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Clifden House Dementia Care Centre

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

Summary of findings

Overall summary

Clifden House Dementia Care Centre provides care and support for up to 59 older people living with dementia. The care needs of people varied, some people had complex dementia care needs that included behaviours that challenged. Other people's needs were less complex and required care and support associated with mild dementia and memory loss. Most people were fully mobile and able to walk around the home unaided. The care home provides some day and respite care for people living locally. On occasions staff can meet more complex care needs with community health care support including end of life care when required. At the time of this inspection 52 people were living at the home.

We carried out an unannounced inspection on 14 and 16 January 2015 where we found improvements were required in relation to the management of medicines, the documentation of complaints and in relation to the supervision and appraisal of staff. The provider sent us an action plan that told us how they would address these issues. We carried out this unannounced inspection 16 and 17 June 2016 to check the provider had made improvements and to confirm that legal requirements had been met. We found that the provider had addressed the breaches found at the last inspection. However, we identified a breach in terms of fire safety.

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 was no advice in care plans about how to evacuate people in an emergency or in the event of a fire. Fire drills were not recorded and whilst alarms were sounded regularly, and staff had regular fire safety training, the provider had not tested that staff knew what to do in an emergency situation.

There were mixed views about the culture of the home. Some staff, visitors and professionals said that there was an open culture and that they could raise any issues of concern. Others said communication with some of the management staff could be difficult. Most of the staff told us they were supported well and had regular opportunities to share their views on the running of the home. All complaints were documented and actions had been taken to address them.

There were safe procedures in place for the management of medicines. There were enough staff employed to ensure that people's needs were met. Staff received ongoing training and support, which included a mixture of online training and attendance at external training courses. They had access to health qualification training and specific training on caring for people living with dementia. There were safe recruitment systems to ensure that new staff were checked before starting to work in the home.

People told us they liked the food served and they could have an alternative if they did not want what was

offered. Nutritional assessments were carried out to ensure that no one was at risk of malnutrition or dehydration. People were supported to attend health care appointments as needed. All visiting professionals told us the home was in touch with them if there was a concern about people's needs. One professional told us, "We have regular contact with the home, and they contact us about residents who they are concerned about and the staff have been caring."

Staff understood the principles of consent and the Mental Capacity Act (2005). Mental capacity assessments were in place and Deprivation of Liberty Safeguards (DoLS) had been submitted when required. Best interests meetings had been held if there was a concern that someone did not have capacity to make a decision. Staff had a good understanding of safeguarding; they were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

People were supported by staff who knew them well, staff were kind and caring and enjoyed looking after people. People told us they were happy with the activities provided. A new minibus had been purchased and they were awaiting delivery by the end of the month. A number of outings had already been planned.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we have taken at the back of the full version of the report.

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.

The provider was meeting the legal requirements that were previously in breach. However, fire safety arrangements were not clear. The provider had not reviewed people's abilities to evacuate the building in the event of a fire and fire drills were not routinely documented.

There were enough staff on duty that had been appropriately recruited to safely meet people's needs.

Staff were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk.

Is the service effective?

Good

The service was effective.

The registered manager and staff had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were aware when restrictions were required.

Staff had access to a range of training to ensure that they met people's needs.

People were supported to access a range of health care professionals to help ensure that their general health was being maintained.

People's nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Some people's dignity was not promoted at mealtimes as they did not have appropriate tables to have their meals at.

Staff knew people well and displayed kindness and compassion when supporting people.

Staff ensured that people stayed as independent as possible for as long as possible.

Is the service responsive?

Good

The service was responsive.

People decided how they spent their time and activities were provided that people could choose to participate in.

Care plans provided clear and detailed information about people's needs and wishes.

There was a clear complaint procedure in place.

Is the service well-led?

Good

The service was well led.

Staff told us the registered manager was supportive and approachable. They were readily available and responded to what staff and people told them.

There were effective systems for monitoring and improving the service.

People were encouraged to provide feedback about the support and care provided.

Clifden House Dementia Care Centre

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 16 and 17 June 2016 and was unannounced. The inspection team consisted of two inspectors.

During the inspection we reviewed the records of the home. This included seven staff recruitment files, training and supervision records, medicine records, complaint records, accidents and incidents, quality audits, policies and procedures, along with information in regards to the upkeep of the premises. We also looked at all or part of seven people's support plans and risk assessments along with other relevant documentation to support our findings.

During the inspection of the care home we spoke with the registered provider, registered manager, deputy manager, the activity co-ordinator and four care staff. In addition we spoke with relatives or visitors of three people. We also spoke with a visiting healthcare professional. We spent time observing the support delivered in communal areas to get a view of care and support provided. This helped us understand the experience of people living at Clifden House. Following our inspection we received feedback from three professionals who told us about their experiences of visiting Clifden House.

Before our inspection we reviewed the information we held about the home, including previous inspection reports. We considered information which had been shared with us by the local authority and other people, looked at safeguarding alerts which had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in January 2015 the provider was in breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because there were risks associated with the unsafe use and management of medicines. A detailed action plan was submitted by the provider that showed how they would meet the legal requirements. At this inspection we found that there were safe procedures for the management of medicines.

People told us they felt safe living at Clifden House. One person told us, "Yes, I feel very safe, if someone is upset or agitated they (staff) come and sit with them and talk to them until they calm down. I lock myself in at night and staff just knock if they want to come in." Another said, "I know I'm safe here." A third person said, "Safe, yes, always, I have nothing to worry about." One person told us that staff gave them their medicines when they needed them.

We observed medicines given and safe procedures were followed. Medicines were stored appropriately and securely in line with legal requirements. We checked that medicines were ordered appropriately and medicines which were out of date or no longer needed were disposed of safely. Staff did not sign Medicines Administration Records (MAR) charts until medicines had been taken by the person. The MAR charts were fully completed to show when medicines had been given or why they had been omitted. Medicines were labelled with directions for use and contained the date of receipt, the expiry date and the date of opening. Creams, dressings and lotions were labelled with the name of the individual. No-one at the home self-medicated, that is managed their medicines independently. One person sometimes refused some of their medicines. We were told that a best interests meeting had been held and agreement reached that this could be given without the person's knowledge if they refused it. There was clear information in the person's care plan about how to give the medicine and this had also been checked with the home's pharmacist. Staff told us they received regular training about the medicines people received and records confirmed this. Regular competency checks were also carried out to ensure safe practices were followed. There were regular audits of medicines which included the MAR charts, ordering, dispensing and disposal of medicines to ensure safe practice was maintained. Where people received medicines 'as required' (PRN), such as pain killers, it was clearly recorded on the MAR chart what to give, and how much to give. However, there was no individual protocol to clarify the steps to be taken before giving, for example to follow guidance in the person's care plan. The home's, 'Taken as Required' policy stated that, 'To ensure the medication is given as intended, a specific plan for administration is developed and the plan is kept with their MAR charts. This will state clearly what the medication is for and the circumstances in which it might be given.' As this had not been done, the registered manager agreed that this is an area for improvement.

All staff had received fire safety training. There were regular fire safety checks in place. A fire risk assessment had been carried out in 2013. There was a list of action points to be addressed but they had not been signed off as actioned. The owner told us that the actions had been addressed. (For the purpose of fire evacuation the home was divided into four zones. This meant that in the event of a fire, only those within the particular zone affected, need be evacuated.) Whilst fire tests were carried out weekly and staff knew where to assemble when the alarms sounded, fire drills were not recorded. This meant that it was not possible to

determine if staff knew what to do in the event of a fire. There was no advice in care plans about how to evacuate people in an emergency. The provider gave us a fire alarm procedure leaflet dated 2013 and four sheets for each of the zones, that included people's names and basic information about how they were to be supported in the event of a fire. However, it was not clear when this had last been reviewed. Following the inspection the registered manager confirmed that fire training had been booked for August 2016 with a practical drill included and that personal emergency evacuation plans had been started for all service users.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Since our inspection we received a letter from the local environmental team to say that they had given the home a rating of one for food safety. We wrote to the registered manager to request confirmation that action has been taken to address the requirements made following their visit and this has been received.

We had a discussion about the use of lap belts on wheelchairs, in relation to them being used as a method of restraint. However, we agreed that such a restraint was appropriate if it satisfied two conditions, that is, if it was necessary to prevent harm and if it was proportionate to the likelihood and seriousness of harm to the person. The registered manager confirmed that risk assessments would be completed for all people using wheelchairs and that belts would be fitted to any wheelchairs that did not have them. A staff member said that they wouldn't take anyone out in a wheelchair unless there was a belt fitted and that this had not been an issue as the majority of wheelchairs had a belt.

Thorough recruitment procedures were followed that ensured staff employed were suitable to work and had the appropriate skills and qualifications to undertake their allocated role. We looked at the personnel files of seven staff which included application forms, interview records, identification, two references and a full employment history. Each member of staff had a disclosure and barring check (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or people at risk.

Staff had received safeguarding training and had an understanding of their responsibilities in order to protect people from the risk of abuse. They were able to recognise different types of abuse and told us what actions they would take if they believed someone was at risk and how they would report their concerns. They said they would not hesitate to raise issues with the team leaders or the manager. A staff member told us, "If you see something inappropriate, you have to report it. We must be the safeguard for that person."

There were enough staff working in the home during the day and night to meet people's needs safely. An activity co-ordinator worked six days a week. Staff told us there were enough staff to meet people's needs on each shift. For ease of organisation, and delegation of staff support, the home was divided into four colour coded zones. One staff member told us that some zones were busier than others. We discussed this with the manager who said that if one zone is busier, once people have been attended to, staff should help out in other zones. They said that they would make sure staff were reminded of this. Since the last inspection the home introduced a staff dependency assessment tool developed by NHS Scotland. The staff model took into account people's individual dependency needs and calculated the number of care hours required to meet these needs effectively. It allowed for changes in care hours required when people's dependency changed. A staff member told us that when one person needed one to one support, an additional staff member was brought in to ensure that this could be provided and it didn't affect normal staffing arrangements. In addition to the eleven care staff there were six housekeeping staff including cleaning, laundry and kitchen staff.

Incident and accident forms had been completed when required. These included information about what

had happened, the action taken and measures in place to prevent a reoccurrence. Where appropriate, these were cross-referenced with safeguarding referrals which enabled the manager to identify further actions that were needed. There was evidence of learning from previous incidents, for example if a person had a fall their care plan and falls risk assessment was updated to reflect the revised risk and where appropriate, mat sensors were provided. Where risks were highlighted that related to people's individual needs, for example in relation to pressure care, moving and handling or using the call system, a risk assessment had been put in place that detailed the actions staff should take to keep people safe. In addition, within care plans specific risks were highlighted and the actions that needed to be taken to reduce the risk of accidents and incidents were also clearly stated.

Regular health and safety checks ensured people's safety was maintained. There were regular servicing contracts in place including checks on the boiler, gas, equipment and electrical appliances and wheelchair maintenance.

Good

Is the service effective?

Our findings

Overall people were happy with the food served. One person told us, We have a good breakfast and lunch, it's very good indeed. A relative told us the food portions are quite small, but the food is actually quite good. They also said that their relative had put on weight since moving to the home. One person told us that the staff looked after their health needs and said, "I see the doctor when I need to."

There was a three week menu in place which was varied and well balanced. We were told that this had been changed in March this year and was based on people's wishes. Menus had been discussed at the residents' forum meeting. A choice of cooked breakfast was available five days a week and a continental breakfast was available the other two days. There was a choice of two meals at lunch time and we were told that if neither option was chosen there was always an omelette, baked potato or sandwiches available. At evening time there was homemade soup and a choice of a hot meal or sandwich.

One member of staff had overall responsibility for ensuring everyone received a meal wherever they were in the home. The majority of people ate their main meal in the dining room, some people chose to eat in their own rooms and some stayed in the lounge area. Staff were allocated specific tasks throughout the mealtime.

People's nutritional needs were monitored. There were nutritional assessments in place and they showed if anyone was identified at risk of malnutrition or dehydration. Staff recorded how much people ate and drank and where this was a concern this was closely monitored. For example, there had been concerns about one person's weight loss and the GP had recommended monitoring their weight daily for a month. This has been done and the outcome had been sent to the GP. The person had gained weight during the monitoring period.

People were supported to have access to healthcare services and maintain good health. They told us that they were able to see their GP when they wanted to. People regularly attended dental, optician and chiropody appointments. One person's GP had referred them on for an audiology assessment. A visiting health professional told us, "Staff are quick to contact us if they have a concern." They also said that staff follow instructions regarding use of creams and make sure people who need to, are turned regularly. Another professional told us, "We have regular contact with the home, and they contact us about residents who they are concerned about and the staff have been caring."

Staff had received training on MCA and DoLS and were able to describe its principles and some of the areas that may constitute a deprivation of liberty. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager told us they presumed that someone had the capacity to make decisions unless they assessed otherwise. Care plan documentation clearly stated the choices people were to be encouraged to make on a day to day basis. Where appropriate, DoLS applications had been made. Records showed that a best interests meeting had been raised recently when one person made requests that the registered manager assessed as unsafe. As a result they made a request for an urgent DoLS application.

The registered manager told us that they were committed to ensuring that the staff team had the necessary skills to carry out their role effectively. Most of the staff either had or were working towards healthcare qualifications relevant to their role. For example, the manager and the deputy manager had completed the registered manager's award and a level four health qualification. Four staff had completed a level three health qualification and two, a level two qualification. In addition, four staff had professional qualifications from their country of origin. The registered manager confirmed that three senior staff had recently started studying for a level five qualification, two staff a level three, and 13 care staff had started a level two health qualification.

The local In Reach team (NHS funded team who deliver workshops to care staff relating to the provision of person centred dementia care.) provided a number of staff training sessions and between 20 and 30 staff attended each session. These included training on dementia awareness, communication skills, use of life story, challenging behaviour, meaningful activities and use of anti-psychotic medicines. Staff told us that as a result of the training they had a better understanding of people's needs.

A staff member told us that when they started working at the home they had two weeks induction which included shadowing staff. A three hour training session on moving and handling was provided by an in-house trainer and they found this very useful. They told us, "There is very good teamwork here, it flows really well. I feel we are doing things right."

Staff received ongoing training and support, which included a mixture of online training and attendance at external training courses. Training included safeguarding, moving and handling, health and safety, fire safety, mental capacity, deprivation of liberty and infection control and food hygiene. The majority of staff had also completed training on dementia awareness and dealing with challenging behaviour. In addition to mandatory training a number of staff had also received training on diversity and equality, developing as a worker, continence promotion and communicating effectively. Staff were very clear about people's needs and how they should be met.

Staff felt well supported. We were told that there was now a more formal system in place that ensured that staff received support to fulfil their role. We were given a copy of a matrix that showed that staff received an annual appraisal and that they were given regular opportunities to attend group discussions at staff meetings and to attend supervision meetings. Senior staff recorded observations made of care provided and if they witnessed a practice that was either very positive or negative a file note was used to document the issue and how it had been dealt with. File notes were then used either at supervision or group discussions as appropriate. A staff member told us, "I feel completely supported by the manager and provider. They back me on decisions."

Requires Improvement

Is the service caring?

Our findings

A visitor to the home told us, "A lot of the staff are really very good." People and visitors told us staff were caring and kind. One person told us, "I can't praise the staff enough, they are brilliant, they couldn't do more." When people needed assistance to move from one area to another, staff explained to people what they were doing and offered reassurance throughout. We observed that staff knocked on people's door's before they entered.

One relative told us that their relative had their meals in the lounge area. Staff told us that the person had their main meal in the dining room but their evening meal in the lounge and that they had an adjustable table so that they could eat their meal comfortably. The person's care plan included conflicting advice about mealtimes. However, we saw that in the evening the person had a round table in front of them and it would not have been possible for them to sit with their knees under the table. We asked staff about the adjustable table and this was brought to them. One other person was sitting with one leg under a very low table and another was using a low table to the side of their chair. As both were eating soup this resulted in a loss of dignity for them. We discussed this with the registered manager who said that this would be brought to staff's attention. They said that there were several adjustable tables available for use in the lounge and no one should have to have their meal using a low table. This is an area that requires improvement.

We spent time in the dining room at lunch time and we observed staff supporting people. When staff started to deliver meals to people they offered a choice of drink and people could choose from two different meal options. Staff told people what was on their plate. The delivery of meals was slow and it was 40 minutes after the start of the meal before people at the back of the room received their meal. At this stage staff were not telling people what was on their plate and just said, "Here is your meal." As a result the meal time for some people was not as positive as for those who received their meal first. We discussed our observations with the registered manager who said that they would do more observations at mealtimes to try to identify why it took so long and to ensure that everyone had the same positive experience. This is an area that requires improvement.

People could refuse to receive personal care. However, we noted that when one person refused personal care this decision was respected, but later in the morning another staff member offered personal care and this was accepted. A staff member told us that they respected people's decisions. However, they knew that sometimes people refused a bath or shower but that when they agreed to have one they always enjoyed the experience. Therefore they made a point of offering at a different time or a different staff member would offer to make sure the person had the choice and opportunity to change their mind. Although one person used an incontinence aid, staff continued to take this person to the bathroom which meant that they were rarely incontinent and this ensured their dignity was promoted.

We discussed the use of tabards at mealtimes and the registered manager was clear that they were only used where assessed as needed. They said that they had explored using plate guards as a way of ensuring people's independence and dignity but this had not worked. However, they were now exploring the use of plates with a central well and coloured rim. If this proved to be successful for some people and added to

their dignity they would ensure that they were made available where needed.

People were offered choices on how to spend their day. Where possible they were enabled to make safe use of all communal areas of the home. We saw staff giving people the time they needed throughout the day, for example when they accompanied people around the home, assisted people with their meals and supported them with activities. Staff were relaxed and unrushed and allowed people to move at their own pace.

People were treated with kindness and compassion by staff who cared about the people they looked after. Staff knew people well and were able to tell us about the support people needed. For example, a staff member told us one person was very anxious and needed lots of reassurance. They said, "I try to take them for walks whenever I can because I know that they like this." We saw that within care plans there was a 'life story' section. This ensured that staff were made aware of information that was important to each person. We were told that this was particularly important as people's memory faded. We heard staff talking with people about their families and interests and people told us they enjoyed this.

Good

Is the service responsive?

Our findings

We carried out an inspection on 14 and 16 January 2015 where we found the provider had not met the regulations. This was because there was no appropriate system in place to deal with all complaints. The provider sent us an action plan and told us how they would address these issues. There was a complaints policy in place that was displayed at the entrance to the home. At this inspection we found improvements had been made in that all complaints were now recorded. In some cases the actions taken were clearly recorded. For example, in one case the complainant had thanked the home for their very positive response and said that since raising the concern, "Staff go the extra mile," for their relative. A relative told us that they raised a complaint and met with the provider to discuss their concerns. They said that since doing so improvements had been made and the provider had made it clear that if they had any concerns they should feel free to discuss them at any time.

During the inspection one person raised a concern regarding their bed. We asked if they had raised this with the management but they said no but they were happy for us to raise the issue. We spoke with the provider about the concern. Following the inspection the registered manager confirmed that the person had been supported to go shopping for a new bed.

There was an activity programme on the notice board. This showed that a range of activities were provided throughout the week. A visitor to the home told us the activity co-ordinator was, "The life and soul of the home."

Planned activities included: choir, poetry, gardening club, cinema club, sensory games, quizzes, arts and crafts, bingo, baking, motivation, pet therapy, bingo and reminiscence. Regular musical entertainment was provided by external entertainers and there was a monthly church service. We were told that everyone was given the choice to take part in activities. Staff said that some activities were more popular than others, for example bingo. The activity coordinator spent one to one time with people who chose not to participate in the structured activities. The home had five chickens (weeks old) and two birds. Staff regularly took people to see them.

During our inspection we observed a bingo session. Approximately twenty people took part and the activity coordinator ensured that everyone was an active participant in the game. It was a fun session and people stayed and where appropriate were encouraged to stay focussed throughout. We were told that a barbeque was being held the day following our inspection. There were also plans to do a seafront walk at the end of the month from one café to another. We were told that a new minibus had been bought and was to be delivered by the end of the month. There were plans to use the bus, and wheelchairs and to support those who could walk the distance, to participate in whatever way they could for the event. Following the inspection the registered manager told us that a local dementia specialist, who provided support to people living locally with dementia, had asked if they could join the walk as a way of raising the profile of dementia in the area.

We were told that one person ran a poetry group and that a large number of people enjoyed this activity. A

staff member told us, "Everyone helps to give the residents what they need, it's a nice place to work. Another staff member told us, "There is a lot of heart here. We are proactive and passionate about what we do. I have never heard anywhere else better than here."

One person told us the activity person was, "Brilliant, she is always doing something. They said, I'm perfectly happy, there is always something new and different to do." At lunch time people were told about the activities for the afternoon and given the choice of watching England playing football or being involved in pet therapy.

Before someone was admitted to the home a full needs assessment was completed. This was completed in consultation with people and their representatives, and was used to establish if people's individual needs could be met. The assessment took account of people's wishes such as what time people liked to get up at and go to bed. Information from the assessment was then used to draw up a more detailed plan of care and all care plans were reviewed monthly.

When staff provided any care or support for people this was then recorded on computer tablets. We were told that if someone refused personal care or refused food, management were automatically alerted to this on the computer system which meant that they could monitor the situation closely and ensure that care and support was offered again later in the shift. At the time of the last inspection there had been a problem with staff not recording when they turned people at night. This matter had been addressed and there were regular entries made on tablets to show that turns were carried out. Staff recorded all care given along with information such as checks on sensor mats, records that creams had been applied, information that drinks had been given and how much had been taken.

Good

Is the service well-led?

Our findings

Whilst there were mixed views about the culture of the home, most of the staff told us there was an open and relaxed culture and that the manager and team leaders were available and they could talk to them at any time. Regular staff meetings were held to give staff the opportunity to share their views and resident's forum meetings gave people the opportunity to share their views.

Family forum meetings were held quarterly. Minutes of these meetings included subject headings and basic information about them. Records showed that representatives of six to seven families were at the last two meetings and we were told that all families were given a copy of the minutes. However, as the minutes gave basic information only, this was a missed opportunity to explain to relatives the work underway to enhance links with the wider community and to describe the positive work of the staff team. Although the registered manager or provider was able to tell us the actions taken in relation to each complaint recorded, the actions taken were not always recorded. For example, sometimes it stated that that matter had been referred to the provider for investigation. Whilst these areas were raised as areas for improvement the registered manager was confident that the appointment of the new administrator would mean that routine record keeping tasks such as minuting meetings and documenting complaints would be addressed more fully.

The registered manager told us that they were trying to expand links with the wider community. Brighton university was doing research with six families of relatives to aid long term research into dementia. There was also involvement with a local school where three pupils visited as part of their GCSE course.

The registered manager ensured that the provider was kept up to date on the running of the home. This was achieved by sending a weekly manager's report to the provider. Reports included a range of topics to ensure that the provider was kept up to date. For example, if there had been any complaints, accidents, safeguarding matters or staff vacancies. The provider told us that they did quarterly environmental checks of the building and that feedback from these meetings was given to staff at staff meetings. Records of the environmental checks included information of any shortfalls found and the actions taken to address them. For example, when a problem with blocked drains was found, a staff meeting was called to ensure that everyone was clear about how to reduce incidences of this occurring again.

Staff had a say in the running of the home. Minutes of staff meetings demonstrated that staff were given and took up the opportunity to share their views on a range of matters that related to the running of the home. For example, staff discussed recent training and what they had learned from it. Meetings were also used as training opportunities and a recent topic included training on equality and diversity. Discussions had also been held on ways of improving infection control.

Resident forum meetings were held periodically. Minutes of the last meeting held were dated February 2016 and showed that 24 people attended. The minutes were very detailed and demonstrated that people raised lots of ideas, all were carefully considered and where possible new activities had been added to the activity programme.

We looked at audits of the management of medicines for the past three months. These demonstrated that medicines had been managed well and that where shortfalls had been identified the appropriate person had been informed and actions taken to ensure they were not repeated. Audits of accidents and incidents were carried out monthly. Analysis of the documentation had been carried out to determine if there were any trends or patterns. Whenever an accident or incident occurred consideration had been given to updating the person's care plan to determine if additional action should be taken. For example, a sensor mat was not working and was replaced. One person's moving and handling was reviewed by the trainer and updated.

There were clear arrangements in place for evaluating care plans. Each team leader was tasked with evaluating 20 percent of care plans within each of the four zones within the home on a daily basis. The manager then carried out a monthly audit of each zone in turn. The system in place ensured that all documentation was checked regularly. Where shortfalls were identified action was taken to ensure that the matters were addressed. Records showed that when a staff member had requested additional training on developing specific care plans for short term care, this had been provided and a support system was put in place should further advice be needed.

Some visitors said that they found some of the management team more approachable than others. One visitor described some of the management as, "Abrupt." A professional told us that communication with some of the management was difficult. Another professional told us, "Senior staff spend a lot of time in the office, which is not unusual, but it (the office) is hidden from a lot of the activity, and I think there is a need for senior staff to lead by example in teaching the more junior." A third professional told us that they had a, "Mixed time in the home. Staff are brilliant, we have a lot of respect for them." However, they also said some of the management, "Don't always speak highly of staff and sometimes show a lack of respect for them." They went on to say that whilst this had been an issue it was improving and was now less of a problem. Another professional told us that they had a good relationship with management and said that staff were quick to call them if they needed support or guidance. The manager told us that the appointment of a new administrator who was due to start two weeks after our inspection would assist in terms of freeing up the management team so that they had more time to spend with people and visitors to the home. Throughout our inspection the registered manager, the deputy manager and one of the team leaders were on duty. Whilst the phone lines were busy, which meant that someone was generally needed to answer calls, their time was equally divided between the office, spending time with people and supporting staff. We observed part of a meeting between the manager and a visiting professional and noted that there was a good rapport between both and it was a productive meeting.

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's support needs in relation to fire safety had not been assessed.