Signature of Marlow (Operations) Limited

Cliveden Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on the 12, 13 July and 3 August 2017 and was unannounced on the first day.

Cliveden Manor provides 24 hour care and nursing for up to 85 people. There are 63 studio suites and one bedroom apartments for people with assisted living needs and the Willows unit which includes 16 studio suites for people with dementia care needs. At the time of our inspection there were 77 people living at the service.

At our last inspection on 22 and 26 September 2016 we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because we found people's medicines were not being consistently recorded and the risks associated with self-medicating were not always being managed. The provider submitted an action plan dated 15 November 2016 which set out the actions they planned to make to address the breach. The current inspection provided an opportunity to assess whether the action plan had been successfully completed. We found risk assessments for people's medicine were mainly in place and records had improved. However, further improvements were required.

Since our previous inspection in September 2016 the service has a new registered manager. They have also changed the way in which medication is administered to people who receive a service under the residential care option. We found at this inspection that there had been a number of medication errors, which the registered manager and their team were managing, but we also found further improvements were required as some practices needed improving and minor errors in recording were still found at this inspection.

There was a registered manager in post. 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.

There were sufficient staff to meet people's needs. Staff rotas confirmed planned staffing levels were maintained. Staff told us they felt well-supported. One commented, "I am well-supported, definitely" and "Staff are the best thing here. They all smile and it cheers you up".

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The service had safe recruitment procedures and conducted background checks to ensure staff were suitable to undertake their care role.

People and their families told us they felt safe at Cliveden Manor. Comments included, "I have never seen anything of concern". One visiting professional said, "Everyone seems quite happy and I have not heard of any concerns".

Staff understood their responsibilities in relation to safeguarding people. Staff received regular training to make sure they stayed up to date with recognising and reporting safety concerns. The service had systems in

place to notify the authorities where concerns were identified. The provider had reported safeguarding concerns where appropriate and in particular with regard to the number of medicines errors which had occurred in May and June 2017. The local authority safeguarding team were investigating one of these concerns at the time of the inspection and we were awaiting an outcome.

People benefitted from caring relationships with the staff. People and their relatives were involved in their care and people's independence was actively promoted. Relatives and staff told us people's dignity was promoted.

Where risks to people had been identified, risk assessments were in place and action had been taken to manage these risks. Staff sought people's consent and involved them in their care where possible.

People and their families told us people had enough to eat and drink. People were given a choice of meals and their preferences were respected. Where people had specific nutritional needs, staff were aware of, and ensured these needs were met.

Relatives mostly told us they were confident they would be listened to and action would be taken if they raised a concern.

The service had systems to assess the quality of the service provided, but these were not always effective. However we found the registered manager and clinical team were attempting to manage errors identified. Systems were in place that ensured people were protected against the risks of unsafe or inappropriate care.

We had mixed feedback from staff about the support they received from the registered manager and all of the team at the service. Staff supervision and other meetings were scheduled as were annual appraisals.

People, their relatives and staff told us all of the management team were approachable and overall there was a good level of communication within the service.

Relatives told us the team at Cliveden Manor were very friendly, responsive and overall well-managed. The service sought people's views and opinions and acted on them.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People received their medicines as prescribed. However, we still found further improvements were required regarding administration of medicines.

There were sufficient staff deployed to meet people's needs and keep them safe.

People and their relatives told us people were safe. Staff knew how to identify potential abuse and raise concerns.

Risks to people were identified and risk assessments in place to manage the risks. Staff followed guidance relating to the management of risks.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the training and knowledge to support them effectively.

The Mental Capacity Act 2005 (MCA) principles were followed by the provider.

People were supported by staff who were supervised and trained.

People had access to healthcare services and people's nutrition was well maintained.

Is the service caring?

Good

The service was caring.

People told us staff were caring.

Staff were kind, compassionate and respectful and treated people with dignity and respect which promoted their wellbeing.

Staff gave people the time to express their wishes and respected the decisions they made. We saw people's consent to care was obtained.

The provider and staff promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to moving into Cliveden Manor to ensure their needs could be met.

Care plans were personalised and gave clear guidance for staff on how to support people. People were supported in their decision about how they wished to spend their day.

Relatives and people knew how to raise concerns and most were confident action would be taken.

Is the service well-led?

Requires Improvement

The service was not always well led.

The service had effective systems in place to monitor the quality of service. However, people's records were not always complete.

People's views were sought on the quality of the service.

People, their families and staff told us there was good management and leadership at the home.

Cliveden Manor

Detailed findings

Background to this inspection

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

This inspection took place on 12, 13 July and 2 August 2017. The first day was unannounced and we told the provider we would be returning for the other two days. The inspection was carried out by one inspector and a specialist advisor (SpA). An SpA is someone who has knowledge in the care of people in a nursing setting and older people's care

We reviewed the information we held about the service. This included notifications about important events which the service is required to send us by law. We sought feedback from the commissioners of the service and other stakeholders.

During the inspection we spoke with seven people who used the service, three relatives of people, two visitors and three professionals.

We looked at 12 people's care records, eight medicine administration records, four staff records and records relating to the general management of the service.

We spoke with the registered manager, the nurse care manager, the dementia care manager, care services manager, one registered nurse, the restaurant manager, the residential care manager, the human resources manager, five care staff, the chef and one restaurant staff member.

We conducted a tour of the building with the registered manager to view the environment and to introduce the inspection team to people at Cliveden Manor and staff.

Requires Improvement

Is the service safe?

Our findings

At our comprehensive inspection on 22 and 26 September 2016 we found staff had not always completed the medicine administration records (MARs) when they administered medicine to people. We also found staff did not follow the provider's policy when completing hand written MAR's and risks were not always identified for people who administered their own medicine.
This was a breach of Regulation 12 of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider's action plan told us how they were going to make improvements, for example, further training of staff and checks that staff were competent to administer medicine.

At this inspection we found further improvements were required. The provider had changed the method of administering people's medicine that lived in their own suites and were classed as having residential care needs only and not nursing needs. People's medicine needs were risk assessed and the provider changed the original arrangement where a nurse would always administer people's medicine in the home. They introduced the method where all care staff would be trained to administer medicine to people in their suites who were deemed as residential care. This was brought into place in May 2017.

In May 2017 there were ten medicine errors and in June 2017 there were nine medicine errors recorded. At the time of our inspection there had been two medicine errors in July 2017. Some of these errors were reportable incidents to safeguarding due to the potential impact these errors may have on the person. The registered manager had identified these errors through quality audit checks, had taken appropriate action, for example, refresher medicine training and further competency checks for staff that had made the errors. The local authority and Clinical Commissioning Group (CCG) contacted us about these errors as they had concerns over the number of errors which had occurred since the change in medicine administration procedures. The local authority safeguarding team and CCG, including the pharmacist who supplied medicines and the GP were working with the registered manager to gain confidence that people were being given their medicine safely and what changes could be made to mitigate against such errors. An action plan was in place which was reviewed every Friday by the registered manager and her nursing care manager to review any errors and progress made of identified actions.

We saw changes had been made to practices following 'reflective practice' and 'root cause analysis' done by the registered manager. For example, some of the errors were around medicine as required (PRN) because they were supplied in MDS (monitored dosage system) blister packs. The pharmacist now supplied these in original packaging only.

On the last day of our inspection we were informed that 85% of residential care staff had been trained and had completed their three stage competency check. People on the Willows unit were having their medicine administered by either a nurse or a senior care staff member. People who had nursing needs, had their medicine administered by a nurse.

We observed the nurse on duty administer medicine to people who required nursing care. They supported people to take their medicine in line with their prescription. Where people had as required (PRN) medicines

in place there were protocols to guide staff on when the medicine should be administered. These were detailed. If a person was not able to communicate verbally if they were in pain, and required PRN pain relief, the signs they might display such as grimacing and calling out was recorded on the PRN chart. Staff also knew what signs identified when people were in pain for those who could not communicate verbally.

We saw one person had PRN for pain relief. The nurse said, "You don't look like you are in pain, but do you have any pain at all?" The person told the nurse they had some pain in their back, the person was given paracetamol. The MAR was not signed until the nurse was assured the medicine had been taken. Therefore national guidance was followed when signing to confirm receipt of this person's medicine. The nurse understood the importance of people having their medicine at the prescribed time. One person had Parkinson's disease. The nurse knew what time the person required their medicine and why it was important. They said, "It's important to stop symptoms showing, like shaking".

Where changes were required to people's medicines, staff noted these changes. For example one staff member had noted when one person's pain relief was not controlling their pain and they asked the GP to reassess this person. The GP visited and prescribed an analgesia patch. Records showed that this person had a new patch applied every 72 hours as prescribed.

Although good practices were observed at our inspection, there were still some practices which needed to improve. For example, we saw one person had swallowing difficulties and they required their pain relief in a soluble version. However, there was no stock of this type of medicine for the person. Another person did not receive their prescribed medicine on 19 June 2017. The MAR chart records stated 'none available, not given'. We were told the stock had not been received in time to administer this medicine to the person.

Some medicines are required to be kept in a fridge to ensure they are still effective. There was a central fridge in the medication room where medicines were stored for people in receipt of nursing care. However, we found some medicines were stored in fridges used for food. The provider's medicines policy had not been followed as fridge temperatures were not being monitored to ensure they were within the correct temperature limit. However, on the second day of our inspection we were told thermometers had been placed in people's fridges and monitoring of the temperatures had been introduced.

Other anomalies of practices identified at our inspection included one person's PRN stock balance being incorrect as the new stock had not been added to the MAR. The stock balance of one person's warfarin was not correct. This may have been because there were two boxes of the same dose in use. One box was dated as opened in May 2017 and another box of the same medicine was dated as opened in June 2017. It is good practice to ensure that only one box of medicine is open at any given time to ensure no confusion of which box should be used by the medicine administrator and to mitigate against stock balance errors. However, in both cases there was no concern these people had not received their medicine as prescribed. Staff failed to identify that one person's diabetic needles were out of stock. This necessitated a staff member to obtain the needles from another pharmacy other than their prescribing pharmacy as they did not have the needles available. The needles should have been ordered before no stock remained. There was the potential the person would not receive their insulin.

We saw where people took their own medicines, they had a risk assessment in place and these assessments were regularly checked to ensure they remained competent to take their own medicines.

Relatives told us they were satisfied that their family member received their medicine. Comments included, "They are good at giving medicine, they come and find [name] if she is not in her room. They are patient with [name]". We saw people were brought their medicines when in the bistro. This meant staff recognised the

importance of people receiving their medicine when required.

People, staff and relatives told us people were safe at Cliveden Manor. One person's comment was, "We are now safe. It's getting better". We explored the comment further with the person and they told us there had been incidents earlier which compromised people's money, but this had now been addressed. Other comments included, "Yes I am safe, I use my wheelchair in the morning and then I am able to walk in the afternoon". Staff commented, "We are able to get equipment quickly and when needed. This ensures people's safety". Relatives told us, "I have seen no evidence of harm", "I have no concerns re safety" and "Mum and I are so happy she is here; she is safe".

The service ensured people's safety. For example, when people went out to Marlow on Thames, they would let reception know and a book was completed of the time they left and time they arrived back.

Safety checks in the home were carried out. We were told by staff and people who lived at Cliveden Manor that fire drills took place and these were regular. However, at the time of our inspection, records of these checks could not be located. We discussed this with the care services manager on the last day of inspection. They told us the maintenance manager had recently changed and they could not locate the records.

Most staff had completed safeguarding vulnerable adults training. Staff we spoke with were able to tell us about the different types of abuse and the signs that might indicate abuse. Staff had a clear understanding of their responsibilities to report any concerns and were aware of which outside agencies they could report to as well as their own management team. Staff said, "It's about ensuring people are safe. For example, from different types of abuse", "Making sure people are safe, including in their environment and not at risk" and "It's about being aware you are working with vulnerable adults. We need to prevent neglect and abuse".

We saw systems were in place for safeguarding referrals to be recorded and appropriate referrals had been made to the local authority and the Care Quality Commission. Details were fully documented which included actions taken, for example a review of the person's needs and changes made to their care plan.

Staff told us they were aware of the providers' whistleblowing policy and would not hesitate to report any concerns. Whistleblowing is where someone can anonymously raise concerns about standards of care. One staff member said, "Yes I would report it. We work for people and for the benefit of people".

People's risks were recorded and monitored. People had detailed risk assessments in a range of areas such as falls, moving and handling, nutrition and hydration, self-medication and prevention of pressure ulcers. Ways of reducing the risks to people had been documented and staff were aware of the risks to people. When we asked staff about specific people and their risk assessments, staff were aware of the risks and mitigating factors. We saw one person who was at risk of choking. When staff noticed they were having difficulties in swallowing, staff referred them to the speech and language therapist (SALT). The SALT team recommended the person have a soft diet and thickened fluids. We looked at this person's care plan and saw the details had been recorded. Staff we spoke with knew how this person should be supported which was in line with the instructions from the SALT team. We asked the person and their partner if staff thickened their fluids and they confirmed they did.

However, this was not always the case for other people, as we found three people who were also on thickened fluids that did not have risk assessments in place which identified the risk. We raised this with the nurse care manager who said they would put risk assessments in place.

Restaurant staff were also aware about how to manage risks for people. One staff member told us how they

ensured the passage way was clear of chairs in the dining room so that people could access their table safely.

Accidents and incidents were recorded and actions to be taken were documented. For example, when people were identified as having a pressure sores we saw the care services manager had undertaken an audit of each person's mattress who lived at the home. This was to ensure people who were at risk of developing a pressure sore had the appropriate equipment in place.

Arrangements for emergencies were in place for people. People had completed personal emergency evacuation plans (PEEPS) in place. We saw these were comprehensive and included people's individual needs, for example mobility. These were accessible to the emergency services as they were stored securely in the reception area by the fire panel. We saw the provider had revised their plans following high profile cases of fire emergencies. The provider had drafted a heatwave plan. This identified actions staff should take to ensure the risks to people during a hot weather were managed safely.

At the time of our inspection there were enough staff to support people and these staff were deployed to ensure people received the support needed. We received varied feedback about staff responses to call bells. Comments included, "Sometimes they are quick, sometimes takes a while", "I have to ring twice sometimes", "I use my call bell and they come quickly", "There is enough staff. Continuity is there and they are good" and "There is always someone around when you need them".

Staff commented; "The staff rota is perfect. We have six staff and definitely enough. We also have one team leader who is responsible for doing allocations, contact with family, GP and auditing medicine" and "We have a good ratio of staff to people. This enables us to give emotional support to people and we can go down and sit with the person in the garden and they (people) really like that". During our inspection we heard the call bell was frequently ringing from the communal areas, including the restaurant. This was rarely cancelled by staff to indicate the call had been answered. One person who lived at Cliveden Manor said to us, "I bet that bell is getting on your nerves?" We were told by one staff member, "Quite a few people need assistance to move from the restaurant and we have to wait. People get impatient, but no one is at risk". Although we saw records to show call response times were within five minutes and when on site people's call bells were answered promptly when in their suites, the noise was, at times constant in the corridors and this marred the quality of people's care experience at Cliveden Manor. We raised this with the registered manager and they agreed to investigate why they were ringing for such a length of time.

One professional said, "Plenty of staff (are deployed) and they are always available for the person, family and us". Another professional told us, "The staff know people well now. It's a lot better now the use of agency has been reduced as they did not always know people".

We saw a dependency tool was in place which was used to calculate the number of staff required to look after people. This was based on their individual needs and took into consideration if they were receiving nursing care or residential care. Details were broken down, for example, into number of care workers were needed to mobilise people, care hours and recent care provision to identify if any changes in people's needs had been identified.

Records relating to recruitment of staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references, the right to work in the UK and Disclosure and Barring Service (DBS) checks. DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people. The provider also had processes in place to check all staff employed as registered nurses were

registered with their professional body. This ensured they were qualified to work in the capacity of a registered nurse.

Records showed staff had completed a job application form and we saw there were no gaps in staff employment histories. Interviews had been completed and photographic identification and health checks were present in staff files.

Good

Is the service effective?

Our findings

Staff told us they had the skills and knowledge to meet people's needs. Staff had completed training which included safeguarding, moving and handling, food safety, dementia and infection control. There were two ways training was delivered to staff. One was by staff completing training electronically and the other was face-to-face training. We saw staff training was monitored and triggers were set to remind the registered manager when individual staff training was due. The copy of the training matrix provided showed there were a high number of staff whose training had expired. We discussed this with the care services manager on the last day of our inspection. They told us Signature of Marlow had changed their training provider at the beginning of 2017. This meant although staff were within their annual training requirements, they were still required to undertake the training again with the new provider. We were provided with evidence that this training was being arranged. For example, we saw fire practical training was being arranged for August and September 2017. We were also provided with an up-to-date training matrix on our last day which also showed further training had been undertaken by care staff.

Staff were complimentary about the training provided and were able to request any additional training they felt would improve their skills and knowledge. Comments included, "I have done a lot of training, it has all been good and it's all up-to-date", "There is opportunity to progress here, which is great", "My training is good and it's mostly up-to-date" and "We all get the same training and I am just doing my food safety training".

People and their relatives said they were happy with staff competence. They said they had no concerns and felt staff knew how to look after people very well.

New staff completed an induction and were supported by more experienced staff until they felt confident to work alone. On the day of our inspection we observed a member of staff working alongside another member of staff who was explaining things. The staff member told us they were on induction. Other staff confirmed they 'shadowed' another staff member before working alone. One staff member told us, "My induction lasted for two weeks. I was allocated a care worker to work alongside with. This enabled me to get to know people before working alone". Staff felt the induction process was thorough and we were told that staff could return to repeat any element they were unsure about.

We saw staff files were well organised and included a 'checklist' at the front of the file which made it easy to locate all supporting documents. The human resources manager told us they were currently reviewing all staff files to ensure all documentation was present. We saw a tracker was in place which showed which files had been checked and where documents were missing.

We saw communication processes were in place to keep staff up-to-date. Handover meetings took place and we saw staff were provided with updates regarding individual people's needs. For example people's risk areas, individual health appointments and mobility needs were discussed.

Staff were supported by the management at Cliveden Manor. Staff had regular supervision meetings. This

was confirmed when we looked at staff files. We saw a matrix of supervisions which showed there were some gaps where supervisions had not been recorded. We discussed this with the care services manager and they told us they were aware some staff needed their supervision and said they were in the process of scheduling these in. Staff said these meetings were an opportunity to discuss any concerns and development needs. Comments from staff included, "I am very happy with the support. It is good and I feel listened to when we have my supervision meeting", "The support is good, any problems I can easily go to [name]. I am listened to. I have regular supervision meetings and it's a two-way conversation and I can raise anything", "I had my supervision four days ago. I was able to raise anything and I know I am listened to. [Name] is very good; makes everyone feel comfortable" and "[Name] is amazing; they support me so well and help me a lot".

People were supported in line with the principles of the Mental Capacity Act 2005 (MCA). 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.

Where people were thought to lack capacity to make some decisions, their care records held decision-specific capacity assessments. For example, decisions were made for using bed rails to stop people from falling out of bed. Care plans outlined whether people had capacity to make decisions on care and treatment, and where appropriate a Lasting Power of Attorney (LPA) was in place which was in accordance with the MCA.

We spoke with staff about their understanding of the MCA. Staff members told us, "The MCA was created for people who cannot understand certain things or make certain decisions; the act is for their benefit" and "It's treating people as individuals and recognising that everyone's needs are different".

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management team demonstrated a clear understanding of their responsibilities in relation to MCA and DoLS. Applications had been made to the supervisory body where an assessment had identified the person lacked capacity to consent to the restriction. There was a mental capacity assessment which identified the person lacked capacity to understand risks. We saw best interest decision meetings had been held with the appropriate professionals, relatives and management at Cliveden Manor. Staff knew which people had a DoLS in place. Applications were kept under review to ensure that people were being supported in the least restrictive way. One relative told us how they were involved in the decision process for their family member. One staff member told us how a DoLS was in place for a person as they had refused to take their medicine. A best interest meeting had taken place and a collective decision was made that this person should have their medicine covertly, for example in food or drink. Another staff member said, "It's about making a decision in the person's best interest and their wellbeing. [Name] has no capacity to be outside of the unit, so we have a DoLS in place". This meant people's individual needs were known to care staff.

We saw people's care plans included consent details. For example, consent to life decisions. Where appropriate 'do not attempt resuscitation' (DNAR) forms were in place for individuals. Where people did not have the capacity to make these decisions we saw professionals and staff were involved and had documented these decisions.

People had enough to eat and drink. We received varied comments about the food quality. People told us,

"The food is good now. There is an excellent choice; long menu to choose from. Wonderful selection of salads, two hot dishes and I like trying different things", "It was very good today, sometimes it varies", "Lots of fresh fruit which is lovely" and "The food is inconsistent. Sometimes it is really bad". We saw drinks and snacks, including fruit were available to people throughout the day. There was also a coffee shop where people could have their meal and people were asked where they would like to eat their meal. People also had kitchenettes in their room and could choose to prepare their own meal if they wished.

The chef had been in post four weeks and was aware of people's varied comments about the food. We saw the chef was working with people to make improvements. They told us that the comments had been more complimentary lately and that they always asked for feedback following meal service. They told us they currently had vacancies in the kitchen and this was being covered by agency staff and that new appointments had been made and believed this would improve consistency of the food.

The chef knew people's individual preferences, including health needs and allergies. They knew people who needed their food pureed and those whose diets needed fortifying to maintain their nutritional intake. They told us they ensured people's meals were person centred. They gave us an example of one person who was allergic to cheese. They told us how they would make up the salad or roast vegetables and remove a portion for this person before adding the cheese. They said, "This is my job to take care of people and think about all of them and respect their choices and needs". We saw the head chef regularly checked fridge and freezer temperatures. This meant the chef recognised the need to keep the food for people at the right temperature and to keep people safe.

We saw menu boards were displayed at the entrance to the restaurant and menus were provided to diners in the Bistro. We observed the lunchtime experience for people. Staff were very caring and knew people's individual needs. Waiter service was available for all people in the restaurant or bistro and staff greeted people by their first names. Tables were laid with napkins, flowers and condiments. One staff member told us people generally enjoyed their food and felt that now the provider had introduced a 'comment card' system, this had shown improvements. Overall people's experience was positive. People who required support to eat their meal were supported by staff who were patient and caring. People were offered protective clothing and a choice of drinks, including alcohol. Staff knew people's individual needs and when assisting people with their meal they took their time and were attentive to people's needs.

We observed the meal experience for people in the Willows unit. A three course lunch was available and people were visually shown each course to enable them make their choice. This is a recognised method when people have difficulty in making decisions. There was a relaxed atmosphere and people were supported appropriately when assisted to eat their meal. The staff member sat at the same level as the person, chatted to them throughout the meal and encouraged and explained to the person what they were assisting them with. We heard one staff member say, "There you go [name], your lunch".

People had protocols in their care records to assess the risk of malnutrition and dehydration. This included the use of a 'Malnutrition Universal Screening Tool' (MUST) that was completed and updated on a monthly basis. Weight charts and food and fluid charts were kept where people's nutritional intake was identified to be of concern. For example, there was concern regarding one person's diet and fluid intake. They had lost weight and were not eating and drinking sufficient amounts. The staff had put this person on a 'two hourly fluid push' to improve their fluid intake. We saw staff visited this person every two hours and encouraged them to have a drink. Records of these visits were maintained. Another person had lost over three kilograms in the last month. They were started on a food chart and referred to the dietician and GP. Staff had established what this person's favourite food was and offered it to them more frequently to encourage them to eat more.

People had access to health professionals when required. People's care plans showed people had been supported to see health professionals, for example their GP or district nurse and each visit was clearly recorded with details of how to look after the person. Senior staff reviewed people's needs and took action when further concerns were noted. We saw this person had been referred to the GP and dietitian due to weight loss. The dietitian had provided advice and support. The GP had assessed the person and was conducting tests to establish if there were medical reasons for their weight loss and lack of appetite.

Good

Is the service caring?

Our findings

People felt Cliveden Manor was a caring place to live. Comments received included, "It's a lovely place. I'm so well cared for", "All staff say hello [use my name]", "The quality of care is quite good", "Staff are friendly and nice", "There are no bad ones (staff), depends on how you are to them" and "Staff are marvelous". Relatives told us, "They handle my mother very well and work really hard when looking after her. They are particularly kind and have her best interests at heart. They sat with mum until the ambulance arrived. Definitely a good attitude", "Staff are nice and very helpful", "We normally come down to the garden and café. Care in The Willows (dementia unit) is brilliant. I see staff interact other people in a really positive manner", "Never seen anything of concern. Staff are really nice" and "My mother is looked after very well". When we spoke with staff they told us relationships with people were important to them. One staff member said, "It's nice here. You get to know people. That makes you feel good when coming to work. I get a thrill when they (people) are happy".

We were told some staff spoke several languages. This enabled them to strike up conversations with people whose first language was not English. We saw on member of staff spoke to a person in Italian. The staff member told us the person liked to practice and speak Italian.

People looked well cared for at Cliveden Manor. People who needed assistance with their personal care looked clean, well-kept and appropriately dressed for the weather. Many caring interactions were observed between staff and the people they were directly supporting. This also included other people who lived at the home. Staff were attentive and were willing to happy to help when people needed it. For example, one person had been to the cafe to get them self a drink. They had decided they would take this back to their room. The person had a walking stick and a handbag and looked like they were struggling to hold the cup and walk. A member of staff noted this immediately and went to the person to ask them if they would like some assistance. The person said "Yes please, that's very kind". The staff member took their cup of tea and walked with the person to their room. They chatted as they walked down the corridor. The person was quite slow at walking. The care worker recognised this and was very patient and did not rush the person. Another person told us staff were very patient. They said, "They are very patient with me when I get muddled".

People and their relatives were mainly involved in their care and reviews of their care. The care files we viewed showed they were written with the involvement of the person and their relatives. We saw consent was obtained from people when using specific pieces of equipment, for example, bed rails and details of their consent was present in their care plan.

We saw individual choices were available to people. People had a choice of their suite depending on availability. We were told people's needs were met individually. One couple who lived at the home had different levels of care needs. One required nursing care and the other person needed residential care. We saw the couple received person-centred care. For example, two staff members visited the couple's suite and carried out their care needs individually. We also saw the staff ensured they ate their meals together and we saw how support was provided to one person to eat their meal.

The service promoted relationships between people. For example, one person was leaving to live at another care home. An event was held for the person and cake and champagne was available for people say their goodbyes to the person.

People told us they were involved in decisions. One person said, "Yes, I was able to have my own made to measure furniture for my bedroom". People were able to have newspapers delivered to their suites. They also had their own telephone in their suites to enable them to keep in contact with their friends and family and be as independent as possible. People had choice of where to have their meals, in their own suite, the bistro, restaurant or café.

Staff recognised individual people's needs. One staff member told us how one person could not vocalise and they relied on the person's facial expressions to let them know how they were feeling. They said the person would laugh, but if not well, they said they would know this as the person would be quiet and appear withdrawn.

We asked staff what made them a good care worker. They said, "I am very empathetic and I express that with people I look after. I like doing one-to-one work with people, I will sit with people and chat" and "You know when you have done a good job, you leave the room feeling good about yourself".

Professionals comments about the staff were, "They are always really friendly, always greet you and say, how can I help?", "People look well cared for", "The home is always clean and tidy"; "There are a number of people who are independent in Cliveden Manor. This is respected by staff and they help people maintain their independence" and "Kind, approachable and people are happy with them".

We saw that staff respected people's choice. For example, in the staff meeting we attended, staff were reminded that they should not open people's post without asking their permission. At the same meeting staff were reminded how to protect people's dignity and show respect. Staff were reminded to always keep personal protective clothing used by staff in cupboards in their suites and if someone had a fall in a public area, staff were informed that the service now had a screen and this was to be used to shield the person who had fallen to enable staff to assist them and to show respect.

People were supported with their personal care discreetly. Staff had an appreciation of people's individual needs and how to maintain people's dignity. One person who was in bed was slightly uncovered. Staff noticed this quickly and ensured the person's dignity was maintained by covering the person with a bed sheet. People were never rushed and when staff were caring for people, they gave them their undivided attention. The chef demonstrated they were aware of people's dignity as they told us when people needed their food cutting up into smaller pieces to enable them to eat independently, they did this in the kitchen and not in the dining area. This meant they recognised the need to protect people's dignity and showed respect for people. Comments received from staff included, "Dignity and respect is very important when delivering personal care. You need to be discreet about personal care and be mindful of people's individual cultural needs. I always put a towel over them when delivering personal care", "It's about working with people in a person-centred way and understanding their needs" and "I always ask people what they would like and explain the options".

Staff talked to and about people in a respectful way. They knew the preferences and needs of the people they cared for. For example, one person's care records stated they preferred a female care worker to assist them with personal care. We spoke with the person and they said, "Only the ladies come to help me wash".

People told us staff were respectful toward them. Comments included "They respect me very much.

Anything goes wrong, we just have a laugh and joke about it" and "They are very good at maintaining my independence".

Staff understood the importance of confidentiality. Comments included "I know my phone should be off and that it is illegal to take photographs of someone without their consent. Also definitely you do not discuss anyone who lives at the home outside of work".

Good

Is the service responsive?

Our findings

Before people came to live at Cliveden Manor their needs had been assessed. People's care records contained personalised information about their health, social care and spiritual needs. They reflected how each person wished to receive their care and support. For example, what time they preferred to get up and what time they preferred to have their personal care. This could be at any time of the day and not just in the morning.

The provider operated an electronic care system. The system enabled staff to update people's care records from a handheld device. We saw comprehensive details were recorded on the system. For example, details of care delivery, food intake and how people were feeling on the day were logged. Symbols were used to note the person's mood. If the person had not received their care at the time specified, a red 'flag' would appear on the system. We saw this was monitored by senior care staff who would investigate why the care delivery appeared to not have taken place. This enabled them to monitor people's care needs and to ensure these were met.

We saw the provider had systems in place to carry out an in depth review of people's care. We saw regular reviews of people's care were undertaken on a monthly basis or earlier if required. The registered manager had a system called 'resident of the day'. This meant staff would concentrate on one person's care plan for the day to ensure it was complete and up-to-date.

We saw people had individual 'round sheets' which detailed the time and type of care required. This system was based on the community care model where people receive care in their own home. This meant the care was more person-centered and people were able to have their support at the time they wished at Cliveden Manor. We were told people could mainly choose when they had their laundry done which also showed people's views were considered and were involved in their care decisions.

Risks to people were recorded. Detailed information was in people's care records for staff to manage these risks. For example, where people had been assessed as at risk of developing pressure sores they had correct equipment in place such as pressure relieving mattresses. We saw people had pressure relieving equipment in place and staff assisted them to change their position regularly in line with instructions in their care plan.

We saw the management team were responsive to risk. For example, we saw one person who had a fall. A full review of the person's health took place and it was identified some of their heath conditions had changed. It was identified that the person's blood pressure was higher than normal and their continence needs had changed, which woke the person up at night. The GP was involved and a review of the person's health needs was undertaken and changes were made to their care plan accordingly.

One visiting professional told us staff were responsive to people's needs. They said, "They recognised one person's hearing aid was not working. They contacted me and I supplied a spare hearing aid for the person. I showed staff how to fit the hearing aid and saw they had made notes in the person's care records of how to do this. They are always responsive, they will pass on messages and things are sorted out for people".

People were supported to spend their day as they chose. They were encouraged and supported to participate in activities that interested them. We saw a group of people preparing the flowers to go on the dining tables. Weekly activity options were displayed in the communal areas at Cliveden Manor. The majority of people who lived at the home were independent and were able to go out shopping for example, into the local town. However, we were told shopping trips were arranged for people to go out as a group to a nearby shopping centre. The registered manager told us how they were planning to start up a restaurant 'critic' group. People would visit a local restaurant and critique the food and provide feedback to the proprietor. People who lived in the dementia unit also had activity options. We saw on the day of inspection a guitar player came in and Tai Chi was planned for the afternoon. The registered manager told us they recognised that choices needed to improve for people in the dementia unit. A new activity manager had been recruited and we were told that they were planning to have a dedicated activity co-ordinator for the dementia unit. This meant specific needs and interests of people would be maintained.

The service promoted specific sports events and encouraged people to become involved by watching the event together on the television and taking part in quizzes. For example, Wimbledon was taking place when we inspected. We saw tennis rackets and tennis balls were displayed in the home and people had strawberries and cream and Pimms to drink. Comments from people and relatives included, "I come down to the café and go out in the garden", "Lots of my own space to do things. The entertainment is very good and you can join in if you wish", "We had an indoor bowls match the other day, it was a fun afternoon" and "People play quizzes, staff read newspapers to them and they have someone visit who plays a guitar to them".

There was a complaints policy and procedure in place. People told us they knew how to raise any concerns. People and most relatives told us if they had made a complaint and that it was well-managed and they had confidence their concerns would be listened to. People told us, "The girls are very good. I lost something in the laundry, my fault. They were very helpful and got it sorted out quick smart" and "When I complained about the heat in my room, they bought in an air conditioning unit and ensured the windows were open for me". One relative said, "Communication is not always 'spot on'. I told the staff and a meeting was arranged for me to discuss my concerns" and "Everyone seems quite happy. I have no concerns. We saw systems were in place to manage complaints and details were recorded along with actions following the complaint. We saw the complaints policy was followed as complaints were appropriately escalated to senior management at Signature of Marlow.

A system to record complaints was in place and we saw actions taken were also recorded. We saw the registered manager had not routinely responded in writing to people to demonstrate they met the provider's policy. They told us they were aware they should have been doing this and said would do so in the future. However we did see the nurse clinical lead had responded in writing to concerns raised and had responded accordingly to the complainant. We spoke with one relative who said they had not felt they had received comprehensive feedback following concerns they raised. We raised this with the care services manager. They told us the dementia care manager had met with the person and arranged further meetings and had taken steps to resolve the relatives concerns.

We saw that the registered manager had responded to concerns raised by people at Cliveden Manor following a recent fire in another service in England. At the residents' meeting on 5 July 2017 this was the first topic and the registered manager explained what actions they had taken to allay people's anxieties and concerns. A meeting had taken place by the group facility manager to come and talk to people about the fire safety measures in place at Cliveden Manor. The registered manager told us this was important to provide support to people who had concerns about a potential fire.

Requires Improvement

Is the service well-led?

Our findings

We saw people were involved in the day to day running of the home. For example, there were regular meetings which people attended and these meetings were themed. We attended the residents' catering forum on the first day of inspection. People talked about the menu and suggestions for changes were discussed. For example, people asked to have white sauce on their cauliflower as an option. We saw the chef was working with people to accommodate their preferences and make changes to the menus. The chef told us they had received a 'thank you' card from one of the people and they were very pleased about this. Other meetings included the residents' forum. We saw notes of a recent meeting in June 2017. Topics discussed included feedback following fundraising events and newly appointed staff members. People were given the opportunity to make comments or raise concerns. The minutes showed people had raised concerns about the temperature being too warm in the home. The registered manager agreed that the heating system was a problem in the home. They took action and involved specialist maintenance people to review and make the necessary changes. In the interim we were told that fans were made available to people to reduce the discomfort of the warm weather.

We saw a comments box was located outside the dining areas to enable people to provide feedback about the food on the day. Staff and the chef told us this was well supported and enabled them to make changes where needed.

We found people's records were not always up-to-date or fully completed. For example, when there were changes to people's method of receiving their medicine, the records did not always contain confirmation of this change from the GP. We were told the GP was aware of this change, but that no record had been retained on this person's care file. Stock balances of medicine were not always accurately maintained. We found one person had been assessed by the speech and language therapist (SALT) as requiring their fluids thickened. However, in this person's care file we saw entries which stated 'fluid drunk but not thickened'. We were told by the nurse care manager that the person chose if they wanted their fluids thickened or not and had the capacity to make this decision. They said that a letter had been received from the SALT team to confirm this however; they were unable to produce this letter on the day of inspection. We also saw there was no risk assessment in place which identified the risk of this person having unthickened fluids. The nurse care manager undertook an immediate risk assessment of this person. The person involved told us they felt able to say when they needed their fluids thickened. Following our inspection we were sent a copy of the original GP referral form which stated 'thickened fluids as required'. We have been told following our inspection a reassessment of this person has been undertaken by the SALT team and this person no longer requires thickened fluids. Another person's care plan had not been updated with information to confirm the person no longer needed their ear drops. The person's MAR stated 'nil in stock'. Therefore it was not clear to staff if this person still required the ear drops as records had not been accurately maintained.

Although people had electronic care plans that were reviewed and updated every two months, people's paper copies of care plans kept in their rooms were not current or up to date. In one case we saw the person's file had not been updated for 12 months and in another case it had been seven months. Care staff recognised that the care plans held in people's suites should replicate the electronic care plans on the

system. One care staff member said, "We should print out as we update (the care plan)". We discussed this with the registered manager and they told us this was a Signature of Marlow requirement as copies needed to be kept up-to-date so that the person and family members have information about their care needs. However, we were satisfied that people's electronic care files were backed up regularly on the computer system and staff were still able to obtain care information through their handheld devices.

Audits were undertaken by the senior team at Cliveden Manor. The audit results were forwarded to the provider by the registered manager on a monthly basis. The audits identified events which had occurred for example, the number of falls, people who had developed pressure sores and medicines errors. Following identified events; we saw an action plan was completed to monitor the progress of the incident and what action had been taken to mitigate the event. We saw specific audits took place. For example, there were care plan audits. We looked at the June 2017 audit and saw people's care plans had been checked. If there were any anomalies, details were forwarded to the relevant manager or senior care staff member who made the necessary changes.

Although audits were undertaken, they did not always identify areas which needed attention or further action. For example, the medicines audit had not identified that soluble paracetamol was required for one person and in the person's care file it stated 'ensure I have adequate stock in the building and to action any signs of pain/discomfort'. It had also not identified when specific equipment was running low, for example needles. Maintenance audits had not identified that records were missing to confirm fire safety checks had taken place.

Providers are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they are carrying on a regulated activity.

At the time of the inspection, the service had an appropriate duty of candour policy. The document provided clear steps for the management to follow if the duty of candour requirement was triggered. The registered manager demonstrated an understanding of the duty of candour.

We saw an annual survey had been conducted to obtain people's views about the service. We saw the results of the survey dated June 2017. Results at Cliveden Manor were compared against other services in the Signature group. The service received the overall rating of 82% as people said the care they received was either 'very good' or 'excellent'. We saw two areas where people had scored the service below 75%. These were catering and activities. The registered manager and their team had taken action to address these areas. For example, regular meetings were taking place with the chef to look at the menu choices and to enable people to provide feedback and take forward ideas. We were also told that a activities team manager was due to start after our inspection and part of their responsibility would be to look at the choices available to all people in the home and to work on meeting people's personal interests.

People, relatives, visitors and staff told us overall they were happy with the way Cliveden Manor was run and communication was good. Comments from people included, "I get on with them (management) well. We have a meeting once a month to discuss matters. They listen and react to us. I take part and put forward my observations and criticisms", "The home is well run, spotlessly clean, laundry staff are very helpful and the housekeeper is very, very good. We have regular resident meetings. We grow flowers in the garden and they are put on the dining tables".

Relatives told us, "The management is good, staff are respectful, not patronising, everyone is quite jolly, management is ok, staff are really helpful and its good care here". They are all good, including the receptionists" and "There was a time of uncertainty, but credit to [staff names] they have been really good, kind and have time for people".

Professionals said, "The communication has improved. The manager is very open about the concerns and comes up with solutions", "Management are good. I have a main contact in the residential side. They are very good and responsive" and "Communication has got better".

Staff told us, "The manager is very competent, so enthusiastic and very good", "Communication not always 'spot on', but we have had a change in management and it's now better", "The home is run very well. There is a lot of support from management. They are always around, even at weekends and there is a duty phone if we need someone, "We had an unsettling time when there was a switch of general manager. But now it's very good and back running smoothly again. Everyone is confident with the management"; "It's good. When I started it was very good. It's been difficult as we did not have a unit manager which impacted on the team and we felt at times, support was not there. Better now though as we have a new unit manager" and "I am supported in my role. The manager is very supportive. They support me to make the changes I need".

There was a recognition scheme for staff. They were rewarded when they had gone 'the extra mile'. One staff member told us they had received a voucher for being flexible in their work and reorganising shifts, which was not normally part of their duties.

When we asked staff what it is was like to work at Cliveden Manor they said, "Staffing levels are good here and staff are knowledgeable. I am proud and pleased to work here" and "It's warm, welcoming and fun".

We saw a resident's monthly newsletter had been introduced. This was called 'Cliveden Chronicle'. Details included a welcome section for people coming to live at the home, special events, including fund raising events and staff news. This ensured people who were unable to attend meetings were kept up to date with any changes or developments in the home.

The registered manager told us they conducted spot checks on a monthly basis at night with one of their managers. They said it enabled them to see how the home is run in their absence and to develop relationships with the night staff team. They said they were developing their management team to lead on this in the future. We saw regular staff meetings took place. This included night staff. We sat in on one meeting on 13 July 2017. The meeting was well structured, had an agenda and minutes were taken. Topics discussed included training, welcoming new staff, medicine errors and new people who had come to live at Cliveden Manor. Where staff were not able to attend, we were told minutes of the meeting was emailed to staff.