacted four health and social care professionals to obtain their views on the service provided to people. All four responded and agreed for their views to be included in this report.

Is the service safe?

Our findings

People said that they felt safe. One person said, "I am safe in here. It is better than me staying at home where I can't look after myself." A relative said, "Yes my dad is safe because people are around him and the security at the doors is good." A second relative said, "I am happy with the safety procedure, which is why I say my dad is safe in here." An external professional wrote and informed us, 'I have found, or seen, no reason to believe the service supplied is unsafe.' Despite these positive comments, we found areas of practice that required improvement.

The registered manager did not always take appropriate action in the event of possible safeguarding concerns and this may have placed people at risk of unsafe care. Prior to our inspection the registered manager had submitted statutory notifications to us in line with her legal responsibilities when incidents occurred that had the potential to place people at risk of harm. However, during the inspection we found two instances where a service user who lived at the home had assaulted other service users and this had not been acted upon in full. The local authority safeguarding team had not been made aware of the incidents and people and their legal representatives had not been made aware of their rights to refer the matters to the police. As a result, people's legal rights had not been upheld and systems, processes and practices had not safeguarded people from abuse. When we drew these to the registered manager's attention she immediately notified the local authority safeguarding adults team and submitted the relevant statutory notifications to CQC.

Other locations operated by the provider have been subject to safeguarding investigations, some of which were on-going at the time of this inspection. We spoke with the registered manager and the area manager about any changes that had occurred or shared learning that had taken place at the home as a result of these. We were shown a 'Senior Management Communication' folder. This contained communication from representatives of the provider to managers within the organisation including the registered manager of Clemsfold House. This confirmed that a new head injury pathway was introduced during September 2017 at Clemsfold House along with good practice guidance about the use and recording of prescribed creams and lotions. Also during June 2017 a new safeguarding tool was introduced to help ensure all relevant agencies and documentation was completed when concerns were raised. The area manager confirmed that all of these had been introduced as a direct result of learning from other safeguarding situations. The introduction of the new safeguarding tool was not effective at Clemsfold House as two incidents of potential assault had not been reported to the relevant agencies. We have reported on this further in the 'Well Led' section of this report.

The provider failed to ensure systems and processes enabled appropriate investigation of potential safeguarding issues, which placed people at risk of abuse. This was a breach of Regulation 13 of the Health and Social Care Act 2014.

Staff we spoke with confirmed they had completed training in safeguarding. One staff member said, "You have to protect vulnerable adults, make sure they are safe and everything". They added that they would report any concerns to the registered manager, but had never been involved in any safeguarding related

issues. A second member of staff said, "I would report immediately to the manager. There must be an investigation. You must not promise people to keep things quiet, to yourself. Concerns must be investigated. Can go higher if needed to area manager or CQC."

People said that they were satisfied with the arrangements in place to safeguard their personal property. One person said, "My property is safe and staff take care of them." A relative said, "I have never had any reason to complain about dad's property."

Inventories of people's personal items and possessions were completed on admission but were not routinely being reviewed and updated. For example, one person's inventory was last amended in 2011. Another person's was updated in September 2016. The registered manager confirmed that inventories were completed when people first moved into the home. She said that people were advised to store items of value in the home's safe but that some relatives did not inform staff when bringing or removing items and therefore this caused difficulties in terms of accurate inventories. The provider's policy did not state a frequency for reviewing inventories. However the registered manager agreed that this should be reviewed in order that processes and practices offered further protection of people's personal possessions.

Incidents and accidents were reviewed on an individual basis in order that actions were taken to reduce risks to people. In addition to this, information about events was collated on a monthly basis and reviewed by an area manager. A report was then submitted to representatives of the provider. Prior to our inspection the registered manager had notified us of a person who was admitted to hospital following a fall which occurred whilst care staff were receiving a handover in the office. When we requested further information regarding the person we were informed that the person had fallen 10 times in the previous 12 months. The registered manager had sought advice each time the person fell including arranging for the person to be seen by a GP and having their medicines reviewed by a psychiatrist. However, they had not requested that a referral be made to an Occupational Therapist (OT) or to the Falls Prevention Team. This was not in line with the provider's policy and had not been identified within the monthly reviews until September 2017. At the inspection the registered manager informed us and records confirmed, that procedures had been reviewed in order that lessons were learnt and improvements made. A member of care staff now had to maintain a presence in communal areas when handover was taking place and the area manager had reviewed and amended procedures so that referrals to the Fall Prevention Team took place for anyone who had experienced two falls.

Another person's falls risk assessment was reviewed three monthly and instructed staff to ensure the person wore suitable footwear to help reduce the risk of tripping. This intervention was observed to be in place during our inspection. Due to the number of falls this person had sustained they were on increased monitoring. From 6 January 2017 to 26 August 2017 they had fallen seven times. Each time medical advice was sought. The registered manager explained, "We have to do this each time as we are not a nursing home and are not qualified to make decisions." Records confirmed that improvements had taken place in ensuring referrals took place when people fell. On 5 October 2017, as a result of continuing to be unsteady on their feet the registered manager requested that the GP make a referral to the falls prevention team. Whilst waiting for this the person fell again and the registered manager again asked for a referral. At the time of this inspection the person was still waiting to be seen by the falls prevention team. No other action had been taken in order to attempt to minimize the risk of falling. The registered manager had not sought advice from other professionals despite the provider employing their own physiotherapist and their policy stating advice would be sought.

The provider's falls prevention policy stated that all staff would be provided with falls prevention training. At the time of inspection six staff had completed this and arrangements had been made for the remainder to

complete this on 28 November 2017.

We observed three members of staff assist a person to transfer from a lounge chair to a wheelchair. Two of the staff stood either side of the person and each placed an arm under the person's arm whilst the third staff member manoeuvred the wheelchair once the person was in a standing position. Although the person did not appear distressed it was apparent that it caused some difficulty to assist the person due to the numbers of staff in a small area. No equipment was used and none was referenced in the person's moving and handling assessment. We discussed this with the registered manager who agreed that an assessment by a suitably qualified person should be undertaken to ensure the support given was safe.

The provider failed to do all that was reasonably practicable to mitigate risks associated with falls. This was a breach of Regulation 12 of the Health and Social Care Act 2014.

Systems were in place to decide safe staffing levels. The registered manager told us that the Northwick Park dependency scale was used to decide safe staffing levels and that this calculated a care staff to resident ratio of one to five during the day and one to 10 at night. The registered manager told us that six staff were on duty during the morning, five care staff during the afternoon and, at night, three waking staff were on duty. Additional staff working at the home included activities staff, housekeeping and catering staff. We were told there were currently five vacancies for senior care staff and four vacancies for care staff, although two offers had been made to potential new staff. Bank staff would cover any gaps in staffing levels where possible, otherwise the same agency staff were used for consistency. The registered manager said, "We always have one agency at night. We always try and have the same people." We were told that all agency staff underwent an induction process and records confirmed this. When asked if they felt staffing levels were sufficient, one member of care staff said, "If someone is off sick, they will call the agency." A second member of staff said, "We manage because we are not full. My manager is very supportive. Like if short of staff she comes and helps us. Covers on the floor."

On the first day of inspection staffing levels reflected those described by the registered manager. On the second day, staffing levels were reduced as there was no activity person on shift as they were on annual leave and a member of care staff had called in sick that morning. We were informed that agency staff could not be sourced to cover the care shift and that additional staff were not routinely arranged to cover when activity staff were on planned leave. We did observe that the deputy manager and the registered manager spent time with people providing care and support and in the main people's needs were met. However, it was noted that although staff appeared dedicated most interactions were task based. On both days of inspection minimal activities took place and during the lunchtime period the deployment of staff did not promote effective care.

It is recommended that the provider reviews the deployment of staff in order to promote personalised quality care.

There was evidence to show that other risks to people's wellbeing and safety were identified and assessed. One person told us how they had their freedom and that they could walk by themselves but were overseen by care staff due to a medical condition that affected their mobility. They said that they were happy with this arrangement and felt that the balance between safety and freedom was appropriate.

We saw risk assessments in relation to skin integrity and mobility. Waterlow charts had been completed for people where needed. Waterlow is a tool that assesses people's risk of developing pressure areas or ulcers. People's care plans and risk assessments for management of developing pressure ulcers included the equipment that was required to protect their skin integrity such as a special mattress and pro-pad cushion.

The assessments also stated that, 'Moisturisers to be applied daily and barrier cream. Any sign of skin breakdown should be reported to the GP immediately'. There was no further information as to what staff should look for and how to identify the signs for skin breakdown. Although this level of detail was not recorded we found no evidence of impact on people. Records confirmed that the district nurses visited the home on a regular basis and the number of people with pressure areas that required their intervention was low.

Another person had a risk assessment for nutritional intake which placed them at high risk. A range of actions were in place including encouraging fortified meals and drinks, weighing monthly and encouraging choice. The assessment also considered the person as an individual as it included information about their mental status and encouraging a positive body image. Records confirmed that the person had sustained a stable weight which demonstrated that the person's needs were being met safely in this area.

Systems were in place to ensure safe medicines management. On the first day of our inspection, we observed medicines being administered to people in the dining room and to people who stayed in their bedrooms. Two medicines trollies were wheeled into the dining room. When we checked, whilst the doors to these trollies had been closed, they had not been locked and had been left unattended. This meant that anyone could have accessed the medicines or supplements housed within. On the second day of inspection we observed that the medicine trollies were locked when left unattended.

We observed the administration of medicines by the deputy manager, who wore a red tabard to denote he should not be disturbed. The deputy manager checked with people whether they had any pain and would like analgesia. Where medicines were administered, people had a cold drink to hand and were given time to swallow their medicines.

The medicines administration records (MAR) we looked at had been completed accurately. However, whilst one MAR for a person recorded their allergy to penicillin, this had not been noted in the person's medication profile in a way to alert staff, nor was it noted in this person's care plan, although the information was recorded in their hospital passport. We have reported on this further in the 'Well Led' section of this report. Where medicines were administered to people on an 'as required' basis, the outcome of each administration had been appropriately recorded on the reverse of their MAR.

Medicines had been stored and disposed of as needed. Dates had been recorded on topical creams and on eye drops to show when they had been opened. The deputy manager told us that all unwanted or unused medicines were disposed of every 28 days when new medicines were ordered. No-one living at Clemsfold House administered their own medicines and no-one had their medicines given covertly, that is, without their knowledge.

Infection control promoted a safe and clean environment. The home was clean and free from offensive odours. Separate domestic staff were employed and regular cleaning took place. We observed that when people were assisted to use bathrooms and toilets the facilities were cleaned after use. Relevant policies and procedures were in place and staff had received infection control training. Three monthly infection control audits were completed. The latest one of these took place during September 2017 and no issues requiring action were identified. The kitchen was awarded a five star food hygiene rating in February 2017 from the Environmental Health Department.

Appropriate recruitment checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This check helps to ensure staff are safe to work with people who use care and support services. There were also copies of other relevant

documentation, including employment history and references, job descriptions and identification evidence to show that staff were suitable to work in the home. Profiles were also in place for agency staff that confirmed they also had the required checks completed on their suitability to care for people.

Checks on the environment and equipment were completed to ensure it was safe. These included equipment used to help people to transfer and fire safety equipment. An emergency contingency plan was in place that gave staff information of the action to take in emergency situations that included fire and floods. This meant the provider had plans in place to reduce risks to people who used the service in the event of emergency or untoward events. Staff understood the procedures that should be followed in the event of an incident or accident. They were able to explain first aid procedures, fire safety processes and accident reporting. Personal Emergency Evacuation Plans (PEEP) were in place that gave instructions to staff on how to safely support people to leave the building if there was a fire. As a result, people would receive safe support in emergency situations.

Is the service effective?

Our findings

People said that they agreed with the care provided. We observed that when people declined assistance staff respected their wishes. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Nine DoLS applications had been authorised at the time of our inspection.

The registered manager had completed a mental capacity assessment dated 17 July 2017 and concluded that the person did have capacity to make decisions relating to their care and treatment. Nevertheless, an application had been made to the local authority to deprive this person of their liberty under Deprivation of Liberty Safeguards (DoLS) legislation. The local authority did not agree that this person should be deprived of their liberty and it was not authorised. People should only be deprived of their liberty where it is assessed they lack capacity. In this person's case, despite the fact that they had been assessed by the registered manager as having capacity to make decisions in relation to their care and treatment, a DoLS application had still been made. The registered manager confirmed that she had made the application in error.

Three people had mental capacity assessments dated 17 July 2017 that were not decision specific as they each stated they were unable to make decisions relating to their 'care and welfare, personal safety, accommodation, medication, DNAR and finances.' This was not in line with the MCA Code of Practice which states assessments should be decision specific. For one of these people, the mental capacity assessment was also inaccurate as it stated the person did not have the mental capacity to make decisions about resuscitation but other records stated that a DNAR was not in place as the person had requested to be resuscitated and a conversation about this had taken place with the involvement of the registered manager and the person's GP. The need to review and update mental capacity assessments to ensure they were decision specific had been identified within an internal audit conducted during September 2017. However, the same audit stated that this action had been completed when we identified that further improvements were required in this area. We have reported on this further in the 'Well Led' section of this report.

The provider and staff had not ensured that they acted in accordance with the Mental Capacity Act 2005 and its code of practice in order to protect people's rights and ensure lawful consent. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with confirmed they had completed training on mental capacity. One staff member explained, "It's to protect and empower individuals who lack capacity to decide for themselves. Simple

choices and decisions, like what to wear, but bigger decisions have to be made through best interest meetings. You should consider people's rights and choices". When asked, the staff member could not remember if they had completed training on equality or diversity or in understanding people's human rights. Records stated that all staff undertook training on equality and diversity during their induction when first employed by the provider.

Equality and people's human rights were considered within the provider's best interest procedure. This asked people involved in making best interest decisions to consider 'any values and any religious, cultural or spiritual beliefs that the service user is known to have.' The registered manager had sought written confirmation from people who had Lasting Power of Attorney for health and welfare or financial matters issued by the Office of the Public guardian to ensure people had the legal right to act on behalf of individuals. Where this had been granted, appropriate documentation was in place.

Efforts had been made to ensure the adaptations and decoration of the premises met people's diverse needs. Clemsfold House caters for people with a range of needs, including people living with dementia. Chairs in the lounges were arranged in small clusters that encouraged conversations between people. Some signage was in use, for example, people's names were written on signs affixed to their bedroom doors; other signs denoted toilets, shower rooms or bathrooms. However, opportunities had been missed to provide a dementia friendly environment to support people to orientate themselves around the home. There were very few objects of interest around the home to offer further simulation for people who lived with dementia. The provision of these would allow people who lived with dementia to have stimulation without the need of staff support.

There were two enclosed garden courtyards at the centre of the home but both were locked and one had a sofa placed in front of the doors. A member of staff told us that the one area was not used and that people could access the other with a member of the activity staff. We were told the risks of people going outside were too great to allow unrestricted access. This had not been included in peoples' individual risk assessments and this blanket approach did not promote personalised dementia care.

It is recommended that the registered person researches and implements changes to ensure a more dementia friendly environment.

People expressed satisfaction with the meals provided. One person said, "The food is very nice." A second person said of their lunch on the second day of inspection, "It's a good one, very tasty." A relative said that whenever they visited they noted that there was always a choice of nutritious meal options. A second relative said, "The food generally is excellent."

People's nutrition and hydration needs were met effectively. Where people had been identified as being at risk of losing weight, supplements and fortified drinks were prescribed and people's weights were regularly monitored. The chef was knowledgeable about the individual needs of people including specialist dietary requirements and personal preferences. Records were maintained in the kitchen of people's specific needs including food allergies and textured meal requirements. The chef understood about nutritional risks associated with aging and for people living with dementia. As such, a range of products were used to fortify food and drinks including the use of full fat milk, butter and fresh cream. Some people were served their meals on red plates as the colour contrast was thought to help stimulate eating. During the morning and afternoon we observed that people were provided with a choice of drinks and snacks. People appeared to particularly enjoy the homemade lemon cake that the chef had baked.

On the first day of inspection we observed people eating their lunch in the dining room and despite five care

staff being present, people sitting at tables were not all served their meal at the same time. This meant that some people had finished their main course before others had received theirs. One person started to eat their food in the hole with their fingers and we had to intervene. Once their food was cut up and they were given cutlery the person was then able to eat independently. We saw that three people had chosen to eat their lunchtime meal in the sitting room; however, no member of staff was present to assist people. These people had left their meals with the majority of food on their plates left untouched. Despite this, records confirmed that in the main people's weights were being maintained. This gave us assurances that risk of malnutrition was being managed. However this did not ensure a person-centred approach to meal times.

On the second day of inspection we again observed the lunchtime experience. Although there were less staff on duty we observed that the majority of people had a better experience than the first day. People received support to eat when needed by staff who sat with them and offered words of encouragement when needed. A member of staff noticed when one person was not eating their lunch. The member of staff offered to get more gravy and once this was provided the person was seen smiling and ate all their meal. Where needed, people were supported to put food on their forks and spoons, to cut items of food up or given full assistance to eat depending on their individual needs. We did note that one member of staff stopped assisting a person to eat and instructed another member of staff to continue to do this. This resulted in the remaining staff member having to support two people to eat at the same time; they alternated placing spoonfuls of food into each person's mouth which did not promote personalised care. The member of staff who had stopped assisting a person to eat was seen clearing plates which could have been left until later.

When giving feedback to the registered manager she acknowledged that the lunchtime experience we observed on our first day was not appropriate. She said that staff had been flustered by our presence.

People expressed satisfaction with the staff who supported them and said that their needs were met. One person said, "Yes my needs are met. Staff are very good and they do know what I need."

Person centred assessment and care planning processes were in place in order that information could be obtained to provide effective care to people living with dementia. People's assessments and care plans included information about their personal history, interests and past employment, family life and likes and dislikes. Staff told us that this information helped them to start conversations with people and to provide care and support that reflected people's preferences. However, we did not see this applied in everyone's practice during the inspection. The assessment and care planning processes also included an osteoporosis management assessment that followed the National Institute of Clinical Excellence (NICE) quality standards published April 2017. The NICE quality standards are a nationally recognised framework that can be used to consider options for prevention and treatment.

The assessment processes in place at the home considered people's physical, mental health and social needs in order that people received effective support and were not discriminated against. It also considered certain protected characteristics as defined under the Equality Act. For example, religious status and disability. We did note that one person who lived at the home had a sensory impairment. A lot of information was recorded in the person's care records about their sensory impairment. For example, their care plan gave detailed information about aids to support their sensory loss, how to fit these and where staff should position themselves when communicating with the person. However some documentation and some of the information shared by staff was conflicting. We discussed this with the registered manager who was unable to confirm the legal status of the person's disability but agreed to clarify this in order that the person's rights were not compromised.

Staff said that they were fully supported to undertake their roles and responsibilities. They received one to

one supervision as well as group supervision and an annual appraisal. One member of staff said, "The manager, she explores my knowledge and provides training which is beneficial to me. I can ask her for advice. I have the support of my colleagues as well." One staff member told us about their induction when they commenced employment at Clemsfold House. They said, "I had all the training and everything – dementia, medicines, fire training, safeguarding, infection control and management of substances that might be hazardous to health (CoSHH)." This staff member said they had supervisions, "Every month or two" and that staff meetings were held approximately every six months.

Another member of staff told us that they had just completed fire safety training, which was mandatory. Other training considered essential to their role had also been completed including moving and handling, safeguarding, infection control and e-learning in challenging behaviour, learning disability and CoSHH. We asked both staff members if they had completed training on dementia and both confirmed that they had. One staff member commented that this had been a few years ago and was about dementia as a whole, rather than focussing on specific kinds of dementia. This staff member also told us they had not completed training in relation to specific health conditions, for example, Parkinson's disease, but that their understanding of health conditions had been gained in their previous employment outside of the UK.

New staff undertook a 12-week induction programme at the start of their employment which followed the Care Certificate. The Care Certificate is a nationally recognised set of standards that health and social care workers should adhere to in order to deliver caring, compassionate and quality care. A training programme was in place to ensure staff knowledge was current. Training was provided during induction that included fire safety, moving and handling, health and safety and equality and diversity. Dementia awareness training was provided for all staff as part of the induction they completed when first employed. Despite being provided with this staff understanding and practice varied. When asked to give an example of good dementia care one member of staff said, "Make sure they are safe. That they are taken care of, safe, not going out. That they have all the care they need and give a lot of patience as they have challenging behaviours. For example, at lunch one ordered chicken but then said didn't like so we had to explain to her she requested this and offered alternative." A second member of staff said, "Dementia can affect memory. Gradually lose brain cells. People may be able to remember things from long time ago such as when they were at school but might not remember what they ate that day. So we do activities around memory and what's important in their world to give a good quality life." The registered manager responded promptly to our feedback on the first day of inspection about the variance in staff knowledge and practice and arranged further dementia awareness training for staff to attend on 23 November 2017.

Whilst the service recruited new staff to fill existing vacancies, they used bank or agency staff to ensure sufficient staffing levels were maintained at all times. We were told by the staff and registered manager that they endeavoured to use the same agency staff who were familiar with people's care needs. We were told that all agency staff underwent an induction process to ensure they understood how to undertake their care responsibilities at Clemsfold House.

Of the 31 staff employed at the home, 19 had obtained either a National Vocational Qualification (NVQ) or Qualification and Credit Framework (QCF) levels 2 to 4. These are nationally recognised work based qualifications.

The registered manager had recently introduced competency assessments for moving and handling that included observing staff members supporting people to move. This demonstrated a commitment by the registered manager to ensure staff continually provided effective moving and handling care.

The relatives of three people told us that they were happy with the support their family members received to

manage specific health needs. They said that their family members had access to a GP and other professionals. One external professional wrote and informed us, 'Any doctor's action or continued treatment that I have suggested has always been acted upon swiftly.'

Records were maintained of the Community District Nursing team's involvement with people who lived at the home in order that specific nursing needs were managed effectively. Records confirmed that people received support from district nurses for areas that included wound management, catheter care and blood tests. In addition to the district nurses maintaining their own records the registered manager maintained a separate book specifically for communicating new or on-going treatment provided. The registered manager explained that this helped when different district nurses visited the home and also staff in the home who may not have been on shift for a while. In addition to this, there was an arrangement in place where a GP visited the home twice a week in order to provide consistent advice and support to people. A separate record was maintained of these visits that could be used to monitor that the agreed actions were being undertaken by all parties. As part of the GP routine visits everyone living at the home had a medicine review in March 2017. Care plans recorded the involvement of other healthcare professionals such as opticians, dentists and chiropodists.

Care plans that we looked at included hospital passports which provided information about people's care and support needs should they need to be admitted to hospital in an emergency. Each hospital passport included a medical history, communication, eating and drinking, medicines, sight and hearing, how the person wished to be supported, behaviour, safety, attitude to medical interventions, things that were important to the person and their likes and dislikes. We did note that one person's hospital passport did not contain information about particular health conditions and allergies that were referenced in their care plan. The need to review hospital passports had been identified within an internal audit by the area manager conducted in September 2017.

Is the service caring?

Our findings

People said that staff were kind and respectful. One person pointed to a member of staff and said, "She's nice. I like her." Relatives also said that staff were compassionate and took the time to get to know their family members. One external professional wrote and informed us, 'I have known (registered manager) for several years and to the best of my knowledge she is and always has been a good leader, treating the residents with kindness and understanding and is respected by the residents, their relatives and staff alike.' A second professional wrote, 'I have no reason to believe the service to the residents is not a caring one, as I have seen no evidence to the contrary.'

Although we observed some good examples of caring practice by staff, this approach was not always consistent. Our observations of staff interactions were variable depending on the member of staff and time of day. This did not ensure that people felt consistently cared for and well-supported. This was an area that required further improvement

We observed that people appeared happy in the presence of staff but that the interactions by staff varied. On both days of inspection some staff were seen sitting with people, holding their hands and having conversations. One person was observed to enjoy hugging staff and it was clear the person enjoyed this contact. However, on the first day of inspection we observed two people were largely left alone from 10.25am until lunch was served around 1pm. The only interaction these two people received from staff was in relation to morning drinks and biscuits being served. Yet at lunchtime, when staff were observed chatting with these two people, they appeared engaged, happy and animated. Therefore it was clear that these individuals would have benefitted from positive interactions with staff throughout their day.

Staff asked people whether they would like a drink and a biscuit and how many sugars they might want in their drink. Conversations were limited and brief and related only to the task of offering refreshments. We saw one person was talking to themselves quite animatedly. A member of staff came up to them, said, "You all right?" then, without waiting for a response walked away. On other occasions staff waited for people's responses and acted upon these. For example, a member of staff was heard asking a person if they required assistance to cut up chicken at lunchtime. The person replied "Yes" and the member of staff promptly did this for them.

On the second day of inspection one member of staff demonstrated particular skill when supporting one person to eat and it was clear that they understood the individual needs of the person. Before this person was supported by this particular member of staff another staff member had been placing food on a spoon and then placing this in the person's mouth. The person had their eyes closed and as the member of staff did not speak to the person it caused them to jump when they felt the spoon being placed in their mouth. When the second member of staff gave assistance their approach was completely different. They sat next to the person and were heard explaining to them about the support they were giving. Instead of feeding the person they placed the person's hand on the spoon and then placed their own hand on top and helped to guide the spoon to the food and then to the person's mouth, all of the time explaining and offering words of encouragement. It took a lot longer for the person to eat but the member of staff was patient and attentive

and we saw that the person became more alert to the point that in the end they were able to load their spoon and feed themselves which promoted their dignity and independence.

We asked one staff member about how they treated people in relation to understanding people's individuality. They talked about delivering personal care to people and how some people preferred to be looked after by female staff. They said, "Dementia can make people behave differently." We asked another member of staff whether they felt they had time to sit and chat with people. They told us, "Yes. We ask them what they need like clothes and ask families. We ask them what they want to eat. People's food preferences are listened to."

People were supported to maintain relationships that were important to them. One person said, "My family visit anytime." A relative said, "I visit my father and I have never been restricted." A second relative said, "The chef is extremely charming and goes out of his way to talk to visitors." Relatives told us that the registered manager and staff telephoned them on behalf of their family members to keep them informed and involved. One relative explained that staff telephoned another family member who lived abroad almost weekly as their father did not have the capacity to do this themselves.

Steps had started to be taken to support people to express their sexuality. People's records included care plans about their sexuality. These focused on if the person was male or female and would benefit from review to ensure people who might be lesbian, gay, bi-sexual or transgender were supported if needed.

People said that they were involved in making decisions and able to express their views. Relatives said that they supported their family members when decisions about their care were needed due to them living with dementia. One relative explained that due to their family member having "A confused state of mind" they helped made decisions on their behalf.

We asked staff how they involve people in making decisions about their care. One staff member said, "He likes to stay in bed in the morning and can be reluctant about personal care. He can usually be persuaded with a cup of tea."

Efforts had been made to provide information in accessible formats, for example large colourful photographs of food were in place which were used to support people to make decisions about meals they wanted. A number of boards were also located in the home that had large print information about the time and date. People's care records included evidence of their or their representative's involvement when they first commenced living at the home. This was not as evident in the reviews of their care that took place thereafter but no one raised this as an issue and people told us they were happy with the opportunities to be involved in making decisions about their care.

People said that their privacy and dignity was maintained. Relatives said that bedroom and bathroom doors were always closed when personal care was being delivered. We observed that staff respected people's private space and as such they routinely knocked on people's bedroom doors and sought permission before entering. Support was provided in a discreet way. Staff addressed people by their preferred name, which was usually their first name. People's records were stored securely and promoted their rights to confidentiality.

People wore clothing appropriate for the time of year and were dressed in a way that maintained their dignity. Good attention had been given to people's appearance and their personal hygiene needs had been supported. Staff had ensured a blanket was placed over one person's legs when resting in a reclining chair to ensure they were warm enough and to promote their dignity.

Is the service responsive?

Our findings

People said that they received a responsive service. One external professional wrote and informed us, 'I have been visiting Clemsfold for at least 10 years now. Personally I do not have any concerns about the care offered there. I find the manager very professional in her approach and she appears to have a good understanding about the needs of the residents in the care home. In my opinion the care home is safe, caring and responsive and as far as I am aware receives positive feedback from the residents and families involved. X (registered manager) seems to understand the health concerns of her residents and will contact the relevant health personnel whenever required. She is very helpful to our medical surgery and as far as I can tell the residents are always kept as comfortable as possible and have all their needs met. They are encouraged to take part in activities whenever possible.' A second professional wrote, 'When I have asked for assistance, the staff have always responded in a timely manner.'

Despite people commenting positively we found that some people did not receive a responsive service based on their individual needs. For example, falls management was not always robust and timely, staff did not always give everyone effective care at mealtimes and interactions by some staff were task focused action. These areas required further improvement in order for the service to demonstrate that they are consistently meeting people's needs and responding to changes.

Some staff were allocated as keyworkers to people. We asked one member of staff, who was a keyworker, what this meant. They said, "It involves taking care of stuff in her room, report any changes to the registered manager or if she needs anything, report to the doctor." When questioned, this member of staff was unable to recall detailed information about the person they were keyworker for, even though this was recorded in the care plan.

People expressed satisfaction with the activities provided. One person said, "We do sing-a-longs." A second person said, "We mainly do singing, playing cards and sometimes go out."

Regarding activities at Clemsfold House the provider's website states 'The activities programme is one of the most important aspects of life at Clemsfold House. A huge range of activities are undertaken by the service users including handicrafts, quizzes, reminiscence sessions, music and movement, cookery and art therapy. The key aims of the programme are the provision of mental stimulation, continuation of hobbies and interests, and prolonging mobility.' We found aspects of this statement in place but not all.

The home employed two activity staff. One was not on duty during our inspection and the other only for the first day. Activity staff maintained an activities register of events that had taken place. Activities included a weekly keep fit session, a weekly external entertainer and the opportunity to go on a weekly outing. People could also go out in the extensive gardens that surrounded the home, although a staff member added, "Not in the winter, because it's cold." Although the activity staff employed had undertaken training in understanding dementia, they had limited training specific to the planning and carrying out activities designed to meet the needs of people living with dementia. We were sent the training certificates for one staff member which indicated they had attended a training session on 'Activities for People with Dementia'

in 2013 and an 'Introduction to Reminiscence' in 2016. Care staff made some attempts to engage people in activities but for most of the inspection people sat around staring into space or dozing. There was either music playing in the background or a television on.

Lists of activities were recorded within people's care plans and logs kept of activities people had participated in. In the dining room on the first morning of our inspection, two people sat at a table knitting and one member of staff sat with them and was being taught how to knit by one person. Another member of staff sat and tried to engage one person with a jigsaw puzzle. Another person seemed content to sit by themselves and was reading a newspaper. Two people were sat at separate tables and occasionally spoke to themselves.

One person's individual activity records included one to one time with activity staff where they chatted about previous employment and seasonal events that were taking place. They also included manicure sessions and regular visits to the hairdresser who visited the home. The registered manager explained how these were particular activities that the person really enjoyed. During our inspection we spent time with the person who confirmed this.

Another person's care records detailed their interests. These included bird watching, talking about football and listening to music from the 1960's. Due to the progression of the person's dementia they were unable to confirm if these were still areas of interest to them so we asked staff about the person and their preferences. One was able to confirm these and the other not. Individual activity records were maintained however for this person the last entry was dated 14 August 2017.

Staff received training on equality and diversity as part of their induction. One member of staff told us what equality and diversity meant when caring for people. They said, "It's about treating people as individuals. They might have different backgrounds but are equal. When we do assessments we need to involve people, find out their history and backgrounds so care is right for them." The registered manager talked about several people and said, "We treat everyone as individuals and respect each person for who they are."

We asked staff how they delivered personalised care to people. When asked about person-centred care, one staff member explained, "You give care and personal care for the whole person; it's holistic. It's people's choices and preferences and depends on their wants and needs." This staff member gave an example of one person who chose to stay in their room and said, "He is an individual, he's unique and that's what he wants." Another member of staff told us, "It's in people's care plans, that their rights and values are acknowledged. You have to respect people's differences, their likes and dislikes." This demonstrated that staff had a good understanding of what is meant by 'person-centred care' and how to support people in a way that respects their choices and differences.

Discussions with the registered manager and examination of records confirmed that appropriate action was taken in response to changes in people's health needs. For example, after a stay in hospital one person returned to the home with different support needs in relation to eating and drinking. The registered manager was concerned and arranged for the person to be seen by a GP who changed some medicines from tablet to liquid form and prescribed a thickening agent for fluids. Despite this the registered manager was still concerned and again arranged for the person to see a GP who agreed the person needed to be admitted to hospital due to risk of dehydration.

Care plans provided information about people's care and support needs including their personal history, communication, mobility, personal care, risks, sensory ability, continence and allergies. We looked at one person's care plan which recorded their religious beliefs and of a visit made by a priest. Staff we spoke with

felt that this person's religion was important to them and told us how they helped them say their prayers at night. Staff said that they were kept informed of changes in people's needs by reading care plans, during handovers and staff meetings. One staff member said, "You have to look at their care plan. Everything about the service user is in their care plan. Care plans are updated regularly. You read them or ask a senior."

People said that they felt able to raise concerns and that these were acted upon. Two relatives told us that when they had raised issues the registered manager had responded quickly. During the inspection the registered manager was seen checking if people were happy and it was apparent from people's responses that this was a normal routine in the home.

The complaints procedure was on display in the home and included the contact details of other agencies that people could talk to if they had a concern. Also on display was the provider's Duty of Candour policy. This helped inform people of their rights to receive a written apology and truthful information when things go wrong with their care and treatment. The registered manager demonstrated understanding of the policy and reflected an open and transparent demeanour throughout our inspection. For example, she explained how one person had lost their dentures the week of our inspection. As a result, the registered manager had arranged for a search of the premises, arranged for a dentist to visit and contacted the person's family to make them aware of the situation.

There was no one who was being supported at the end of their life at the time of our inspection. However, the registered manager explained that procedures were in place with the GP and district nursing team so that people would receive a comfortable, dignified and pain free death. This included access to pressure relieving equipment and pain relief medicines.

Is the service well-led?

Our findings

Quality assurance systems were in place that included audits by the registered manager and representatives of the provider. These included monthly audits by an area manager and an annual audit by the provider's head of quality. The latest annual audit had been completed in February 2017. The audit assessed the service against the five domains of safe, effective, caring, responsive and well led. The audit identified further training was needed in safeguarding and this was completed. It also identified that people's risk assessments required updating and stated this had been completed in March 2017. The area manager's monthly audits identified that further work was required to ensure mental capacity assessments were decision specific and people's hospital passports were completed in full. The September 2017 report stated that both these actions had been completed. This did not reflect what we found during our inspection. Three people's mental capacity assessments were not decision specific. Also the audits had not identified that risk assessments and care plans contained conflicting information and that activity staff had received limited training relevant to their role.

Records confirmed that accidents, incidents, falls, manual handling incidents, drug errors, safeguarding, violence and aggression and choking incidents were audited on a monthly basis. The form allowed for details in relation to date, name, details, action taken, explained or unexplained, if safeguarding or CQC notification raised and details and outcome that is, closed, on-going or no further action. The form also included a section for recording any details of any trends developing and noted actions taken. Despite this being in place, two incidents of aggression by a person who lived at the home had not been reported to the relevant authorities and referrals to relevant health professionals had not taken place in line with the provider's policy when people fell.

Clemsfold House is registered to accommodate a maximum of 48 people. At our previous inspection the registered manager told us that the maximum they would accommodate was 28 because they had closed a part of the home and made some double rooms into single occupancy. At this inspection the registered manager told us that they would only provide accommodation to a maximum of 31 people. The provider had not taken action to ensure that their registration information reflected the service they provided. This had not been identified within the quality monitoring systems in place.

Records were not always accurate or up to date. Despite records stating they had been reviewed risk assessments and care plans contained conflicting information. For example, on 28 September 2017 under the section which asked, 'Has service user lost weight recently?', the staff member had ticked 'Yes', but no information had been recorded in relation to completing this person's weight loss score. Under a section entitled 'Special risks', the person had been identified as living with dementia, which scored four, but under the 'Motor/sensory' section, it had not been recorded that they also lived with Parkinson's disease. Under the section, 'Mobility', it was recorded that this person was 'chair bound', but in another part of the care plan it stated they were mobile with a walking frame. The total score arrived at did not provide a true indication of the risks for this person as the information required to arrive at an accurate assessment had not been completed correctly.

Another care plan for end of life arrangements stated that a person had no religious preferences but in other records it stated that their religion was important to them. One person had an allergy to penicillin that had not been recorded in their medicine profile or care plan.

Regular meetings took place where representatives of the provider met with registered managers and heads of department in order to discuss service provision, changes in procedure and to share information in order to promote continuous learning and improvement. As a result of safeguarding situations at other locations operated by the provider a safeguarding expert had been sourced and a new system implemented to help ensure appropriate action was taken when incidents and events occurred. Registered managers were provided with a presentation about the new monitoring system at a managers meeting held in July 2017. In the managers meeting held in September 2017 representatives of the provider explained that a review of the serious incidents procedures was taking place and that guidance from the National Reporting and Learning System (NRLS) was being used to influence this. The NRLS is a systems used by the NHS to collate and analyse information from incidents to identify hazards, risks and opportunities to improve the safety of care provided to people. Despite these changes, the findings from this inspection demonstrated that the provider had failed to fully embed learning from situations that had occurred at other locations they operated. These included the application of The Mental Capacity Act, the provision of training specific to the needs of people who receive services, reporting of safeguarding concerns and the provision of person centred activities.

The provider had failed to ensure there were appropriate systems implemented to assess, monitor and improve the quality of the service. The provider failed to maintain accurate records. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

In addition to internal audits, aspects of the service were audited by external companies on behalf of the provider. On the first day of our inspection a health and safety audit was being completed by an external agency. The home scored 94 per cent.

The provider had core values in order to promote a positive culture. The core values of the provider were 'Compassion, Dignity, Quality, Life and Respect.' The core values were reflected in the homes statement of purpose and service user guide. These documents also explained to people how the provider would meet people's diverse needs and human rights. Equality, diversity and human rights also featured in many of the provider's policies and procedures. For example, the care policy stated 'The home will endeavour to ensure that the needs and wishes of all service users are ascertained, respected and met wherever possible, particularly religious, ethnic and cultural factors.'

On the 1 November 2017 amendments to the Key Lines of Enquiry (KLOE) came into effect with five new KLOE and amendments to others that all regulated services are inspected against. We explored these with the registered manager and an area manager who represented the provider. Neither were aware of any changes that the provider had introduced as a result of the amended KLOE or of any communication by the provider about how the amended KLOE's would be met. However, during the inspection we observed that CQC guidance and information about the amended KLOE's was obtained and both the registered manager and area manager sourced and booked themselves on a course about the changes.

We discussed the topic of equality and diversity with the registered manager. She explained that all staff received equality and diversity training as part of their induction and were asked to read the relevant policies when they had spare time. We asked staff about the provider's policies and procedures and how they would apply the requirements of these. One staff member said, "They're in the office. We look at them constantly, safeguarding, whistleblowing, dress code, it's all there." They added, "Team work is important here. The manager is very supportive. I feel my suggestions are listened to." There were whistle blowing

procedures in place which the registered manager said were discussed with staff during induction and in supervision. Staff confirmed this and were able to explain what these were when asked. They understood how the whistleblowing procedures offered protection to people so that they could raise concerns anonymously.

The registered manager was aware of the need to create a positive culture at the home. Everyone that we spoke with said that the registered manager was a good role model. Staff told us that they felt fully supported and that they received regular support and advice. One member of staff said, "She is very supportive. You can tell her how you feel and she helps you." A second member said, "I like her. She's very supportive and I don't feel pressurised. I love dementia care. There can be very challenging behaviour, but you can have a laugh with people. They all want to go home. We reassure them and say, 'Everything is here and we will look after you'."

Records and discussions with staff confirmed that staff meetings took place and people were encouraged to be actively involved in making decisions about the service provided. One staff member felt she was treated equally with other members of staff and that not having English as their first language had not been an issue. The registered manager monitored staff practice on a daily basis as she spent time helping them to care for people. When she identified areas for improvement these were acted upon. The registered manager also told us that she was going to enrol on the level 5 Diploma in Health and Social Care qualification to supplement her other qualifications and to ensure her own knowledge was current.

People and staff told us that the registered manager had a high visual presence in the home and we saw this to be the case during our inspection. It was apparent that people felt at ease in the presence of the registered manager. During lunch on the second day of inspection the registered manager sat and assisted one person to enjoy their meal. It was obvious by the conversation that flowed that the person felt comfortable and as such enjoyed the time with the registered manager. The registered manager operated an open door policy which she said helped promote an inclusive atmosphere for people. Several times during our inspection people were observed walking freely into the registered manager's office. Each time they were welcomed. People smiled in response indicating their satisfaction.

The registered manager was not aware of any work having been undertaken by the provider to implement the Accessible Information Standard and said she had not done anything either. From August 2016 all organisations that provide NHS care or adult social care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss are provided with information that they can easily read or understand so that they can communicate effectively. Some records had been produced in ways to help people to communicate, for example, hospital passports but further development was needed to ensure people were not disadvantaged.

The registered manager explained that due to the needs of people who lived at the home group meetings did not take place and that individual meetings were held instead. Surveys were sent out to people from the providers head office in order that people's views could be obtained and used to drive improvements. The registered manager said that if people raised issues these were acted upon. The registered manager was not aware of any analysis of the findings from surveys. She said that if this took place the information was maintained centrally. However, there were copies of the completed surveys in the home; the most recent ones completed in July 2017 did not identify any concerns. People said that they were happy with the service provided, staff, food, activities and the environment.

The provider offered support to staff in order to help sustain sufficient numbers of staff within the

organisation. One member of staff said, "I've worked in two of the homes. They provide specific training if you request it. They provide a free bus for staff and help with staff accommodation. You can choose places near your work." To ensure a sustainable and knowledgeable workforce the provider's organisation also includes a training academy who arrange a mixture of outsourced and internal training to employees. The registered manager explained that the academy also provided advice on particular topics if needed. Staff employed at the academy include clinical nurse tutors and a mental health tutor. As well as providing training to all employees the academy offers training and seminar's to other local care and health companies. Regarding training of staff at Clemsfold House the providers website states 'Sussex Health Care offer the QCF qualification in dementia care to all our staff.' We discussed this with the registered manager who confirmed that staff received information about courses including the QCF but at present she was the only member of staff with this qualification. She explained, "It's offered but not always easy to take up."

In the months prior to this inspection the provider had been subject to a number of separate safeguarding investigations at other locations that it operated. Although they did not directly relate to Clemsfold House letters had been sent to people informing them of investigations currently being completed by the local authority and the police, in relation to other services of the provider. This demonstrated an openness and transparency by the provider.