Highcliffe Care Centre Limited

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

Summary of findings

Overall summary

The inspection took place on 20 June 2016 and was unannounced. A second day of inspection took place on 24 June 2016 and was announced.

We previously inspected the service on 10 October 2013 and found the service met the regulations we inspected against at that time.

Highcliffe Care Centre is a two storey, purpose built care home that provides residential care and support for up to 60 people, some of whom are living with dementia. At the time of our inspection there were 60 people using the service.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the provider had breached a regulation. Pre-assessments were completed prior to people moving to Highcliffe Care Centre. This was to ensure the home could meet people's needs. Clinical assessment tools were completed with people and their families on the day of admission. During the inspection we found these documents didn't always correspond which impacted on people's care such as pressure damage. Appropriate equipment was not always identified and implemented for people. For example, an airflow mattress for a person with a high risk of pressure damage.

Some records were inaccessible and could not be located by the registered provider. We have made a recommendation about information governance procedures.

People and their relatives told us they felt safe and well looked after living in the home. People had risk assessments in place and associated care plans were clearly linked and updated in line with risk assessment reviews.

Staff we spoke with were confident in their role in safeguarding people from potential abuse. Staff received regular training and were knowledgeable about the different types of abuse and the organisations procedure on safeguarding.

During the medicines round people were given the time and support they needed to take their medicines. Medicines were managed effectively with safe storage and appropriate administration. All records were complete and up to date with regular medicine audits being carried out.

We reviewed the rotas and saw staffing levels were consistent. Staff personnel files showed clear recruitment procedures had been followed and all staff had the appropriate checks in place.

The home had an emergency kit bag which contained records such as personal emergency evacuation plans (PEEPs), fire file and the service's business continuity plan. It also included emergency equipment such as a light, a high visibility vest and an albac mat (to be used for vertical and horizontal evacuations for people with mobility issues).

Staff told us they completed an induction before starting work at Highcliffe Care Centre. Staff received regular training in areas such as safeguarding, moving and handling, safe handling and medicines and first aid. The home had identified champions covering areas such as dementia, wound care, nutrition and end of life.

Staff told us they received regular supervisions, as well as annual appraisals. Records we viewed reflected this.

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Best interest assessments were evident within care files and DoLS authorisations were in place where appropriate.

We observed during mealtimes that people enjoyed their meals, some independently and others with support from staff. There were choices available for people and support was provided by staff with patience and at an appropriate pace to each individual.

Care plans were personalised, detailed and contained people's personal preferences, likes and dislikes. Care plans were up to date and reflective of each person's individual needs.

There was a wide range of activities available both within the home and in the community for people to become involved in and enjoy. The home had a full time activity co-ordinator who worked with people and family members to design activities programmes tailored to people using the service. There was also a part time activity worker who provided additional support to people when doing activities.

People and their relatives told us they knew how to make a complaint and would feel confident and comfortable in raising any concerns about the service if they weren't happy.

The registered manager and the management team conducted regular audits of the service the home provided which supported improvement. They also operated a 'resident of the day' scheme which meant that each person living at the home had their care plans and preferences reviewed on a monthly basis.

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.

Pre-assessments and risk assessments didn't always correspond and risks to skin integrity were not always identified.

People and their relatives told us they felt save living in Highcliffe Care Centre.

Staff we spoke with were confident in their role of safeguarding people.

Medicines were administered in accordance with good practice and people were supported in a friendly manner.

The staffing levels were consistent and the service had a robust recruitment procedure which meant people were recruited with the right skills and experience.

Is the service effective?

Good

The service was effective.

Staff had regular training, supervision and annual appraisals to ensure they had the skills and knowledge to care for people.

The Mental Capacity Act (2005) was followed appropriately and Deprivation of Liberty Safeguards (DoLS) were authorised.

People had access to healthcare professionals as they needed them.

Is the service caring?

Good

The service was caring.

People and their relatives told us the care they received was good and staff were friendly and helpful.

People told us they were encouraged to be independent and their dignity was maintained. We observed this was done in a supportive manner.

People accessed advocacy support when required and information was available throughout the home.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed, up to date and reflected the individual needs of each person.

A wide range of activities were on offer for people both within the home and in the community. Activities were tailored to peoples' individual needs and preferences.

People and their relatives told us they knew how to complain and would feel comfortable raising any concerns. There was a clear procedure in place for dealing with any complaints.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some documentation could not be located by the provider and the location was unknown.

Staff told us they felt the registered manager was supportive, approachable and operated an open door policy.

The registered manager and management team completed regular audits on the service the home provided and ensured wherever possible they learnt from any accidents or incidents.

The service operated a 'resident of the day' scheme to help ensure that at least once a month every person had all of their care needs and personal preferences reviewed.

Highcliffe 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 comprehensive inspection took place on 20 June 2016 and was unannounced. A second day of inspection took place on 24 June 2016 and was announced. The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection took place we reviewed the information we held about the service. This included notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider also completed a Provider Information Return (PIR) and this was returned before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make.

We contacted the local authority commissioners of the service, the local authority safeguarding team and Healthwatch. Healthwatch England is the national consumer champion in health and care.

As part of the inspection we conducted a Short Observation Framework for Inspection (SOFI) during the lunch time. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We also spent time in the communal areas.

During the inspection we spoke with four people, one relative and two visiting health care professionals. We also spoke with seven members of staff, including the regional manager, the registered manager, a unit manager, a senior care worker, a care worker, a kitchen assistant and the administrator. We looked at four people's care records and four people's medicine records. We reviewed three staff files, including records of the recruitment process. We reviewed supervision and training records as well as records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Pre-assessments were completed by the registered manager or unit manager prior to people moving into Highcliffe Care Centre. This was to ensure the home could meet their needs effectively. We found that for one person a pre-assessment had highlighted the potential risk of breakdown to specific areas of skin. District nurses had previously been involved when redness had occurred. From the assessment the home determined that no specific equipment was required to meet the person's need.

A clinical risk indicator tool was completed on the day of admission, which included pressure damage. The outcome of the assessment identified the need for staff to observe. Upon review we found that the tool contradicted the information recorded in the pre-assessment, for example it stated there was no history of pressure damage. A waterlow assessment (this is an assessment designed to prevent the risk of pressure ulcers to the skin) had been completed which indicated the person was high risk. We found that the home had continued to care for the person which specialist equipment, such as an airflow mattress, which the waterlow assessment highlighted as appropriate. Other care plan documentation stated the person was to have 4-hourly positional changes. Records requested recorded that this care intervention had taken place on only one out of four days which meant we were unable to confirm that this care intervention had taken place as required. The impact of this failure was that the person required hospital admission for treatment. A coroner's investigation reported that the home had contributed to the person's deterioration.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt the service was safe. One person said, "I feel very safe indeed." Another person told us, "I never felt anything other than safe." A third person we spoke with said, "Yes, I feel very safe here." One relative told us, "It's safe, there is good security on the doors." They went on to say, "Two people always walk with [family member]. On the whole, I feel they are safe and well looked after." A health care professional told us, "They do a really good job here from what I've seen. We haven't had any safeguardings or concerns."

We spent time with staff whilst they were completing their medicines round. We noted medicines were administered in accordance with good practice and people were treated with respect and patience. The senior care worker told us they administered people's medicines either before or after their meals, depending on what time they chose to eat. The service operated a protected meal times so people weren't disturbed during those times to administer medicines.

The majority of medicines were contained in colour co-ordinated blister packs which corresponded with colours on medicine administration records (MAR). The different colours represented different times of the day for morning, lunchtime, afternoon and nights. We viewed MAR records and found they were fully completed. There were PRN protocols in place for people receiving 'as needed' medicines. Associated care plans lacked information about signs people may show to inform staff when they required medicines. However, they did guide staff to complete an abbey pain scale to help guide them. We advised the registered manager and the regional manager that the existing PRN protocol templates didn't prompt staff

to record potential signs people may show. The regional manager revised the template and implemented it with immediate effect.
Competency checks were regularly completed to ensure staff administering medicines were safe and experienced to do so. In addition regular audits were completed by the registered manager, unit managers and senior staff which would help any medicines errors being identified.

Staff told us they were confident in monitoring safeguarding concerns and could describe the process they would follow, should they identify any potential signs or concerns. Staff had up to date training in safeguarding people. We saw the home had a safeguarding file that contained the reporting procedure and copies of referral forms. The file also contained a log of safeguarding alerts made to the local authority and clear outcomes. The registered manager held electronic records of safeguarding investigations that were sent to head office for collation. The registered manager also monitored safeguarding concerns to identify any trends. At the time of the inspection there were no trends in safeguarding concerns.

People had risk assessments in place where required. Risk assessments were stored within care files and were regularly reviewed. All identified risks had appropriate care plans in place which detailed how care was to be provided to prevent those risks. For example, where someone had been assessed as being at risk of a fall, they had a moving and handling risk assessment and a specific mobility care plan. A referral had been made to the falls team and the service had arranged for appropriate equipment to be put in place. Equipment included a sensor mat and wheelchair.

The provider also had general risk assessments for the premises and environment which included asbestos, legionella, windows, hot trolley, manual handling, slips, trips and falls and infection control. We saw each general risk assessment was stored centrally and reviewed on a regular basis to ensure it was up to date and relevant.

Accidents and incidents were recorded and monitored. Details included details of the person, their mobility and dependency needs, what happened, any injuries sustained, treatment required, whether witness or unwitnessed and whether the Care Quality Commission had been notified. The registered manager completed a monthly analysis of all accidents and incidents to identity any particular trends. For example, time of day accidents/incidents occurred and probable causes. During the inspection we noted the registered manager had identified that one person had suffered a number of falls from a standing position. The home had made a referral to the falls team and created a falls risk assessment (as the person was previously not at risk of falls). They also updated the person's mobility care plan to include recommendations from the falls team of a change in equipment from a walking stick to a wheeled walking frame and had alerted staff to observe the person closely.

Records in staff files demonstrated staff were recruited with the right skills, experience and competence. Recruitment checks had been completed before new staff started working with vulnerable people. These included checks of their identity, references, proof of qualifications and a disclosure and barring service check (DBS). DBS checks are used as a means to check whether applicants had a criminal record or were barred from working with vulnerable people.

People told us there were enough staff to meet their needs. One person said, "Yes I think there is enough staff." Another person told us, "I know they are there, when I ring my buzzer they come quite quickly." A third person said, "They come when I ring the buzzer." A health care professional visiting the service told us, "We've never had a problem finding a staff member. There always seems to be a carer in the day room."
The home had a system in place to analyse staffing levels and ensure sufficient staffing cover was available. On-call arrangements were in place for staff to be able to contact an appropriate senior member of staff

during out of hours. We reviewed staffing rotas for a four week period and found staffing levels to be consistent and in line with the assessed level of need. The registered manager told us staffing cover was provided by staff within the home and the unit managers as and when needed. The home did not use any agency staff.

During our inspection we did not observe any occasions where people were left unassisted for a long period of time, or had to wait for support. We noted call bells were answered in a timely manner throughout the day and people were regularly checked by staff to ensure they had support if required.

Personal emergency evacuation plans (PEEPs) were in place for every person who used the service. These included details about the level of support each person required, how many staff were needed and any equipment to be used. We noted cognitive needs weren't included in the plans and we raised this with the registered manager. The registered manager informed us they were in the process of introducing a new, more detailed personal emergency evacuation plan for people that would include cognitive impairments.

The registered manager had an emergency kit bag in the office which was designed to be able to grab in the event of an emergency. The bag contained a high visibility vest, fire file (which contained a copy of a PEEPs table with everyone's needs), the service's business continuity plan, a light, identity bracelets and an albac mat (which could be used for vertical and horizontal evacuations for people with mobility issues). This meant the home was equipped and prepared to deal with an emergency evacuation while minimising risks to people.

Good

Is the service effective?

Our findings

People told us they felt supported and cared for by staff who were skilled and experienced. One person said, "They are good, very patient and caring." Another person told us, "They all seem to know what they are doing." A relative we spoke with said, "They are observant and seem to know when [family member] is ill or unhappy."

Staff had up to date training including safeguarding adults, safe handling of medicines, moving and handling, first aid and fire safety. One of the unit managers had completed train the trainer courses and delivered training to staff in the home. All new staff completed a six day induction course which the unit manager told us, "Cover's all of the mandatory training. One staff member said, "I had a week induction before I started work here, even though I had been a carer before. It was good." Staff then had twelve weeks to complete the care certificate which included observations and competency checks. The registered manager told us new staff could spend additional time shadowing existing staff and have more observations and competency checks completed if they didn't feel confident following the standard 12 week training. This was to ensure staff felt supported and comfortable when commencing their official role.

The registered manager told us they had staff who were trained champions in specific areas such as dementia, nutrition, end of life care, safeguarding, continues and MCA and DoLS. Regular discussions about their champion roles took place during supervisions or additional one to one meetings, when required.

Staff told us they received regular supervision and annual appraisals. Supervisions are regular meetings between a staff member and their manager to discuss how their work is progressing and to discuss training needs. Records confirmed regular supervisions and annual appraisals had taken place for all staff. Discussions during staff supervisions included any training completed, what had gone well since the last supervision and what could be improved. Other discussions included any strengths and weaknesses staff had and any development opportunities. Any agreed actions were recorded and followed up during the next supervision sessions. The annual appraisal process consisted of the staff member and appraiser rating key areas of the staff member's role prior to meeting. Areas included appearance, time keeping/attendance, report writing, communication, team working and caring approach. During appraisal meetings staff members and the appraisers discussed the ratings and rationale and agreed an overall rating.

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 explained how best interest decisions were made and demonstrated knowledge of MCA and DoLS. People's care records contained best interest decisions which corresponded to the information contained in the DoLS authorisations. Detailed care plans were created to ensure the least restrictive options were considered for people.

For those who required a DoLS authorisation there was a clear audit trail showing when DoLS applications had been submitted to the local authority, and in the most, when outcomes had been received and authorisations for those granted. There were some instances where a best interest assessor had visited the service and given the registered manager verbal authorisation. But written authorisations were outstanding. The registered manager monitored outstanding DoLS authorisations.

Staff understood the principles of MCA assessments and when they may be completed. Staff also had an understanding of DoLS including what they were, when they were used and understood that a number of people living at Highcliffe Care Centre had a DoLS in place.

People were very complimentary about the food at Highcliffe Care Centre. They told us they really enjoyed their meals and there was always enough to eat. One person said, "The food is very nice, I get offered two choices, it is good and there are lots of snacks." Another person told us, "The food is excellent for me, it is well cooked." Another person said, "I like my meal, I like the vegetables they keep me healthy." We received similar feedback from a relative we spoke with who told us, "The food is generally very good. I sit with my [family member] to encourage her to eat."

We observed a meal time experience in the dining rooms on both floors. The atmosphere was lively and people were served their food in a polite, and respectful manner. Staff encouraged people to eat independently where possible. People who required support to eat their meals were patiently supported at a pace comfortable to them. Staff also prompted others where needed which seemed to be effective as we saw people who became distracted refocus and continue to eat their meals.

People had a choice of two meals every mealtime and the service also offered alternatives for those with specific dietary requirements. For example, a vegetarian diet. They also offered alternatives such as omelettes, sandwiches and jacket potatoes if people did not want either of the meals on offer. Due to the complex needs of some people, they were unable to choose a meal when asked verbally. We observed care workers showing people both options plated up and asking them which one they wanted. Staff explained what each option was. We saw people pointing to choose the meal they wanted.

The registered manager told us they operated a phased mealtime service rather than a specified sitting time. This meant people could eat their meals at a time suitable to them and those who required more support with their meals could go to the dining room first. We saw people making their way to the dining room in their own time to have their lunch. Those who ate later still had the choice of two meals and the food was of the same standard. The arrangements gave the dining experience a relaxed flow and allowed staff to give people their undivided attention when supporting them to eat their meals. Some people chose to eat their meals in their rooms. We observed staff taking dressed trays to people's rooms with their meals appropriately covered, cutlery, condiments, napkins and drinks. One person told us, "The food is good; I can have my food in my room or the dining room." Another person said, "I have my tea in my room, usually ask for ham sandwiches, which is sufficient for me."

A refreshments trolley was taken around the home in between meals. People were offered hot and cold

drinks as well as biscuits, cakes, scones, sandwiches, pastries, yoghurts and fruit. This meant there was always a variety of food and drinks available for people throughout the day.

People had access to a wide range of health professionals including doctors, speech and language therapists, specialist nurses, dieticians, podiatrists and chiropodists. One person told us, "I see doctors when I need to." Another person said, "I see a podiatrist and a doctor." One person we spoke with had recently suffered a fall and told us, "I got help instantly, I recently fell in the care home, they came to help me and gave me a thorough examination. Two state registered nurses checked me and staff came later to check on me. They also informed my next of kin." Records of any professional visits to the home or appointments were kept, as well as contact notes of discussions staff had with health professionals or treatments people had received. We noted from care files that health professionals completed the professional records themselves, documenting the details of their visits.

Good

Is the service caring?

Our findings

People and a relative told us they were happy with the care they received at Highcliffe Care Centre. One person told us they were "always treated nicely" and that staff were "very friendly and helpful". Another person said, "Staff seem to be a happy bunch of people, it's a happy place to be." A third person said, "They have a joke with me. (They are) kind and pleasant people." Another person commented, "They put themselves out for you." A relative we spoke with was of the same view and when asked if staff were caring, told us, "Yes, they do it well. My relative likes to wear necklace and make up, if I don't do this the staff will. Some staff are marvellous."

The atmosphere was warm and welcoming. One visiting health professional told us, "We come in twice per week. They're very welcoming and helpful. Nothing seems to be a problem for them. The residents always seem to be presented well."

Throughout the inspection we observed staff treated people with dignity and respect. Staff spoke to people in a respectful and polite manner, and referred to them by their preferred name and with familiarity. Staff knocked on people's doors and waited for a response before entering. We observed staff offering support to people and gaining their consent before providing it. For example, when supporting a person to mobilise from the dining room to one of the lounges when they had finished their meal. People told us they felt respected by staff. One person said, "They treat you with dignity and respect." Another person told us, "They treat you well and listen to you." One relative we spoke with said, "I think they treat [family member] with dignity and kindness."

We observed staff supporting people to mobilise around the home with equipment such as a wheelchair or walking frame. We also observed staff supporting people without the use of equipment such as minimal physical assistance or encouraging prompts. We also observed people being supported with everyday tasks, such as eating, drinking and doing various activities. Staff supported people gently and patiently, providing prompts and encouragement when required and at a pace comfortable to each individual. We observed staff sitting with people and doing their nails and other activities. Staff could also be seen chatting with people either while supporting them - or when spending time in communal areas with people. Interactions were observed to be positive, friendly and familiar. There were lots of smiles in the dining room, lounges and communal areas with people interacting with each other as well as with staff and visitors.

People were supported to make individual choices and decisions where possible. For example, one person wasn't happy with their seat in the dining room at lunch time. Staff gave alternative seating options and supported the person to move to the table of their choice. Staff addressed people with compassion and spoke about them with genuine affection. Staff were able to explain people's usual routines as well as their individual interests, likes and dislikes.

At the time of our inspection we focussed on a person was receiving end of life care. We viewed their care file and found they had a 'Do not attempt cardio pulmonary resuscitation' (DNACPR) as well as a detailed emergency health care plan and a future wishes plan.

Clear information about a range of advocacy services was displayed in communal areas should the time come where this should need to be considered. Advocacy services information included independent mental capacity advocates (IMCA) and independent mental health advocates (IMHA). The registered manager told us one person was receiving advocacy support at that time. They also told us, wherever possible, they tried to ensure people's relatives were available to support them when discussing key areas of their care.

The home had a quiet lounge that people could use when they received visits from relatives to ensure they had a more private space to talk that was an alternative to their own rooms. We observed people using the room when their relatives visited. Staff made sure the person and their family members had refreshments, cake and biscuits during the visit. The registered manager told us they had plans to restyle the quiet lounge to resemble a vintage tea room. There was a door leading out onto an enclosed patio area where the registered manager planned to place tables and chairs so people could sit outside when the weather was warm.

There was an outdoor communal decked balcony on the first floor of the home which had a garden table and chairs as well as a variety of potted plants and hanging baskets. Staff told us some people enjoyed planting flowers and vegetables and others enjoyed sitting on the decked balcony. We observed a person being supported by staff to water their vegetable plants. The person responded enthusiastically to staff prompts. They picked up the watering can and went with staff to fill it up. Then they went out onto the decked area and began to water their plants. They were smiling broadly throughout and clearly enjoyed the activity.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs, wishes and preferences. One person we spoke with said, "They look after me well." Another person told us, "They listen to my care needs and help me." A third person said, "Staff like people to have their own way. I like to do everything for myself."

People told us they felt in control of the care they received and were supported by staff to do things they wanted. One person said, "I love a bath, I have just had one and they (staff) washed my hair." Another person told us they preferred to have a bath and said, "It's a superb custom-made bath, I feel safe and I am going to have another one tomorrow."

Records showed pre-admission assessments were completed in relation to people's needs. For example, medicines, medical history, sleep pattern, skin assessment, dietary needs, personal care and wellbeing. This meant the service were able to put care plans in place that were reflective of peoples support needs.

People had a range of care plans in place to meet their needs including mobility, personal hygiene, sleeping, breathing, skin integrity, communication and activities. Care plans were personalised, and included people's preferences and choice. They were regularly reviewed and reflected the needs of the person. For example, one person's personal hygiene care plan stated they liked to look their best, preferred to have a bath after tea and were able to wash the top half of their body with verbal prompts as support. The care plan went on to state the person required full support to get dressed and were able to choose what they wanted to wear from a small selection of clothing.

Staff we spoke with were able to tell us about people's individual needs and how best to support them. They were also able to explain people's routines, preferences, likes and dislikes in relation to daily routines. For example, what time people tended to get up, what drinks they liked and what their day usually entailed. This meant staff had a good level of knowledge about people.

The home had a full time activity co-ordinator and a part time activity worker who worked with people to design an activity programme people would benefit from and enjoy. The activity co-ordinator also arranged a number of fund raising events such as raffles, themed days and fetes to raise money for charities chosen by people who lived in the home. The registered manager told us all activities were funded by the registered provider which allowed fund raising events to be dedicated to charities rather than to fund outings for people. There were a wide variety of activities that had taken place in the home recently which included singers, gardening, knit and natter and a coffee morning. We observed people taking part in a sit and be fit session as well as getting their nails done and doing arts and crafts. A singer arrived on the afternoon to put on a show and the registered manager told us staff were supporting people to go to see a parade in Seaburn for armed forces day.

People and relatives we spoke with told us they knew how to complain and commented they felt comfortable and able to raise a complaint or concern if they were unhappy with any aspect of the service. One person said, "I have no need to complain. I would be able to talk to them (staff) if I needed to." Another

person told us, "I am sure I could, but I have no reason to complain."

The complaints procedure was available for people to access throughout the home. The registered manager kept a record of complaints received and how these had been managed. We saw that where formal complaints had been received the registered manager had communicated in writing to the complainant and informed them of the investigation and conclusion.

Regular resident and relative meetings were held in the home and various topics were discussed regarding the premises and the service. For example, activities, meal times, nurse calls and maintenance. Suggested improvements for the home were discussed and actioned. For example, staggered meal times was suggested as a way to improve the meal time experience for people. We observed this had been actioned and staff told us it was working well. This meant that people and their relatives were involved in the future developing and planning of the service.

Requires Improvement

Is the service well-led?

Our findings

Some records relating to people's care were unavailable as the registered provider informed us they could not be located. Following a report from a coroner we asked the registered provider for further information around pressure care. The registered provider informed they could not locate a waterlow assessment, a personal hygiene care plan and records of positional changes. We requested the information as the coroner informed us of their conclusion that the deterioration of one person was related to the care they had received. This meant governance procedures were not always effective as documentation was not available and could not be located.

We recommend that the service improve their governance procedures and seek training, for all staff, about managing, maintaining and securely storing data and information.

The home had an established registered manager who had been in post since 1 October 2010. They were proactive in meeting their responsibilities in relation to submitting relevant notifications to CQC.

Staff told us they felt the service was well-led. They said the registered manager was supportive and approachable and they could raise any questions, queries or concerns.

We received similar feedback from the people, relatives and visiting professionals we spoke with. One person we spoke with told us, "(It's a) good standard of care, they (staff) are very kind and caring." Another person said, "It all seems to work well." One relative told us, "I worked closely with the staff when my [family member] moved in to help them understand her." They went on to tell us, "It is a nice home and all staff are approachable. The manager and staff keep me informed." One health professional told us, "The records are good. Any advice we give them (staff) they seem to follow up." When discussing the registered manager, one health professional told us, "We've had no problems. She's approachable and there's nothing rushed. I think they are accepting and understanding of the benefits of the team (of community matron's and sisters visiting the home regularly)."

The registered manager operated an open door policy in the home and encouraged staff to come to them with any queries or issues. We saw staff enter the office to speak with the registered manager and deputy manager with queries and also to obtain files appropriate to care provision.

There was a management presence in the home with the registered manager and one of the unit managers readily available for staff, people who use the service, relatives and visiting professionals to speak to. A health professional told us, "I think it's really good that there's [registered manager] then there's the deputy managers on each unit. It's good for us when we need to speak to someone senior." During out of hours, the registered manager told us staff had access to contact details for them and the unit managers should staff need to speak to management or have any issues or problems. There was also a rota of out of ours regional managers for staff to contact if necessary. This meant staff always had access to management whichever shift they were working.

The registered manager and unit managers completed a number of audits in the home which varied in frequency. They completed service audits based on person centred care planning as well as other audits such as health and safety, medicines management, health and safety and people and relative involvement. These were effective in identifying issues and required improvements which were then acted upon.

The registered manager completed a self-audit programme each month and sent the scores via the monthly quality indicator return form, to the operations manager, clinical development manager and the operations administrator. The self-audits were reviewed and action plans were created for the registered manager to complete for any identified improvements. Senior registered provider staff visited the home regularly and reviewed action taken.

As well as the regular audits the home also operated a system called 'resident of the day'. On that day staff would ensure they reviewed all risk assessments and care plans in relation to that particular person. They would be visited by staff from the various departments within the home, such as activities, housekeeping and the chef, to ensure they were happy with the service they received and whether all of their needs and requests were clearly documented. Staff told us they tried to ensure that as part of this review process they also spoke to relatives of the person to make sure all areas were considered. The registered manager told us the scheme ensured that the needs and care documentation for each person were thoroughly reviewed at least one a month.

Staff told us they had regular staff meetings. Discussions included person centred approaches, communication, holidays, staff rotas, using mobile phones, skin bundles and the staff smoking area. Minutes of staff meetings were available in the main office and any actions agreed were reviewed in the next meetings that followed. For example, a review of the phased/staggered mealtimes.

Other regular meetings included catering and health and safety committee meetings. Catering meetings included discussions around new members of staff, the ordering of food, kitchen hours, menu planning and communication between staff. For example, introducing a kitchen diary to relay messages to each other. The health and safety meetings included discussions of any accidents or falls that had occurred in the home and any identifiable trends. Other areas discussed included training updates, infection control, emergency planning and fire prevention. We viewed an analysis and noted that no trends had been identified and one noted action was to continue with fire drills.

Highcliffe Care Centre regularly received thank you cards from people's relatives, complimenting the service their family members received whilst living at the home. The registered manager stored these in a file in the office for staff to view. Compliments received included, 'Over the time our [family member] lived there she received first class care and I would commend all of the staff at the home and recommend Avery and particularly Highcliffe Care Home without doubt to anyone.', 'The home provides a friendly, welcoming environment and is run with efficiency and warmth by its manager and her team. [Registered manager] has a talent for recruiting, training and retaining the right sort of staff which enables great continuity of care for residents. From the start [family member] was cared for, which was an enormous comfort to all the family. From going into the home he was very well cared for and all of the staff have been excellent in his care and making his last year comfortable and in treating him as a person and getting to know him and his needs.