

Mr Nial Joyce

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

Overall summary

Clifden House Dementia Care Centre is a detached property in Seaford a seaside town between Eastbourne and Brighton. It provides care and support for up to 59 older people living with a 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 51 people were living at the home.

This inspection took place 14 and 16 January 2015 and was unannounced.

Summary of findings

At the last inspection we found the service non-compliant with regulation 10 (2) and regulation 20 (1)(2) of the HSCA 2008 (Regulated Activities) Regulations 2010. Concerns were about the lack of systems to regularly assess and monitor the quality of service that people received and risks associated with a lack of accurate record keeping. At this inspection some improvements were noted but further improvements were required.

The service had 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.

Medicines were not always managed safely. Records were not always accurate and systems did not ensure that variable dosage medicines were given as required. Some prescribed medicines were not available as required. This meant that medicines were not always given in accordance with prescriptions.

Staff did not receive regular supervision and appraisal, therefore, there was no system to review and monitor staff performance and development of skills.

Written and verbal complaints were not always responded to in a timely and proactive way. This meant information of concern was not always used to improve the service and some complainants did not have their concerns addressed.

Whilst, observations indicated that the staffing arrangements ensured staff were available in such numbers and skills to respond to people's needs in a timely fashion. There was no system used to assess the number of staff required to ensure adequate staffing throughout the day and night. We were therefore not assured that the staffing numbers were reflective of people's needs at all times. .

The home's recruitment procedure ensured relevant checks were completed on staff prior to employment. One reference was sourced along with a verbal contact was made with another reference. All staff had a disclosure and barring check (DBS) completed by the provider before working in the home unsupervised.

The registered manager used a number of audits to review the quality of the service and these were reported on during staff meetings to improve care. People's views were obtained through a variety of sources and systems were in place to encourage feedback from people. This included annual satisfaction surveys and on-going feedback system through the services website. Formalised analysis from these systems had not been established.

People were cared for by staff that knew them well and responded to their individual care needs and preferences. Staff were kind, friendly and patient with people. Staff were mindful to people's privacy and dignity taking account of their individuality

Feedback received from people and their representatives through the inspection process was positive about the care, the approach of the staff and atmosphere in the home. Some general comments included, "As soon as I saw it I thought this was the place – it's alive," and "It's better than I ever dreamt it could be."

Staff were trained on safeguarding and understood their responsibilities to keep people safe from abuse and were clear what action they would take if they had any suspicion of abuse occurring.

The service was clean and well maintained with safety issues taken into account and responded to. Individual risk assessments were undertaken and reflected those associated with people living with dementia and reflected a person centred response to individual risk. Health and safety checks were undertaken and procedures were in place to ensure emergency situations were responded to.

People had a variety of food available at mealtimes and snacks through the day. Mealtimes were unrushed and people were encouraged and supported to eat a nutritional diet. There were systems to monitor people's diet ensuring everyone had something to eat wherever they were and whatever they were doing.

Systems for sharing information between staff were established. Staff had regular contact with other health and social care professionals. This included the GPs and community mental health team along with the district nursing team who visited the home most days. Health care professionals told us that staff always, 'did their best' and sourced help and advice when they needed it.

Summary of findings

People were able to move around the home and garden freely. People had their choices and preferences responded to by staff who understood their responsibilities in ensuring they gained consent to care. Staff had training and an awareness of the Mental Capacity Act 2005. The senior staff were more skilled and had applied for Deprivation of Liberty Safeguards (DoLS) as necessary to ensure people had their rights taken into consideration if any restriction was considered.

Activity, entertainment and staff interaction was tailored to individual need. There was a variety of arranged activity including group and one to one interaction. Staff responded to what people wanted to do on a daily basis.

The registered manager and registered provider had a high profile in the home. There was a staffing structure that allowed staff to report to senior staff who managed areas of the home. On call arrangements were in place and staff knew who to contact when they needed any advice or guidance.

We found a number of breaches 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.

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?

Some aspects of the service were not safe.

The registered provider had established a recruitment procedure to follow.

Medicine records identified that medicines were not always managed safely. People were at risk of not receiving the correct prescribed medicine as records were not clear or accurate.

People said they felt safe within Clifden House Dementia Care Centre.

There were systems in place to make sure risks were assessed and measures put in place where possible to reduce or eliminate risks.

Staff knew how to recognise and respond to any suspicion of abuse correctly. Risks were managed and people's safety was supported.

Requires Improvement



Is the service effective?

Some aspects of the service were not effective.

Staff were not fully supervised and supported to deliver care in a way that responded to people's needs.

Staff ensured people had access to external healthcare professionals, such as the doctor or district nurse when they needed it.

Staff were aware of the Mental Capacity Act 2005 and how to involve appropriate people, in the decision making process. DoLS were applied for and used appropriately.

Staff monitored people's nutritional needs and people had access to food and drink that met their needs and preferences.

Requires Improvement



Is the service caring?

The service was caring.

People's privacy and dignity were well respected and responded to.

People were supported by kind and caring staff who knew them well.

Everyone was positive about the care provided by staff.

People were encouraged to make their own choices about what and when they did things.

Good



Is the service responsive?

Some aspects of the service were not responsive.

People were made aware of how to make a complaint however these were not always responded to quickly or in a proactive way.

Requires Improvement



Summary of findings

People told us they were able to make individual and everyday choices and we saw staff supporting people to do this.

People had the opportunity to engage in a variety of activity inside and outside of the home that met individual interests. People living at home had their social arrangements assessed and responded to.

Is the service well-led?

Some aspects of the service were not well-led.

There were systems in place for monitoring the quality of the service. This included regular contact with people, residents meetings and the use of satisfaction surveys that provided feedback on many aspects affecting the service. This information was not always reviewed and documented to show how it was used to develop the service.

Clifden House Dementia Care Centre had identified aims and objectives that were shared with people and staff.

The registered owner and registered manager were a visible presence in the home and were approachable. They were readily available to people staff and visitors and responded to what people told them.

Requires Improvement



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.

On 1 April 2015 the Care Act 2014 came into force. To accommodate the introduction of this new Legislation there is a short transition period. Therefore within this inspection report two sets of Regulations are referred to. These are, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. All new inspections will only be completed against the new Regulations - The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This inspection took place on 14 and 16 January 2015 and was unannounced.

The inspection team consisted of two inspectors and an expert-by-experience, who had experience of older people's care services and dementia care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before our inspection, we reviewed the information we held about the home which included previous inspection

reports, safeguarding alerts, associated investigation undertaken by the local authority and notifications received. A notification is information about important events which the service is required to send us by law.

We spoke to a commissioner of care from the local authority before the inspection. After the inspection we spoke with a nurse from the district nursing team a member of the community mental health care team and a member of the Deprivation of Liberty Safeguards assessment team We received feedback from a number of GPs that work from the two local GP practices.

During the inspection we spoke with six people who lived at Clifden House Dementia Care Centre. We spoke with eight visiting relatives, 12 care staff, a senior housekeeper, the registered manager and the registered provider.

We observed care to get a full view of care and support provided across all areas, and in individual rooms. We observed lunch sitting with people in the dining room and activities held throughout the day. The inspection team spent time sitting in areas throughout the home and were able to see the interaction between people and staff.

We reviewed a variety of documents which included eight care plans and associated risk and individual need assessments. All care documentation was stored and recorded within a computer system accessed via lap tops and hand held tablets. We looked at five recruitment files and records of staff training and supervision. We read medicine records and looked at policies and procedures, record of complaints, accidents and incidents and quality assurance records.

Detailed findings

We last carried out an inspection at Clifden House Dementia Care Centre in July 2014 when we had concerns about the lack of systems to regularly assess and monitor the quality of service that people received and risks associated with a lack of accurate record keeping.

Is the service safe?

Our findings

People and their relatives said that they felt safe at Clifden House Dementia Care Centre. Relatives comments included, "I could go away for the weekend and know that dad is safe, he's warm, well fed and will see friendly faces" and "I am sure he is very safe here." There was positive feedback received about the staff and their availability. People said, "Staff are very good. I have not seen any that are not" and "The staff are there to help when needed." However, one person told us they used a stick to gain staff attention if the bell was not answered quickly. They said, "They do take a bit of a while to come." Observation indicated that their bell was responded to in a timely fashion to respond to his needs.

However, our own observations and the records we looked at showed that people were not always protected from the risk of harm. We found that medicines were not always managed safely. The Medication Administration Record (MAR) charts were not always accurate, they had not been completed fully and signed by staff to confirm if medicines had been given or not. It was not possible to confirm that people had received their prescribed medicines. We also found that one person had not received their prescribed medicine for five days and a visiting professional told us that a routine injection was not available when required in the correct dosage. This may have impacted on people's health and well-being as medicines had not been administered as prescribed. Some medicines were 'as required' (PRN) medicines. People took these medicines only if they needed them, for example, if they were experiencing pain. The MARs did not record when pain killers were given therefore staff could not be sure when it would be safe to administer further pain killers. Individual guidelines for the administration of PRN medicines were not in place for each person. These guidelines should record why, when and how the medicine should be administered for example maximum four dosages in 24 hours. The lack of clear guidelines for staff to follow meant that medicines may not be given in a safe and consistent way.

This was a breach of Regulation 13, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff who administered medicines undertook relevant training and their competency to administer medicines was reviewed by senior staff. However, the registered manager was aware that the management of medicines was not always safe and systems were being established to monitor and audit their administration more closely.

The medicine storage arrangements were appropriate. These included a trolley and suitable medicines storage cupboards. We saw staff administer medicines individually from the medicines trolley, completing the MAR chart once the medicine had been administered.

Staff undertook safeguarding training each year. Staff understood their responsibilities to keep people safe from abuse and were clear what action they would take if they had any suspicion of abuse occurring. Staff were familiar with safeguarding procedures and knew how to raise concerns with the police or the social services directly if necessary. One staff member described how they had made a safeguarding referral directly as a member of the management team was not available and they wanted to report the incident quickly.

The home was divided into four areas for staffing purposes. People told us there were enough staff to look after them. Call bells were responded to promptly and when people asked for assistance staff attended to them quickly. For example, one person tripped and fell and was attended to quickly by staff. Staff checked on people who were spending time in their own rooms at regular intervals to enquire if they were 'alright' and if they 'needed anything'. Staff were available to provide support and guidance to people and distracted them if they were undertaking an activity that put them at risk. For example, one person wanted to put their hands into the waste food, they were gently led away to have their dessert.

Staff felt there were enough staff to meet people's needs on each shift as long as all staff allocated to work attended. Staff told us that staff absence had been a problem in the past but this had improved recently. Staff told us that people became more active and restless in the afternoon and this was a regular pattern. The registered manager told us that the staffing levels were not based on a planning tool which took into account the amount of help each person needed at any time within the day. The provider told us they had taken these patterns into account within the

Is the service safe?

planning of staffing numbers but was unable to show that staffing levels were based on people's need through an assessment process. This meant that the staffing numbers provided may not be suitable to meet the needs of people throughout the day and night. This was identified as an area for improvement.

Clifden House Dementia Care Centre was clean. Visiting relatives were positive about the homes presentation and commented on the cleanliness. "It's very clean, and never smells." The maintenance man worked each day and issues identified to him were addressed immediately. For example, a staff member noted that an outside door was not closed properly and may allow people to exit the home without being seen. This door was secured immediately. Health and safety checks were undertaken on a monthly basis by the registered manager. The registered manager had systems in place to deal with any foreseeable emergency. On call arrangements were in place and staff had access to the registered managers and registered owners telephone numbers. The home had an emergency planning policy which identified procedures that ensured emergency situation were responded to appropriately. For example a fire procedure was in place that planned horizontal evacuation. Each person had been assessed to identify how they would be assisted to evacuate.

Systems were in place for staff to assess risks for people. The care plan format reminded staff of the practice to be followed in the event of incidents occurring or a suspicion

of abuse. Risk assessments were part of the care documentation and were used routinely to assess risks. For example, the risks associated with pressure damage to skin were reviewed on a monthly basis. People were supported to move safely around the home with support provided when needed and offered when people looked unsteady.

Some people showed signs of frustration that could put other people at risk in the home. The care documentation reflected mental health behaviour and described behaviours people could show. They recorded the triggers and what was known to be an effective response for staff to follow. For example, asking another member of staff to take over from them. For safety staff would move the person away from other people in the home.

There was a designated senior staff member allocated to the task of recruitment. There was a recruitment policy and procedure to follow. Records confirmed that these procedures were followed when employing new staff. Records included application forms, identification, references and a full employment history. Each member of staff had a disclosure and barring checks (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or people at risk. All new staff were interviewed by the allocated staff member One written reference was obtained and the second was a recorded verbal contact. This was in accordance with the recruitment procedure.

Is the service effective?

Our findings

All feedback about the food was positive. People told us that the food was of a good standard and provided in good quantities. People said they were given plenty of choices and if they did not like what was offered they could always get an alternative. Comments made included, “The food is good. If you really don’t want what’s on the menu, they’ll make something else, something on toast,” and “You get a choice to a certain extent. We have five meals a day and it’s always good.” Relatives felt the food was well presented and appropriate for people. One relative was surprised how satisfied their relative was with the food and said that their father “Has no complaints about the food. He could have because he’s fussy, but he doesn’t.”

The provider had not ensured that all staff were appropriately supported to undertake their role.

Staff told us that they felt supported and two senior staff told us that they received regular supervision and appraisal. However, for other staff regular supervision and appraisal had not been established. There was no formalised system to review and monitor staff performance and there was no system to record and progress the development of staff skills. The provider needs to be assured that staff practice is observed and reviewed with any gaps in skills being identified and responded to. The above issue was a breach of Regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they received training and support that provided them with the necessary skills and knowledge to meet the needs of people living in Clifden House Dementia Care Centre. Records confirmed that a programme of training had been established and a designated staff member co-ordinated the training programme along with the induction training. The induction training was based on Skills for Care. These reflect the standards that care staff need to meet before they can safely work unsupervised. One new staff member told us the induction programme had included two weeks shadowing as they were new to this kind of work. They had felt well supported as they worked with an allocated senior staff member.

Staff confirmed the essential training they completed on an annual basis included, health and safety, safeguarding, dementia awareness, mental capacity, infection control, safe moving and handling. Records confirmed that a rolling programme of training was in place. Staff told us they could attend additional training and that they were supported to undertake a diploma in health and social care if they wanted to. The training co-ordinator confirmed that most training was completed by staff on the computer. This was supported by some practical training when required. For example, when learning how to move people safely. The training records confirmed some training was planned but not achieved. For example, training for people on behaviours that challenge. Without this specialist training staff would not have the skills or understanding to respond appropriately to situations that may occur when caring for people with dementia. The registered manager told us that the need for more specialist training on dementia care had been identified and was to be progressed. This was identified as an area for improvement.

Care records were used to communicate the care provided and staff used hand held computers to update themselves on care provided and planned. These records were not always accurate and did not routinely record the care provided. This meant that clear and accurate guidance was not always provided to staff to follow and the care provided was not recorded accurately. For example, repositioning charts were not always used when the care plan indicated that they should be. The registered manager and registered owner were aware that the systems for recording needed further improvement. However, these records gave information to staff on people’s past life and what people liked to do. This encouraged staff to know and understand people as individuals.

Staff worked with external health and social care professionals to support people with health and social care needs. The local GPs and visiting health professionals felt systems for communication could be improved. They felt that when they talked to different staff they did not all have an understanding of people’s changing needs. Visiting professionals told us that staff “did their best.” And worked hard to meet people’s health and welfare needs. One GP complemented the staff saying they had met the needs of a person needing palliative care very well. We heard staff talking to a variety of health care professionals on the phone and when they visited the home. This included an audiologist, two GPs and a community nurse who all

Is the service effective?

visited the home during the inspection. Care records confirmed regular contact and review of people's health needs with supporting professionals. Feedback from health professionals confirmed regular contact and that guidance and advice was followed which ensured that people's health care needs were attended to on a daily basis.

Lunch was mainly eaten in the dining room where food was served from a servery. This allowed flexibility in response to people's individual preferences and choices, with some people coming up to the servery and choosing directly from the food displayed. One member of staff had overall responsibility for ensuring everyone received a meal wherever they were in the home. Some people had chosen to eat in their own rooms and where people wanted to eat was respected. One staff member said, "They can have them in the dining room or in the lounge. We just make sure they are comfortable, it's all personal preference really."

People had access to food and drink throughout the day and were not rushed to complete their meals. A wide range of drinks were available from the drinks trolley including milky drinks. Staff offered people drinks and additional foods including cakes, biscuits and cut fruit regularly. Staff allowed people to eat food at a speed that suited them. For example, one person was eating their breakfast in the dining room at 10.30 am. Staff told us they liked a later breakfast and liked to eat slowly.

A system was in place to record and monitor what people had eaten and in what quantity. Risk assessments were used to identify people who needed close monitoring or additional support to maintain nutritional intake. For example a nutritional risk assessment was used routinely for people and staff monitored people's weights regularly to inform this risk assessment. Staff encouraged people to eat often and frequently and for some people finger food was supplied to encourage regular eating. Staff asked for professional advice if people lost weight or showed signs of difficulty with eating.

Systems for organising work and communication between staff had been established. Each shift began with a handover which covered the whole home. Staff were given written information for the people within the area that they

were working in. This highlighted specific care needs. For example, reminders for staff to give and record fluids to people and to reposition people on a regular basis when needed. Staff were allocated to one of the four areas in the home this was done in a consistent way whenever possible. Staff told us that this allowed staff to know people they looked after well and to develop a rapport. One staff member said, "I only work with these people so I know about all changes and we develop close relationships."

All the people using the service had some cognitive impairment. Staff had received some basic awareness training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). The registered manager and senior care staff in the home had received additional training on the Act and DoLS and demonstrated a working knowledge of both.

There were relevant guidelines in the home for staff to follow. This act protects people who lack capacity to make certain decisions because of illness or disability. The safeguards ensure any restrictions to their freedom and liberty have been authorised by the local authority as being required to protect the person from harm. Records in the home confirmed that when DoLS were applied for correct procedures were followed and conditions set were reflected within the individual care plans. A visiting professional involved in the process confirmed that the home's management dealt with DoLS appropriately and involved the local authority as required to safeguard people's rights

People were able to move around the home and garden freely. Staff monitored people to ensure their safety and guided them towards areas where they could have a drink or sit comfortably. People told us that they could go where they wanted and chose what they wanted to do and when.

One person said, "I can get up when I like and go to bed when I like." Another person had taken himself back to bed following breakfast. People's preferences and choices were recorded and included if they wanted a female or male staff member to attend to their personal care.

Is the service caring?

Our findings

People were supported by kind and caring staff. People told us staff were attentive and responded to their needs in a kind way. One person said, “Staff are all very good. I haven’t seen any that aren’t.” Another said, “There’s not been one that’s not been attentive.” Other comments included, “Staff are kind, interesting, and help you when they can,” and “There are some fabulous staff.”

A few bedrooms were shared. There were practical issues that impacted on the privacy and dignity of people who were using these rooms. The bed space nearest the door was a throughway for the other occupant and when the privacy curtain was used one bed space had no natural light. We were not shown any records that recorded these implications and how they were responded to. However the registered owner assured us that all these matters were clearly documented within individual care plans. He also confirmed future plans included changing the use of these rooms to singles.

We observed and heard all staff including domestic, catering and maintenance staff interact with people in a caring and patient way. Staff approached people in a sensitive way they did not rush people and supported them to do things that they wanted to do and in a way that took account of individual preference and needs. One person who was not able to communicate verbally was assisted with their food in a kind patient way. The staff member maintained conversation despite the lack of any reply and used non-verbal communication including eye contact to encourage interaction.

Observations in main lounge and entrance area showed staff were continuously attentive to people. They responded immediately to requests from people. The communal areas were well supervised and this ensured people’s needs were attended too quickly. When staff worked in pairs they maintained interactions with the person rather than each other.

People told us that they were treated with respect and had their dignity protected. One person described how personal care was provided, “It’s respectful, I never feel uncomfortable.” Records and staff actions were seen to

support people in a respectful and dignified way. For example, staff were consistent in their approach to one person to minimise behaviours that put them at risk, this did not undermine them as a person. Another staff member maintained a person’s dignity by understanding an individual’s perception, this person said they could not go to the lounge for a cup of tea as they had no money, the staff responded by assurance that this was not a problem.

Staff responded to people’s preferences that promoted individual dignity. Records directed staff to respond to people’s needs specific to them that promoted their independence, including spectacles and hearing aids. Staff knocked on doors before entering and spoke to people as adults. They were kind and smiled when with people. People were dressed according to their own wishes and tastes. Some men wanted to wear a shirt and tie, another wanted to wear a beret related to his military service and this was respected. Women were dressed differently according to their wishes and tastes, with some wearing jewellery and having nail varnish, whilst a younger woman was happy to wear jeans. One relative when asked about maintaining dignity said, “He is kept clean and changed.” Another relative said, “The staff never ignore my mother, they always offer help.” One person asked for a male carer to help him to go to the toilet and this request was met.

People’s bedrooms varied in terms of the personal items on display, with some rooms full of individual, memorabilia. It was clear that where people wanted to have personal items in their rooms, they were free to do so. Most rooms had photographs of family and/or older photographs of themselves at a younger age. This gave staff a point of reference for conversation and gave people a sense of identity.

People’s care records showed they or their representatives had been involved in developing their care plans. When people moved into the home staff spent time getting to know the person to assess their needs, choices and preferences and this was recorded in their individual care plans. Records confirmed that staff asked people about who they wanted to represent them and details about enduring power of attorney were recorded.

Is the service responsive?

Our findings

People told us that they would raise a complaint if they needed to, and told us about a variety of routes that they would use. Comments included, “If I had any complaints, I’d go to the office,” and “If I had a problem I’d start with the activities co-ordinator, then ask her who to go to.” A number of relatives were seen in discussions with staff who were available to answer any questions.

People said there was plenty to keep them occupied in the home if they wanted to join in. Comments included, “During the day there’s all sorts of things going on, a big sing-song, the majority of them like that, me included,” and “The activities co-ordinator is a star, an absolute star. She’s always got something going on.” There were two activities co-ordinators and they worked together to ensure a variety of activity and entertainment was available to suit individual need and preference.

The registered provider had an established complaints policy in place this was displayed in the front entrance of the home. We viewed examples of complaints that had been responded to promptly and in accordance with the policy. One relative told us they had raised issues with the deputy manager and the registered manager and they had been resolved. However, there was evidence that not all written complaints and verbal complaints had been recorded and responded to, which included a copy of a written complaint shared with the inspector. This meant that the complainant had not had their concerns looked in to, issues raised had not been investigated and addressed. The provider had not used the information to improve and develop the service. In addition information of concern raised through social services but not investigated by them had not been recorded and investigated by the provider. The registered manager accepted that information that could be dealt with within the complaints procedure process was not used in this way. In addition two visitors told us that they found staff ‘defensive’ when raising a concern. This could stop complaints being investigated in an open and constructive way. There was not an effective system for handling and responding appropriately to complaints and comments. These issues were a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the service was in breach of regulation 20 of the HSCA 2008 (Regulated Activities) Regulations 2010. Concerns were around risks associated with a lack of accurate record keeping. At this inspection some improvements were noted but further improvements were still required.

Staff used computer tablets to record care given and people’s responses as they occurred. Staff said the recording system was easy to use and that they could access care plan information easily and regularly. Prompts within the system ensured certain care actions were completed and recorded. However, some records were not accurate. For example, despite being told and the care plans indicating that people were checked each hour during the night this was not recorded on the computer system. Therefore staff were not always recording accurately and this meant we and staff did not know what care and support had been provided. This was raised with the registered manager as an area for further improvement.

Despite some poor record keeping and the need for further embedding of the computer system used it allowed senior care staff to review the information put into the computer to ensure care was recorded and delivered as required and to pick up on any areas for further action. Any concerns were raised directly with the senior staff. We heard staff consult with the two senior care staff (team leaders) throughout the day, sharing information about people. For example, updates on skin conditions and level of pain being experienced.

Activity, entertainment and staff interaction was tailored to individual need. Assessments undertaken informed the care plans and took account of people’s past lifestyles, likes and dislikes. For example, records indicated where one person preferred to sit in the lounge and what specific support was needed during activity and outings. There was guidance on how to interact positively during one to one and what key areas people were interested in.

There were group activities including Bingo and a review of the newspapers in the morning and sewing in the afternoon. One person involved in sorting buttons said, “I come here every day, it is wonderful.” Small groups in the lounge were having drinks, talking and watching the television. The home had large communal areas that most people used and at times the noise generated by activity

Is the service responsive?

and people talking was loud. Visiting professionals indicated that the home appeared at times with the movement of people to be 'chaotic', with limited space for people who wanted to sit quietly. The registered manager and provider told us of plans to provide a garden room for people to use away from the main area of the home. The provider had taken account of individual needs for meaningful activity and entertainment and was progressing further facilities to accommodate people who preferred quieter areas. Staff were seen to help people to their own rooms if they wanted to. .

People also had the opportunity to spend individual time with staff. We observed an activities co-ordinator with a person in their own room. They were talking about a topic of interest for them and arranging to view pictures on the home's iPad.

Records showed the attention provided to individuals and the encouragement to join activities or to engage in some interaction. They also recorded where people had spent their time, anything they had done and how they had presented during day. In this way staff maintained awareness of individuals in communal areas and in their own rooms.

People had full needs assessment completed before admission to the home. 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 beliefs and cultural choices. For example, what religion or beliefs were important to people. Care plans were written following admission and reviewed on a monthly basis. The care plans included daily preferences for example, when people like to go to bed and get up and how often people like showers and baths. Reviews undertaken took account of health, social and emotional changes. For example, one person had requested to play cards during one to ones and this had been reflected within the care plan.

Staff knew people well and were able to tell us what their care needs were and what they liked to do now, and in the past. Staff told us about the approach used for one person to reduce behaviours which challenged and told us of one person who loved to ride horses. This approach and knowledge was reflected in the care plans.

Visitors were welcomed and able to stay in the home for meals and entertainment if they wished.

People were encouraged to continue to see friends and relatives and access the community with staff or relatives. One relative told us they visited regularly and that staff enabled her to take her father out for lunch. Staff knew visitors well and maintained effective relationships with them to the benefit of people living in the home.

Is the service well-led?

Our findings

People told us they were happy at Clifden House Dementia Care Centre and that it was a 'good place'. Other comments included, "I can't fault the place, "I think it's pretty good," "It's very good. The staff are all very good" and "It's better than I ever dreamt it could be." People and visitors remarked on how hard the staff worked. Visiting professionals also commented on the staff and they shared the opinion that 'staff did their best'.

At the last inspection we found the service non-compliant with regulation 10 of the HSCA 2008 (Regulated Activities) Regulations 2010. Concerns were noted around the lack of systems to regularly assess and monitor the quality of service. At this inspection improvements were noted but further improvements were required. .

The registered manager did not have the resources or did not deploy them appropriately to ensure the management and quality of the service was appropriately monitored reviewed with suitable action taken to improve and maintain a quality service. For example, systems were not in place to ensure staff were suitably supported, complaints were not recorded and dealt with in a proactive way and despite auditing systems being established the management of medicines was not safe.

People's views were obtained through a variety of ways and systems were in place to encourage feedback from people. This included annual satisfaction surveys and on-going feedback system through the services website. The annual surveys had not been audited although the registered owner had responded to most comments posted on the website. Information received was responded to on an individual basis but there was no report to show the information was used as a tool for learning for the whole service. .

Feedback was also gained through 'resident's forum' and regular contact with people. Meetings were used to discuss what people thought was done well and what could be improved. Activities and food were central to conversations and discussions. People said that they wanted to be involved in making Christmas decorations and Christmas cards. One person said they wanted to send one to their relative.

People knew the registered manager and the registered owner well as both had a high visual presence in the home.

When walking around the home they made a point in engaging with people, visitors and staff. The office was close to communal areas and ensured that the registered manager and senior staff were accessible.

A management structure was in place consisting of an experienced registered manager and four team leaders (one of which worked in a deputy role) who support the registered manager. Care staff included an identified senior role. Care staff were clear about who was in charge and were given areas of responsibility and tasks to perform at the beginning of each shift. On call arrangements were in place and staff knew who to contact when they needed any advice or guidance.

Staff told us they enjoyed working at Clifden House Dementia Care Centre and felt they were supported, listened to and could raise any issue with the registered manager and senior staff working. One member of staff said, "I can go to my manager if there are any problems, or the registered manager or whoever is in the office". The home had an appropriate whistle blowing policy in place, which encouraged staff to raise concerns. Staff had the telephone number of the registered owner and he told us that he was often contacted when staff had a concern they wanted to raise with him directly.

Staff meetings were held on a regular basis and all staff had the opportunity to participate. Minutes showed they were well attended, with representatives from each shift, including nights. The meetings included a training element as well as opportunities for staff to make suggestions for improvements. The registered manager used these meetings to praise the staff and to arrange and discuss team events that promoted team working.

Clifden House Dementia Care Centre had a written philosophy of care that was shared with people within the home's brochure and website. These included the goal of a 'better life. 'Staff reflected on the philosophy of care through conversations that were held. The registered owner confirmed that his vision for the home was to provide a high quality standard of care for people living with a dementia and a community resource for local people to use. He told us that he was already promoting this through supervision of the managers and the on-going training of staff.

There were quality assurance systems in place to monitor aspects of care and safety. An environmental check

Is the service well-led?

identified areas around the home that required work and attention. For example, redecoration and missing curtains. Where unnamed shampoos were found these were removed for safety reasons. This was to prevent staff using the product for more than one person and to remove a possible risk of people drinking the shampoo. Where issues to be addressed were identified these were passed to the maintenance man and registered owner to address.

Audits were undertaken and covered areas that included care records, medicines and infection control. Information gathered was used and reviewed at management meetings to improve the service and reflected within staff meetings for any required actions. For example, staff were reminded of the importance of accurate records to record the care provided.

Notifications were sent to inform the Care Quality Commission (CQC) when certain incidents had taken place as required. These had recently included information relating to an infectious outbreak in the home. The registered manager had ensured that this had been dealt with appropriately with all the relevant authorities notified and involved as necessary.

The registered manager recorded accidents and incidents. The auditing of these did not clearly record information to identify themes or record action taken. We saw from individual accident reports that risks were reviewed following an accident to reduce potential accidents.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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

Accommodation for persons who require nursing or personal care

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

People were not protected against the risks associated with the unsafe use and management of medicines.

Regulation 12(1)(2)(g)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

The registered person had not made appropriate arrangements to ensure staff were appropriately supported to enable them to deliver care and treatment to safe and an appropriate standard.

Regulation (18)(1)(2)(a)

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

The registered person had not ensured an appropriate system was in place to deal with all complaints.

Regulation 16 (1)(2)