Care Quality Commission

Signature of Marlow (Operations) Limited

Cliveden Manor

Inspection report

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Date of inspection visit: 02 March 2015
Date of publication: 14/08/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

Cliveden Manor provides accommodation for up to 85 older people who require nursing or personal care. The accommodation provides 63 studio suites and one bedroom apartments for people with assisted living needs and 16 studio suites for people with dementia care needs, all of which have en suite facilities. All assisted living suites are also provided with a kitchenette facility.

The accommodation is arranged over three floors. The ground floor consists of the reception area, a café, a communal lounge area, a licensed restaurant. The first floor consists of an activities room, library and a terrace overlooking the front of the home. There is also a Bistro serving breakfast. Lighter meals can be taken in any restaurant area. There was a further terrace overlooking the rear garden and water feature. A hairdressing salon, therapy room and an assisted spa bath was also located on the first floor. The second floor incorporated the Willows unit for people with dementia care needs, which provided sixteen studio suites, a variety of communal areas including a large lounge, kitchen/dining area and a quiet lounge. There is also a Galley Coffee bar which provides refreshments throughout the day.

Summary of findings

At the time of our inspection 57 people were using the service; 47 in assisted living and ten in the Willows unit. The assisted Living area and the Willows offers 24 hour residential and nursing care for both individuals and couples.

Cliveden Manor has a registered manager in place. 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.

The inspection was unannounced and undertaken by two inspectors on the 2 March 2015.

Staff understood the needs of the people living in the home and were committed to improving people's quality of life. They provided care and support with kindness, empathy and compassion. People were cared for and supported by a dedicated caring team of staff and the values and ethos of the manager are shared by the staff team.

The organisation's medicine management policy and procedure was not always being followed. Handwritten entries on one person's medicine administration records were not witnessed and countersigned. It was not always clearly documented why people's medication was not given.

People living in the home told us they felt safe and the staff responded promptly to any requests for assistance. Staff demonstrated a good understanding of their responsibilities in relation to safeguarding and were knowledgeable about how to keep people safe. They knew how to identify any suspected abuse and how to escalate it further to the correct people.

Risks to people using the service were identified and incorporated into their care plans to enable staff to manage any such risks appropriately and keep people safe.

People were involved with meal choices and menu planning so they met their individual needs and at times which were suitable to them.

Staff were knowledgeable about the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and how it related to people living in the home. The MCA sets out what must be done to ensure the human rights of people, who may lack capacity to make decisions, are protected. People's rights were protected because staff were trained to understand this.

Selection and recruitment processes were thorough to protect people from being cared for by unsuitable people. Staff were provided with training to support them to care for people safely. Quality checking systems were in place to manage risks and assure the health, welfare and safety of people who received care at the service and the staff who supported them.

People living in the home and their relatives found it to be a well-managed home, which centred around the people who lived there.

We have made a recommendation about training for staff regarding end of life care.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Records related to people's medicines had not always been completed accurately. This was not in line with the providers medicine management policy and procedure.

Staff understood their duty of care and responsibilities in relation to safeguarding people from harm.

There were sufficient staff to meet people's needs and the recruitment procedures were robust to ensure only suitable people were employed to work in the home.

Is the service effective?

Requires Improvement

The service was not always effective

Staff were not always effective in escalating any concerns to their line manager in a timely way, which had the potential to place people at risk of their needs being unmet.

The service followed the provisions of the Mental Capacity Act 2005 to ensure where people lacked the mental capacity to make decisions any decisions were made in people's best interests.

Staff supervision and appraisal systems were in place to monitor their work and identify any personal development needs.

Is the service caring?

Good

The service was caring

People were treated with respect and their privacy and dignity were upheld and promoted.

People and their families were consulted with and included in making decisions about their care and support.

Staff supported people in a caring, compassionate manner. They were familiar with people's needs and supported people according to their wishes and preferences.

Is the service responsive?

Good

The service was responsive

People were provided with activities and entertainment to ensure their social needs were met and to ensure they were not socially isolated.

Before people moved into the service, a full assessment of their needs was undertaken.

Summary of findings

Is the service well-led?

Good

The service was well led

There was an open culture within the home and the provider encouraged people to provide feedback on the care and services people received. This enabled them to make improvements to areas which mattered to people living in the home.

Staff felt well supported by the management team and were confident that any issues raised would be dealt with.

The management had systems in place to assess and monitor the quality of the services and implement changes where improvements could be made.

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.

The Inspection took place on 02 March 2015 and was unannounced, which meant staff and the provider did not know we would be visiting. It was carried out by two Inspectors over the course of one day.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information provided within the PIR and information we hold about the service. We noted the provider always notified us of any important events that affect people's health, safety and welfare as they are required to do under the Health and Social Care Act 2008. The notifications were received in a timely manner and provided information on any actions they had taken to ensure the health, safety and welfare of people who used the service.

During the inspection we spoke with the registered manager, seven people who use the service, five staff and three relatives. We looked at a selection of care records, policies and procedures, a selection of quality audits, staff recruitment and training records and reviewed staff rotas. Over the course of the day we observed the care and support people received and the interactions between the staff and those they supported

Requires Improvement

Is the service safe?

Our findings

People living in the home told us they felt safe and would speak to staff if they had any concerns.

Robust systems were in place for obtaining, recording, handling, using, safe keeping, safe administration and disposal of medicines. However, the organisations medicine management policy and procedure was not always being followed. We found instances in which medication administration records (MAR) had been handwritten and had not been countersigned and witnessed by a second member of staff. This was not in line with the organisations policy and procedures. The organisations medicines policy reviewed in March 2014 stated 'all manual transcriptions will be countersigned by two staff authorised to administer medication.'

It was not always clear why people's medicines had not been administered. Each MAR had a coding system in place to enable staff to record the reason why people's medicines had not been administered. However, this had not been used robustly to indicate why it was sometimes not administered. We saw no records of what actions staff had taken when people refused their medicines. One person's MAR had been incorrectly completed, it indicated two medicines had been administered the day following our visit, however the medicines still remained in the monitored dosage system and showed they had clearly not been administered.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted people's medicines were stored securely in locked medication cupboards in their own accommodation. People were encouraged to maintain responsibility for the administration of their medicines within a risk management process. This enabled people to maintain independence where they were able to do so. Regular monthly audits of people's medicines were undertaken to ensure procedures were being followed safely and people received their medicines as prescribed by their GP. Where any concerns were highlighted actions were put into place to ensure people were protected from any risks.

Staff who handled medicines had completed medication training and competency checks were undertaken before staff took on the responsibility of managing and administering people's medicines.

People had the facility to lock their bedroom doors if they wished to. One person we spoke with told us they did not do so as they did not feel this was needed. One person expressed some concern with regard to access to the home. Their concerns were that access was through electronic doors which remained unlocked whilst the reception was staffed and felt there was the potential that people could walk into the home.

Car parking was under ground and was secure. Access to the home from the car park was via a lift which only permitted access to the floor where the reception was situated. This ensured people were not able to freely enter or exit from any other floor.

Care and support was planned with people's safety and welfare in mind, People were supported to make choices and were involved in decisions about any risks to their health and welfare and the management of these. For example we saw risk assessments in place for moving and handling, falls, pressure area care, medicines, and the use of bed rails. The management of any risks were documented well in people's individual care plans, which provided staff with details of how to manage such risks and the desired outcome people wanted. We saw these were reviewed each month or as people's needs changed.

Staff understood their duty of care and responsibilities in relation to safeguarding people from harm. Through discussions with staff, it was evident they were knowledgeable about what constituted abuse. They knew how to deal with any incidents, suspicions or allegations of abuse and who to report them to. Staff told us they received safeguarding training during their induction and regularly thereafter. We saw a copy of the training matrix which verified this. In addition, our records confirmed that the registered manager notified the Commission of any allegations or suspicions of abuse and followed the locally agreed procedures for notifying the local authority too. The service worked collaboratively with them to safeguard and protect the welfare of people who used the service.

The staff we spoke with were familiar with the whistle blowing policy and were confident they would be protected if they raised any allegations of poor practice to

Requires Improvement

Is the service safe?

their line manager. The commission had been notified by the provider of an incident in which staff had raised such concerns prior to our visit. Appropriate actions had been taken in response to the concerns to protect people using the service.

Safe procedures were in place for recruiting new staff. The recruitment files for staff showed recruitment checks had been carried out to ensure only suitable people were employed to work in the home. These included gaining references, full employment histories and checking criminal records to make sure they were of good character and safe to work with the people living at Cliveden Manor. Any gaps in a person's employment history was followed up and documented.

Staffing levels were determined according to people's assessed dependency levels. People told us they felt there were always enough staff available to meet their needs both during the day and night and had no concerns in this area. We were informed ten staff were rostered on duty from 7am to 2.30pm, seven staff from 2pm to 9.30pm and two waking staff from 9.15pm to 7.15am. The willows unit was staffed by four staff on the morning shift, four in the afternoon and two waking night staff. In addition there were two nurses throughout the day and one nurse at night. The nursing care manager and care services manager were also trained nurses who also worked alongside staff to meet people's needs.

The registered manager told us they were recruiting for a further eight staff and at the time of the visit they were planning a recruitment day. The manager informed us they used agency staff alongside their permanent staff during periods in which they were short staffed and during times of sickness and annual leave. We were informed regular agency staff were used to ensure people were familiar with them and to allow for continuity of care. People living in the home told us they did not notice any difference in the quality of the regular permanent staff and the agency staff.

Staff told us they felt there were enough staff on duty to meet people's individual needs and they had time to read care plans and records at the start of their shift. They were also able to take their allocated breaks and usually finished their shift on time.

During our visit we found the staffing levels were appropriate to meet the needs of people living at Clivedon Manor. We saw that call bells were answered quickly and people's care and support needs were met within a timely manner.

The service had arrangements in place for responding to emergencies. For example we saw that personal emergency evacuation plans were documented and completed in people's care plans. These informed staff how people were to be evacuated in the case of an emergency such as fire.

Requires Improvement

Is the service effective?

Our findings

We noted staff were not always effective in escalating any concerns to their line manager in a timely way, which had the potential to place people at risk of their needs being unmet. Whilst reviewing one person's records, we noted their fluid intake was to be monitored. We saw their monitoring record indicated their fluid intake had fallen below acceptable levels with only 100mls having been recorded the previous day. Records indicated the person had been drowsy for almost two days and had remained in bed. There were no records to show the person's physical observations had been monitored for over 24 hours, with the last reading indicating the person had a slightly elevated temperature. We raised our findings with the registered manager, who took immediate action. The registered manager visited the person, ensured their observations were taken and recorded and the GP was called. The management team expressed concern that staff had not escalated this to senior staff so that all necessary actions were taken in line with the organisations nutrition and hydration policy to ensure their health and well being. The registered manager informed us actions would be taken to ensure that people using the service were protected against the risks of receiving care or treatment that was inappropriate or unsafe.

These were breaches of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were provided with effective training which provided them with the skills and knowledge to undertake their roles competently. They confirmed they received training during their induction period, after which they shadowed experienced staff until they felt comfortable and had been assessed as competent to undertake their role safely. Staff signed an induction agreement agreeing to complete their induction during their first three weeks of employment. The induction covered areas relevant to the needs of the people who used the service and covered subjects which the provider deemed as mandatory. These included health and safety, infection control, moving and handling, safeguarding, dementia awareness, food safety and basic life support. We saw a copy of the staff training matrix to verify this. Staff competencies were assessed by their line manager who observed their practice to ensure the learned skills and knowledge were put into practice safely and effectively.

The registered manager informed us they analysed staff training needs regularly which enabled them to implement further training and support in specific areas of care and as the needs of people using the service changed. We noted the service had training schedules in place to develop and update staff skills and knowledge. We looked at the training schedule for February 2015. This showed training had been booked for staff to attend and included dementia awareness, medication, record keeping and care planning.

One healthcare professional we spoke with following our visit told us they felt the nursing staff would benefit from some end of life care training, to provide them with a greater understanding of the needs of people at end of life. They told us their nursing team had provided support to staff according to people's individual end of life needs but had not provided any form of formal training. They told us they had offered to provide some further formal training for the staff team although to date the service had not accessed them for such training.

People's records were held electronically and each person had a paper copy of their individual care and support plan. Staff were issued with hand held devices which they logged onto and recorded the care and support given throughout their shift. The devices had the ability to flag up when particular aspects of people's care were due to be undertaken and if they had not been undertaken on time. For example where a person was assessed as requiring two hourly turns. The system had built in alerts to indicate where changes had been made and when reviews were due. The registered manager had full access to the electronic records which were also used for monitoring and auditing purposes.

Documentation within people's files showed people were supported to see appropriate health professionals to meet their specific health needs. For example speech and language therapists, district nurses, GP, dental and hearing routine check ups. The registered manager informed us there was not a regular visiting dental service who came to the home, but a local dental surgery could be accessed to visit people if required otherwise staff accompanied people

to the dentist. We saw such visits had been documented in people's care files and any actions or changes to their care and support was documented and their care plans updated accordingly.

We reviewed the records for one person who had severe ulceration to their lower limbs and we saw staff were managing this. At the time of the visit the person was being reviewed by a doctor (GP) after the out of hours doctor had seen them over the weekend. A request was made for an urgent vascular appointment following the GPs visit and an entry was made in the person's records. We also noted, however, the patient had a history of blood pressure problems. Their blood pressure had been monitored three weeks prior to our visit but there was no record this had been repeated. There was no reason documented to explain why it was no longer being monitored. The registered manager was unsure why and assured us this would be looked into.

People were generally supported to have sufficient amounts to eat and drink to promote and maintain a balanced diet. People's care plans contained an assessment of their nutritional and hydration needs and they were weighed regularly to ensure they received adequate nutrition and maintained a healthy weight. Where people had been assessed as being at risk of malnutrition and/or dehydration guidelines were documented on how staff were to manage the risk and monitor and document their food and fluid intake. Information about people's specific dietary needs, their likes and dislikes and the level of support they needed was documented in their care plans. We noted one individual had difficulties with swallowing and saw that appropriate referrals had been made to the GP and the Speech and Language therapist to assess and provide advice.

We observed lunchtime in the willows unit and in the assisted living area of the home. We saw people were provided with a choice of food and drink. They were able to choose from two starters, a meat, fish and vegetarian main course and a selection of desserts. People told us if they didn't like what was on the menu they could choose an alternative. We observed staff sitting with and assisting people in a friendly caring manner and people could enjoy their meals in an unrushed manner. People were provided with supportive equipment to enable them to eat and drink independently where required.

People were invited to provide feedback and have involvement in the choice of meals available within the home through monthly food forums. People we spoke with told us they attended these and felt able to speak and their suggestions were acted upon. For example lunch was provided from 12.30pm onwards, but following suggestions at the food forum, the home was trialling a 12pm lunch to accommodate people's suggestions and was to be reviewed at following food forums.

Staff were provided with one to one supervision meetings These enabled them to meet with their line manager to discuss aspects of their work. This included discussions in relation to their performance, communication, relationship with people using the service, families and staff any further learning and development needs and to reviewed their training. Spot checks were also undertaken and documented in staff files. This enabled line managers to monitor staff knowledge, skills and practice and address any areas of concern.

We were informed there was a policy in place to ensure staff received an annual appraisal of their work. We were informed that whilst the home had not yet been opened for a year twelve staff had received an appraisal of their work and the remaining staff would receive one when they became due.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 (MCA) to ensure any decisions were made in people's best interests. The MCA is a law about making decisions and what to do when people cannot make some decisions for themselves. The Deprivation of Liberty Safeguards (DoLS) are part of the Act. They aim to make sure that people in care homes, are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

The registered manager demonstrated a knowledge and understanding of the MCA and DoLS and when an application to deprive someone of their liberty was to be made to the authorising local authority. For example entry and exit to the Willows unit was locked and controlled by staff to ensure the safety and welfare of people who lived in the Willow unit. Such a restriction meant people with dementia care needs could not leave the unit alone but rather with the support of staff or family members. Because of this restriction, appropriate applications had been made to the local authority for Deprivation of Liberty Safeguards

Requires Improvement

Is the service effective?

(DoLs) assessments. We saw some urgent as well as standard applications had been made. This showed the service had undertaken the correct processes to ensure people were appropriately assessed and any decisions made on their behalf were made in their best interests to ensure people were not unlawfully deprived of their liberty.

Staff we spoke with demonstrated an understanding of capacity and consent and acting in people's best interests.

They told us they had received MCA and DoLS training. We saw a copy of the training matrix which verified this. They showed a good knowledge in this area and how it related to people who lived in the home.

We recommend the service finds out more about training for staff based on current best practice in relation to end of life care.

Good

Is the service caring?

Our findings

People we spoke with were complimentary about the staff who worked in the home. Two people's comments included "staff are very good" "very nice" "there is nobody nasty here". They told us staff often sat and chatted with them and we observed staff spending some one to one time carrying out a pampering session with some of the ladies painting their nails. People commented on the professionalism of staff. One person told us "Staff couldn't do better, they [staff] are more than willing to help", whilst another told us "I can't say anything too good, It's first class." They went on to tell us the attitude of staff had impressed them saying "They [staff] do it from the heart".

We were able to speak with some visitors during the course of the visit and one person described Cliveden Manor as a "much better place" than a previous home.

People told us the staff on reception were "wonderful" and we observed staff from both the care side as well as administration side, engaging with people in a friendly, caring way. People told us they appreciated staff being cheerful even though they worked very hard. They also told us they felt respected by staff and told us staff always knocked before entering their rooms and used their preferred names. People told us staff respected their privacy and dignity whilst providing them with personal care and support.

Staff respected people's dignity by knocking on people's doors and waiting to be invited in before entering their rooms. Where personal care was provided, this was undertaken in privacy to ensure people's privacy and dignity was respected.

People's bedrooms were personalised with items of personal furniture and memorabilia and they were encouraged to bring such items with them when they came to live at Cliveden Manor. Similarly two people had brought their dogs with them and had been provided with accommodation to suit their needs in that they had access to a patio area outside their rooms.

People told us they were given appropriate information about the home and the facilities that were available to them when they came to live at Cliveden Manor. We saw the home's brochure was displayed in the reception area which was readily available for people using the service and visitors to access. We were told this could be provided in various formats to meet people's individual needs. Similarly there was information about advocacy services which people could access or be supported to access if they wanted an independent advocate to speak up on their behalf or support people during their reviews of care if they felt they needed support in the process.

We saw documentation within people's files to show that people's end of life care had been discussed with them and/or their families. The records contained details about how they wanted their care to be provided, who they wanted involved and whether they wished to receive resuscitation. Resuscitation had been discussed with them, their GP and their family/ lasting power of attorneys where they had appointed one and was documented in their care plans. This was to ensure people were involved in making important decisions about their end of life care, treatment and support. This enabled staff to provide their care and support according to their last wishes. We were informed support from the Iain Rennie nurses was available to the service to support them to ensure a person's last wishes of being pain free were upheld, when required. The registered manager informed us they had "fantastic" support from Iain Rennie nurses and that they provided advice in relation to appropriate medicines and general end of life care for people on end of life care. The registered manager informed us formal training dates were being agreed with Iain Rennie and were awaiting confirmed dates. This was to ensure staff received the appropriate skills and knowledge to care for people on end of life care.

There was a keyworker system in place so people had a named member of staff who reviewed their care with them each month or sooner if their needs changed. People could speak with their key worker if they had any concerns or issues. People we spoke with verified they had a keyworker who they would speak to if they had any concerns. A keyworker was an allocated staff member who had particular responsibility for a person using the service. This enabled staff to develop close working relationships with people they provided care and support for.

Good

Is the service responsive?

Our findings

People we spoke with told us they were happy with the care provided at Cliveden Manor and were complimentary about the staff. They told us staff responded promptly to requests for assistance and we saw calls showed up on a hand-held electronic records system which each member of staff carried with them. One person said "I have used the call bell and they (Staff) come quickly, they look after me very well." During our visit we saw calls were responded to in a timely way.

We spoke with two healthcare professionals after our visit who visited the home and provided support and advice. Both told us the service was responsive and followed any advice given. One informed us "I have no concerns whatsoever….any problems they refer people to me and they do follow my advice." Another told us the service were responsive in that they followed any advice given and some changes in practice had been made as a result of their advice given.

People told us their needs had been assessed prior to moving into the home. This enabled people and their families to discuss their health, social and personal care needs, what they were able to do themselves and how they wished staff to support them. This enabled people and their representatives to make an informed choice about whether they felt the home was suitable to their needs. It also enabled the home to be confident they could meet people's individual needs before a place was offered. We looked at examples of pre admission assessments and found information was included such as next of kin, GP details and other health care professionals involved in their care. There was also detailed information in relation to their social interests, medical histories, medicines and nutritional likes and dislikes. The home drew up an initial care plan from the assessment which was later developed and added to as staff got to know the person

We found people's care plans had taken into account people's individual wishes and preferences in the way they wished their care and support to be provided. They were individualised and person centred. We saw some signed documentation to show they and/or their representatives had been consulted with and they had signed documentation agreeing to the care and support detailed in their plan of care. Care plans were regularly reviewed in consultation with the person, their representatives and their key worker to ensure they were up to date and met their needs accordingly. Where any changing care needs had been identified they had been documented in their care plan and communicated to the staff team.

People told us they were consulted with in the care planning and review process and involved in making decisions about their care and support. We saw signed documentation to show where people were able to express their wishes and contribute to the care plan. They had signed a consent form to verify they had been consulted with in the care planning process. In situations where people did not have the capacity to contribute, best interest meetings were held which involved family or representative(s) who signed the consent forms on their behalf. Where people had lasting powers of attorney in place, this had been documented appropriately within people's care files.

People's life histories had been documented and completed with them. These provided staff with a picture of the person's life history, their hobbies and interests and family connections. People told us they were supported to follow their interests and take part in social activities both within the home and within the local community. For example visits to the library, local theatre and places of interest. Whilst religious services and Holy Communion were made available to people in the home, people were supported to attend such services within the local community where they had chosen to do so. People we spoke with told us there was a varied programme of activities throughout the day from which they could choose to attend. Two people we spoke with said there was a "large range" of activities which they could take part in if they wished to. Activities included word games, gentle exercises, card games, movie nights, discussion groups and one to one activities were provided for people where required. There was also a hair salon and a treatment room in the home and a visiting hairdresser and therapist visited regularly to provide people with hair dressing services and therapies such as manicures and pedicures.

Information about how to raise a complaint and the timescales in which they could expect their complaints to be dealt with were clearly documented. The registered manager informed us any complaints received were documented in a complaints log and were audited to check for any trends where improvements could be made. We were informed there were no current complaints.

Good

Is the service responsive?

People we spoke with told us they felt able to raise any concerns or worries with staff and were confident of a response.

We were informed resident forum meetings were held every month which people could attend. People we spoke with verified this. We saw notices posted within the home informing people of when these were scheduled. The monthly forums included an activities forum, restaurant and catering forum and meet the managers forum. These provided people with the opportunity to raise any concerns and discuss what was working well and where improvements could be made. For example some people told us changes had been made as a result of comments made in the restaurant and catering forum. These were in relation to the time that lunch was provided. The service were trialling a change in time of lunch in response to their comments. The meetings were minuted and shared with people who lived in the home.

People we spoke with told us they felt able to raise any concerns or worries with staff and were confident of a response.

Good

Is the service well-led?

Our findings

The registered manager was supported by a care services manager, a nursing care manager, dementia care manager, residential care manager and a dedicated team of staff. The management team were very much involved in the day to day care and support provided to people who used the service, which meant they were able to monitor staff practices and any issues raised or observed could be dealt with immediately.

Staff told us the registered manager and management team were approachable and they had no concerns in bringing any matters to their attention. They described their line managers as supportive and we observed positive and friendly interactions between staff and managers throughout our visit.

People told us the management team had an open door policy and they could meet with them without the need for making an appointment.

The service provided people with the home's brochure and statement of purpose when they moved into the home. These provided people with information about the services provided as well as the organisations aims and objectives. It also included details of the registered provider and registered manager's qualifications and experience of the staff team.

Visitors told us they felt able to raise any issues with the senior managers but were less clear about who to contact at a more junior level. Some were not clear about the lines of seniority above the care staff and below senior managers.

Staff were knowledgeable about the homes vision and values which were centred around people's individuality and provided an inclusive community in which they lived. Both the people who lived in the home, their relatives and staff were involved in the way the service was run collaboratively to ensure people received individualised care and support according to their wishes and needs.

The provider had systems in place to monitor the quality and safety of the service provided and to ensure they consistently met the needs of people who used the service. These included monthly internal audits of key activities including the care provided, an analysis of any accidents and incidents and any trends, an analysis of any complaints received and an audit of the management of people's medicines. Where any areas of concern were highlighted, action plans were put into place detailing actions to be taken and addressed within a specified time span. The clinical director visited the service regularly to undertake further clinical audits and discuss the progress of any actions from the previous month's audits. The Group Care Quality Director was able to remotely access people's care records to monitor the care and support provided and visited the home to provide support to the management team and to monitor and review the quality of different aspects of the service. This included reviewing and auditing complaints, any staffing issues, notifications and safeguarding issues within the last month. They also included reviewing any maintenance issues, and speaking with people who used the service and with staff to gain feedback on their experiences of living in the home and working in the home. Following the visit agreed improvements were planned with the registered manager and the management team and an action plan put into place to address any areas where improvements could be made.

The registered manager informed us that there was a formal process in place to gain feedback about the services offered at Cliveden Manor. The feedback was gained via satisfaction surveys which were provided to people using the service, their relatives and or representatives. These were undertaken twice a year in May and October. We were informed a satisfaction survey had not yet been issued since the home had only opened in August 2014, although plans were in place to send satisfaction surveys in May 2015. The registered manager informed us the returned surveys would be collated and analysed and from the results an action plan would be put into place to address any identified issues. They told us the analysis and action plan would be displayed in the reception and presented and discussed with people as part of the monthly forums.

Staff surveys were sent annually for completion to gain feedback on the service and their working conditions, their work environment training, support and supervision. These were sent out in October 2014 and the service were in the process of collating and sharing the findings with staff at the time of our visit.

Good

Is the service well-led?

People's views were also sought through day to day discussions with staff and through regular monthly forums. Where any areas of concern were raised actions were taken to address their concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** People who use services were not protected against the risks of dehydration by means of support to enable people to drink sufficient quantities for their hydration needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People who use services were not protected against the unsafe use and management of medicines by means of making appropriate arrangements for the recording of medicines.**