Signature of Marlow (Operations) Limited

Cliveden Manor

Inspection report

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on the 22 and 26 September 2016 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. During our inspection there were 74 people living at the service.

In the most recent inspection of Cliveden Manor in March 2015 we found breaches 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 there was also inconsistency in how effectively people were protected against the risks of dehydration.

The provider submitted an action plan dated 17 August 2015 which set out the action already taken or to be taken to address this. The current inspection provided an opportunity to assess whether the action plan had been successfully completed.

The service had a registered manager. 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.

We found progress had been made to address previously identified areas of concern. For example, there had been improvement in medicines management and fluids monitoring. Some concerns with aspects of medicines management remained however which has been reflected in this report.

We received mostly positive feedback on the quality of the service from people who lived in Cliveden Manor and their relatives. In a few cases, people's experience of the service had not been positive. At the time of the inspection their concerns were being addressed through the provider's complaints procedure. Healthcare professionals we contacted were very positive about the standard of care they observed and the communication and co-ordination that existed between Cliveden Manor and themselves. They told us they were able to work well with staff and that the service responded to and took part in projects being carried out within the health and social care sector locally.

There were safeguarding procedures in place and staff received training on safeguarding vulnerable people. This meant staff had the skills and knowledge to recognise and respond to any safeguarding concerns. The registered manager and staff demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. They understood that where people lacked capacity a mental capacity assessment needed to be completed and best interest decisions made in line with the MCA. Staff had a good understanding about giving people choice on a day to day basis and this was supported by our observations during this inspection.

Risks to people were identified and managed well at the service so that people could be as independent as possible. A range of detailed risk assessments were in place to reduce the likelihood of injury or harm to people during the provision of their care.

We found staffing levels were adequate to meet people's needs effectively. The staff team worked well together and were committed to ensure people were kept safe and their needs were met appropriately. Where agency staff were used, the service tried to use staff who were familiar with Cliveden Manor, its routines and the people who lived there.

Staff had been subject to a robust recruitment process. This made sure people were supported by staff that were suitable to work with them.

Staff received appropriate support through induction and supervision. All the staff we spoke with said they felt able to speak with the registered manager or care service manager when they needed to. There were staff meetings held to discuss issues and to support staff.

We looked at summary records of training for all staff. We found there was an on-going training programme to ensure staff gained and maintained the skills they required to ensure safe ways of working.

Care plans were in place to document people's needs and their preferences for how they wished to be supported. These were subject to review to take account of changes in people's needs over time. We found the use of both paper and system based care records led to some lack of consistency. The system based records, including the hand-held ones used by care staff, were very comprehensive and up to date.

The service was managed effectively. The quality of care was regularly checked through audits and by giving people the opportunity to comment on the service they received and observed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was in relation to the management and monitoring of medicines.

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 consistently safe.

People's medicines were not being consistently managed safely. Although previous concerns had been addressed, areas of ongoing concern were still identified.

People said they felt safe. Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised. They had completed training in safeguarding of vulnerable adults.

People were protected as staff levels were adequate to meet their individual needs. There were effective recruitment processes in place.

Is the service effective?

Good

The service was effective.

People received safe and effective care. Staff were supported to achieve this through structured induction, regular supervision and training.

People were encouraged to make decisions about their care and how it was provided. Decisions made on behalf of people who lacked capacity were made in their best interests.

People received the healthcare support they needed to maintain their health and well-being.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff protected their privacy.

People were supported by staff who engaged positively with them whilst they provided care and support.

Staff knew people well and understood their different needs and

the ways they liked their support provided.

Is the service responsive?

Good

The service was responsive.

There was a care planning process in place which helped staff provide people's care in the way they wanted them to.

The service responded appropriately when people's needs changed. This ensured their needs continued to be met and that they could remain as independent as possible.

People were supported when they wanted to take part in activities and social events in order to provide stimulation and entertainment.

Is the service well-led?

Good

The service was well-led

The registered manager was available for people who lived in Cliveden Manor, their relatives and staff. The care services manager was very active within the service.

The management of the service helped support staff, who worked well together as a team.

There were quality assurance systems in place to both monitor the quality of care provided and drive improvements within the service. People who lived in Cliveden Manor, their relatives and staff were involved in and could contribute to this process.

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 22 and 26 September 2016 and was unannounced on the first day. The inspection was carried out by two inspectors, a Care Quality Commission pharmacist specialist and an expert by experience on the first day and one inspector on the second day. An expert by experience is a person who has personal experience of using or caring for someone who uses or has used services.

In August 2016 the provider submitted 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. During the inspection we gave the registered manager the opportunity to discuss this with us and update any information. They provided us with any additional information about the service when we asked and were open and co-operative throughout and following the inspection.

We reviewed notifications and other information about the service we had received since the last inspection. A notification is information about important events which the service is required to send us by law. Prior to our inspection we received two complaints about aspects of the service, including the quality of care and the management of medicines. We followed these up during the inspection.

During the inspection process we contacted health and social care professionals to seek their views about people's care at Cliveden Manor. We received four detailed responses to these which we have taken into account in making our assessment of the service.

During our visit we spoke with 14 people who lived in Cliveden Manor and also to two relatives of people who lived in the home who were visiting the service. We spoke with the registered manager and the care services manager, the senior member of staff responsible for medicines management and with 12 staff members including catering, domestic and activity staff. The expert by experience and one inspector carried out three periods of observation when they were able to see how staff and people who lived in Cliveden

Manor interacted.

We checked records about how people's care was provided. These included nine people's care plans and 13 medicine administration records. We also looked at three staff files containing recruitment checks and supervision and training monitoring records for all staff.

Requires Improvement

Is the service safe?

Our findings

In our inspection of Cliveden Manor in March 2015, we found staff were not consistently following the provider's medicine management policies. This was because handwritten entries on medicines administration records (MARs) were not always witnessed and countersigned. In their action plan of August 2015 the provider indicated that staff would receive further training on the recording of medicines and would familiarise themselves with the provider's medicines management policies.

During the current inspection, we looked at the systems in place for managing medicines. We spoke with staff involved in the governance and administration of medicines and looked at 13 medicines administration records (MARs).

Since the previous inspection it is recognised steps had been taken to improve the management of people's medicines. We found the service had processes in place to ensure that residents received their medicines as prescribed. Medicine storage was temperature monitored, secure and only accessible to authorised staff.

We found that whilst the MARs gave a comprehensive list of residents' medicines, staff did not always sign to indicate a medicine was given. Sometimes staff made handwritten additions to the MARs; the medicine policy stated that 'all manual transcriptions will be countersigned by two staff authorised to administer medication'. Staff did not always get a second check on handwritten MARs and we saw two examples where the MARs did not match the pharmacy label.

It was positive that the provider encouraged individuals to maintain independence with their medicines. However, although staff completed regular risk assessments for the self-administration of medicines, the auditing was not always identifying potential risks. For example, one resident filled a dosette box but the staff did not check the box was filled correctly and the staff were not aware of one of the medicines the person was taking.

These were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored appropriately within the treatment rooms. When staff administered a controlled drug, the records showed the signature of the person administering the medicine and a witness signature. The record book showed monthly stock checks.

Staff who administered medicines had received face-to-face training and a competency assessment. Staff said that the managers allowed them to progress through the medicine training at their own pace. They felt comfortable to address any concerns with the management team. If a member of staff made an administration error then their competency was re-assessed.

The staff administered medicines in a way that respected the individual. Staff tailored the administration to

the needs and preferences of the individual and understood the importance of keeping to exact administration times for residents with Parkinson's disease.

The management team conducted monthly medicine audits and staff did random monthly medicine checks. As noted above, these had not always identified where the provider's medicines management policy was not being followed consistently. The service had a medicine steering group that discussed medicine incidents and other medicine management matters. The home had a clear process for reporting medicine incidents. We saw evidence of medicine incident reports that had been investigated and actioned. Staff said there was an open culture for identifying medicine errors and they felt comfortable to highlight their own errors or errors made by colleagues. In their PIR the service reported there had been 42 medicines errors in the previous 12 months. These governance processes should help to keep medicine processes safe for residents.

One person who contacted us before the inspection and another person we spoke with during the inspection raised concerns about the availability of specific medicines or delays in obtaining them. We found the home had recently made improvements to the medicine ordering process. The person we spoke with also noted that whilst they had problems in the past, (a named member of staff) had "now got on top of it." This meant their medicines were now available and suitable for use. We also found medicine waste was managed in line with legislation.

The majority of people who spoke with us told us they felt safe living in Cliveden Manor, comments included; "Oh yes I feel safe, this is better to where I was" and "Yes I feel safe here" and "Yes I feel very safe. The security here is good…I went into hospital for approximately nine weeks and when I returned everything was in the same place as I left it."

To help us assess if there were enough staff available when people needed them we asked if they had used their call bell when they needed assistance and if so how quickly was it answered. We received a range of answers from; "I've used it sometimes yes, and they come very quickly" to "It takes them up to 20 minutes for them to respond." One person assessed that call bell response times were very good during the daytime, but less good at night. During the two days of the inspection there was very little activation of call bells and where there was, they were answered very promptly.

We confirmed with the care service manager that call bell response times were collected and analysed at provider level in order to ensure they remained within safe and acceptable limits. We saw the analysis records for the period January to August 2016. These showed the average of response times for emergency calls and assistance (non-emergency) calls were within the range of 28 seconds to one minute and 34 seconds for emergency calls and two minutes and fifty two seconds to three minutes and fifty one seconds for assistance calls. Within these average figures some were quicker and some slower which reflected the varying opinions of response times expressed to us during the inspection.

We did not find that staffing levels were a particular issue during the inspection. In the analysis of the residents' survey for Cliveden Manor in June 2016, 80% of the people who responded thought staff were available when they needed them. People commented on the use of agency staff, some favourably, because they felt they were familiar with the home and the people's care needs, others less favourably where that was not the case. When we spoke with staff they did not raise staffing levels as a particular concern. They told us they worked well together as a team and were able to cover when there were any short notice staff absences; "Staff all pull together". They confirmed that a number of the agency staff were used regularly and so knew the home's routine and the people they provided support for.

Staff confirmed they had received safeguarding training to help them recognise the signs of potential abuse. They knew what action to take if they saw or suspected abuse had occurred. There were contact details for the relevant safeguarding bodies displayed in the home and the registered manager recorded and dealt with safeguarding issues appropriately. Staff were aware of the Signature policy on whistle-blowing and said they would use it if the need arose. However, they all told us they felt able to take any concerns to the registered manager or care service manager and were confident they would be addressed. Staff had a good understanding of their 'duty of care' and one summed it up as; "It is our job to make sure people are safe."

We looked at both system based and paper care records. We found risks to people were identified and managed. Individual risk assessments were in place and were reviewed to ensure they remained up to date and relevant. These included, for example, the risk of falls or of significant weight loss, skin breakdown or pressure ulcers. This meant people were protected from avoidable risks and appropriate action taken to minimise risks where they could not be entirely eliminated.

We looked at three recruitment records for recently employed staff and spoke with staff about their recruitment. We found safe recruitment practice was being followed, for example with the necessary checks carried out before people were employed. This meant people were protected from the employment of staff who were not safe or suitable to provide care and support for them.

We found people lived in a safe and well-maintained environment. We saw records relating to health and safety, equipment maintenance, fire safety and fire drills were maintained appropriately. There were recording systems in place and being used to record accidents and incidents, together with any corrective action required or taken. This meant people could be satisfied they were protected appropriately from avoidable harm or injury.

People were protected from infection and their health and safety was supported by the policies, procedures and staff training in place and being followed. In their PIR the service provided details of their infection control policies and practice. There was an infection control lead person within the service to promote and monitor good infection control practice. Infection control audits had been completed and action plans drawn up to address any issues identified.

Staff confirmed they had access to the necessary protective personal equipment, for example aprons and gloves. There were hand washing and cleansing facilities throughout the home. Staff confirmed they had received training in infection control and health and safety. Health and safety audits had been carried out by an external specialist last year and any issues addressed.

People were protected, as far as possible to do so, from risks associated with fire or faulty equipment. We saw there were personal emergency evacuation plans in place for each person. Statutory inspection files were in place covering, for example, fire equipment, assistive baths, hoists and lifts. We were told the service had received and would follow advice provided by the fire service in the event of fire.

Good

Is the service effective?

Our findings

Whilst we received some very negative comments about how one person's care had been co-ordinated we also received some very positive comments from other relatives.

On the basis of what we found and the assessments we received, people's needs were being met appropriately. People were overall very positive about the support they received from staff. "From the housekeepers to the carers and nurses – a great bunch" was one person's assessment.

People's specific needs were very well understood by care staff. When we talked with staff about specific people who they provided care and support for, their knowledge and understanding was never less than good and in some cases excellent. Staff had built up a good understanding of the individuals' needs over time and this was reflected in care planning and delivery. People told us staff were approachable if they had a problem. "Yes, I think the staff are caring and they do listen to what I say." Another person told us; "Yes they have some staff that have been here since the beginning and they use some agency staff. But the agency staff have usually been here before and know what they are doing."

People received care and support from staff that were appropriately trained. We spoke with 12 members of staff and with members of the management team. They were all positive about the training they received. "Training is excellent." was one assessment.

Staff confirmed they had received a full induction when they started working. A newly appointed member of staff told us how a lead carer had given them a pack of information to go through. They had then shadowed a more experienced staff member and had a series of competency checks against a checklist. They told us; "This is my first time in care and I was very well supported and not rushed."

The registered manager showed us the systems which helped them ensure staff were up to date with the appropriate training for their role. They provided us with details of all the training provided and planned for staff. These records showed they were up to date with the training determined to be essential by the provider; for example moving and handling, safeguarding and infection control.

Health and social care professionals we received feedback from said they felt the staff were competent to carry out their roles. One noted; "The care and patience showed by the carers was outstanding."

Staff confirmed they received appropriate support to help them effectively fulfil their specific roles within the service. We saw records were kept of when staff had met with their line manager for supervision. Additional assessments and annual appraisals were carried out to assess and monitor staff performance and development needs throughout the year.

Staff told us communication was good within the service. We observed a staff handover session at the beginning of a shift. We found it was comprehensive and effective. Staff had a good understanding of individuals' needs and how they were to be met. Staff maintained daily records of people's health and

welfare. Staff meetings took place to discuss and improve practice. The staff we spoke with told us they had no hesitation in discussing any issues or concerns with the management team or senior care staff. Talking about the staff team, one member of staff told us; "Never had an issue with anyone, it is a really nice team, residents and staff are all one family."

People's healthcare needs were monitored effectively. Any changes in their health or well-being prompted a referral to their GP or other healthcare professionals. For example, people could be referred to the dietitian and speech and language therapists if staff had concerns about their well-being.

Care plans identified any support people needed to keep them healthy and well. The records showed people routinely attended appointments with healthcare professionals, for example, dentists, opticians and hospital specialists.

GPs visited the home regularly from the local surgery. This provided consistency for the people concerned and enabled the home to plan when people could have a routine consultation. Additional visits by the GP or access to other health services were arranged on an 'as required' basis.

Those healthcare professionals we received feedback from were positive about communication with Cliveden Manor and also indicated they thought referrals to their services were appropriate and timely. They said they felt Cliveden Manor management were supportive of them and "listened and learnt." They told us, for example, that Cliveden Manor had accepted an offer of specific training in identifying and managing swallowing problems in people with dementia. This had enabled them to continue best practice and to cascade knowledge throughout the staff team. One specialist nurse told us; "We discuss any concerns and queries when I visit the home. We work well together to achieve our goal to provide patient centred care."

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

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When we talked with staff about this, we found they had a good knowledge and understanding of the MCA and had received relevant training.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people by ensuring if there were any restrictions to their freedom and liberty these had been authorised by the local authority as being required to protect the person from harm. We found that the registered manager understood when an application should be made to the relevant authority and how to submit one. At the time of the inspection we found appropriate applications in respect of DoLS had been made to the local authority but had not yet been determined.

People were given choices in the way they wanted to be cared for. People's capacity was considered in care assessments in line with legal requirements, so staff knew the level of support they required while making decisions for themselves. If people did not have the capacity to make specific decisions around their care, staff involved their family or other healthcare professionals as appropriate to make a decision in their 'best interest' as required by the MCA. We found, in conversations with staff, that their understanding of the implications for their practice of DoLS was very good. People were assisted and encouraged to have the

opportunity to consent to the details of their care and how it was provided. Throughout the inspection, we observed staff spoke clearly and gently and waited for responses from the people they provided care and support to.

People were given plenty to drink. Where necessary people's food and fluid intakes were monitored and recorded to ensure they were appropriate for the maintenance of their health and well-being. People's care records also included details of any allergies or food intolerances, for example to gluten or personal lifestyle choices such as vegetarians.

We received a range of contrasting assessments as to the quality and variety of food on offer. "It's ok normally, but it is not a good choice." "The food here, yes it is good, it's ok, we get a good choice of menu." "The food is very uninteresting, but I would say you wouldn't die of starvation". "The food I find is quite good. We have a food forum and we get a good choice." "Variety of menu to choose from;" "Some bits of the food are not so good, but otherwise the rest of the menu is good;"

We observed part of the lunch period in the main dining area. Care workers provided assistance sensitively to those people who required it. Staff took time to provide support and talked with the people they supported calmly. The people we spoke with about food confirmed any staff assistance they required was provided appropriately. We saw people had a choice of where they ate. This could be the dining room, other shared areas of the home or in their own rooms if they preferred.

We saw that some staff ate with people who lived in Cliveden Manor; extra portions were available and offered to people. We also saw people being offered choice during the meal. Where they could not understand a written menu, visual choices were offered to help them decide. We did note one member of staff was trying to support two people to eat at the same time and also have their own meal. This was achieved, but was not ideal. However, sharing people's mealtime helped make it a positive experience for both staff and those who they provided support to. We observed drinks being offered throughout the inspection which ensured people had enough fluid intake. Following meals, food intake was checked and recorded where appropriate. In the lunch settings we observed, there were no undue delays in serving people.

Cliveden Manor was a purpose built care home and provided a safe and effective environment for people with, for example, appropriate assisted bathing and lift facilities in place.

Good

Is the service caring?

Our findings

People told us they felt the staff were caring. One person told us; "I have never had a problem with any of the staff, they are kind and respectful." Relatives we spoke with also had mostly very positive views of the service and staff; "The carers are very good, kind and caring." One person did comment unfavourably about the continuity of staff at times, however, overall, they told us they "were very satisfied" with the standard of care they received.

In the 2016 resident survey, 93% of those who responded agreed they were treated in a caring and compassionate way. This represented an increase as a percentage compared with the same survey for 2015.

We were informed there was a 'leading light award' for staff. Staff could be nominated by other staff, people who lived in Cliveden Manor or relatives of people who do.

People received care from staff that understood them and knew their personal tastes and preferences. We observed people appeared very comfortable in the company of staff. Interactions between people were relaxed and demonstrated a sociable atmosphere in the communal areas of the home, especially at mealtimes. "There are no staff that I am not comfortable with" one person told us. One member of staff told us; "Residents and staff are all one family."

Staff confirmed they had received training in equality and diversity and how this should be reflected in appropriate and sensitive care provision. The staff team was representative of people who lived in Cliveden Manor.

During the inspection we saw that when people asked for assistance, for example, with going from a shared area to their rooms or to the toilet facilities, staff responded very quickly and with patience.

Staff had received training during their induction and afterwards in the need to promote people's dignity and maintain their privacy. If people needed to be supported to move, this was done in a way which promoted people's dignity and staff spoke with people throughout the whole process.

Throughout our inspection we saw staff consistently treated people with dignity, respect and compassion. For example, we observed staff knocked on bedroom doors and waiting for a response, before entering the room. Those relatives we spoke with were positive about how their relatives' privacy and dignity were preserved during their visits. "The staff treat her with kindness and respect and give her chocolates which always puts a smile on her face." When we spoke with staff, they had a very good understanding of the need to protect people's dignity during the provision of care; "Imagine it is you in that situation" was how one person summed their approach up.

People were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. People were able to make choices about their day to day lives for example if they wanted to spend time with others

in one of the lounges, or if they preferred to spend time alone in their rooms.

We received different assessments from people about how involved they were in the planning of their care. "Yes I've looked at it and it's just been updated and I've signed it" and "Yes, I have seen my care plan, I can read it and I have updated it," to "They asked me to review it and sign it but it was still wrong. Now it is on top of my wardrobe and nobody has looked at it."

Staff training included the implications for their care practice of providing care to people at the end of their lives. Following the inspection we were sent feedback from staff about an end of life seminar held on the 5th October 2016. "Brilliant, very helpful and informative" and "An excellent discussion on a very difficult subject" were typically positive comments.

Staff told us that part of their role in providing end of life care was to; "look after the family." In their PIR the provider told us an 'End of Life Champion' would be identified and additional bereavement training be made available for care staff within the next 12 months.

We were told by the registered manager that they would always try and meet people's wishes to remain in what was their home, rather than be transferred to hospital. This was unless their medical needs could not be appropriately met within the home, even with external specialist input. This assessment process had been the cause of a significant complaint by the family of one person and was still the subject of an ongoing complaints process.

People were supported to make decisions to refuse treatment or appoint someone with lasting powers of attorney if they wished to do so. When this was the case, the appropriate details were included in the persons care plan. This included who they had appointed where relevant and their legal responsibilities in respect of which decisions they could be involved with. In their PIR, the provider informed us there were 12 people who had given another person a valid and active lasting power of attorney. They also reported that 23 people had 'Do not attempt resuscitation' (DNAR) forms or agreements in place. One person was recorded as having a specific care plan setting out their advanced care preferences.

People had access to advocacy services when they needed them. Advocates are people independent of the service who help people make decisions about their care and promote their rights. We were told that where advocacy was required, most people had members of the family who did this on their behalf. There were however details of independent advocacy services available.

During our inspection we saw GPs carried out consultations with people in a shared lounge area. This had the potential to compromise people's privacy and dignity. This was reported to the Care Services Manager who took it up with the GP practice. We were informed this was not the service provider's normal practice, as all consultations were usually conducted appropriately, in private. Both the service and the GP practice indicated they would be reviewing their procedures as a learning opportunity to see if improvements could be made."

Good

Is the service responsive?

Our findings

People had their needs assessed before they moved into Cliveden Manor. This ensured they could be met appropriately, based on robust and accurate information. Information had been sought from the person, their relatives and other relevant professionals involved in their care. Information gained through the assessment was then used to draw up an individual care plan. This enabled staff to have ready access to key information about people's care needs and how they were to be met.

People's care plans detailed daily routines and preferences specific to each person. There were sections in care plans about supporting people with different areas of daily living, for example, their health, dressing, washing, continence and mobility.

We found that care plans were being used in two formats. The system based care planning tool was very comprehensive, well-completed and kept up to date, and contained all the information care staff required to identify and meet people's needs appropriately. Staff were provided with hand held devices which enabled them to access and input into the care record contemporaneously. However, we found that the paper care plan records were not always as well-completed or up to date. This was discussed with the registered manager and care service manager as it could potentially be the cause of confusion or error.

People continued to receive appropriate support when their needs changed. Care plans showed evidence of reviews taking place, involving the person concerned, their family where appropriate as well as key staff with knowledge of the person. This meant changes to people's circumstances, for example, to their mobility or weight could be identified.

From what people told us and from what we observed during the inspection, including at lunchtime, people were offered choice. They could, within reason, determine how their care and support was provided. Staff were able to tell us in detail about people's needs and how they were met.

People received care and support from staff who knew them well. Staff showed concern for people's well-being in a caring and meaningful way, and they responded to their needs quickly. People told us they were happy with the care they received.

Staff knew about people's individual communication needs. People could move freely around the home and choose where to spend their time. Staff respected people's choices to be in their rooms if they wished. There were areas in the building where people could sit and talk with visitors and family.

Activities were arranged to reflect different cultural celebrations, important national events and other special occasions, for example Christmas and New Year. We spoke with an activities co-ordinator. They had an activity programme for the home over the next few weeks. This included, for example, in the current week for the Willows unit, musical activities, exercises, quizzes, Tai Chi and dance, music and movie night. They confirmed they were supported by the registered manager and provider with the required level of resources and staff support. The service made use of the grounds for activities when the weather permitted.

We observed activities being undertaken. Staff actively involved people in decision making about what was happening, and offered choice. We observed people were able to spend time in their own rooms or to sit quietly without being pressured to 'join in' when they showed no signs of wanting to do so. As well as communal activities, activity staff undertook one to one sessions with those people who preferred their own company or were restricted to their own rooms through ill health or choice. One person we spoke with assessed activities as; "Excellent, always something going on and plenty to do."

The service had appointed a new activities manager. We were told that the programme of activities was kept under review and would be developed, involving people who lived in Cliveden Manor, to make sure it continued to meet their needs effectively and reflected best practice, for example for those people who lived with a degree of dementia. The service were members of a recognised organisation which promoted positive and effective activities within care settings. This meant activities in Cliveden Manor could reflect best practice and take account of current research.

There were procedures for making compliments and complaints about the service. Information about this was displayed prominently in the home. In their PIR, the provider informed us in the last 12 months they had received 18 written compliments and 23 complaints that were managed under their formal complaints process. Of these, 22 had been resolved at the time the PIR was returned. We saw from the records of complaints that they had been dealt with within the appropriate timescale. Some recent complaints we were aware of were still awaiting a final determination through different stages of the complaints process. One complaint was in part about how the transition between Cliveden Manor, hospital and an alternative care setting was assessed, arranged and communicated. This was being dealt with through the Signature complaints policy and procedure.

Good

Is the service well-led?

Our findings

The staff we spoke with told us overall they felt supported and were able to speak up and voice their views and raise any concerns. Information was shared between care staff and care management in a variety of ways, for example face to face, during handovers between shifts and in team meetings. Staff also commented on how well they worked together as a team. We saw staff interacted with the care services manager, registered manager and each other to provide people with support with everyday tasks and to ensure people were cared for in a timely manner.

We received a variety of different views about the management of the service; "Yes you can speak to the manager when you ask and I'm not sure if she's doing a good I don't see her often enough." "Yes I think the manager must be doing a good job, you don't see them" and "As far as I am concerned I can always talk to the manager." "She (The registered manager) does listen and act on it" (The question was if you ask anything does the manager act on it?). One overall assessment was; "They always come and talk to me, I have no complaints with management." A number of those people who raised concerns with us prior to the inspection visit also indicated the recent strengthening of the management team had been beneficial. As noted in this report, at the time of the inspection there were two complaints being actively dealt with through the service's formal complaint process.

The registered manager understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). They had submitted any notifications to us, in a timely manner, about events or incidents they were required by law to tell us about. We used this information to monitor the service and ensure they responded appropriately to keep people safe.

The registered manager was aware of the new requirements following the implementation of the Care Act 2014, including the duty of candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment provided. 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. Throughout this inspection process, during the site visits and afterwards, the registered manager had been responsive, open and co-operative.

The home worked in partnership with health and social care professionals to promote people's well-being. We received positive feedback about the liaison and co-operation between the service and health community services. "We have found the nursing and care staff willing to take time to sensitively discuss the difficulties and needs of their individual residents thereby helping our assessment process;" "Last year the home was offered training in identifying and managing swallowing problems in people with dementia…..the training and accompanying good practice guide has allowed them to continue best practice.." "I work in partnership with the carers and nurses to provide evidence based and safe care to people living with diabetes." "When visiting the dementia floor carers are always helpful, friendly and interested in their patients." Feedback also included confirmation that care staff supported and encouraged people with exercise programmes devised for them by health professionals.

Quality assurance systems were in place to monitor the quality of service being delivered and the running of the home. There were regular internal quality assurance audits undertaken which looked at how the service performed as a whole. These covered, for example, medicines management, care plans and health and safety. This helped ensure people benefitted from a service which was self-critical and challenging. The improvement in medicines management from the previous inspection is noted in this report, however the ongoing issues also identified indicate progress had not been monitored closely enough to fully deal with them to date. We saw copies of the Signature resident survey for Cliveden Manor carried out in July 2016. This was comprehensive and included analysis of all areas of the service's operation. We were told this report was used to identify those areas where improvement were required. The service then developed improvement plans for the service, based on the findings of the report.

Overall, records were satisfactorily maintained. We have noted in this report the discrepancy, in some cases, between the very comprehensive system based care records and the paper ones. Any records or information we asked for during the inspection were provided promptly. Staff had access to general operating policies and procedures on areas of practice they required, for example safeguarding, restraint, whistle blowing and safe handling of medicines.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use services and others were not consistently protected against the risks associated with the proper and safe management of medicines.