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Clyde Court Nursing Home

Inspection report

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16 November 2016

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

Summary of findings

Overall summary

Clyde Court is a large three storey detached house in Manchester. The home provides nursing and residential care for up to 41 people. There were 36 people living at Clyde Court at the time of our inspection. The home has a large communal area to the ground floor, incorporating a dining area within this and two smaller lounges off the main area. The kitchen is also on the ground floor of the building. All floors were accessible by a lift and stairs.

This inspection took place over three days on 9, 11 and 16 November 2016. The first day was unannounced, which meant the service and the staff did not know in advance that we were coming. The second and third day was by arrangement.

At the comprehensive inspection of Clyde Court on 4 and 12 March 2015 we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (HSCA). We issued the provider with four requirements stating they must take action to address these breaches.

Following that inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to these breaches. This inspection was undertaken to check that they had followed their plan, and to confirm that they now met all of the legal requirements.

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

The registered manager was not present for all the days of the inspection due to annual leave and other personal commitments. The registered manager was supported with the running of the home by a clinical lead and two residential deputy managers.

We found some working practices poor in relation to the control of infection. Checks to prevent the spread of infection were either not carried out or not fit for purpose.

We looked at how the home ensured people received their medication safely. Medicines were administered by either a nurse or a senior member of staff, trained and competent to do so. We looked at how medicines were monitored and checked by management to make sure they were being handled properly and we were confident that systems were safe. The service had good protocols in place for 'when required' medicines.

The service carried out risk assessments in relation to people's health and care needs and measures were identified to minimise risks wherever possible.

Staffing levels for Clyde Court were adequate for the needs of the people living in the home. The atmosphere during the three day inspection was on the whole relaxed and pleasant. Staff did not appear hurried or under pressure when undertaking care duties, although meal times were seen to be less structured and chaotic. We observed a care worker checking a mobile phone on more than one occasion during the meal time serving which was against company policy.

We found staff were recruited safely. Suitable checks were made to ensure people recruited were of good character and had appropriate experience and qualifications. Staff had received appropriate training and supervision to support them in their roles.

We found accident and incident records at the home were completed and evidence showed people were monitored effectively following an accident. However we found that following a fall, body maps were not always completed.

The home had undergone some improvements since our last inspection however more work was needed to be done to ensure people's safety was not compromised. One carpet within the home was loose and caused a trip hazard. A number of repairs to fixtures and fittings had been identified during home audits but these had not yet been addressed. The environment could be improved to better meet the needs of those people living with a diagnosis of dementia.
Discussion with the registered manager showed they had an understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for. There were policies in place relating to the MCA and DoLS. Where people did not have the capacity to make decisions about their care, meetings were held with people, their relatives, and health and social care professionals to help ensure that any decisions were made in the best interests of people using the service.

Staff we spoke with confirmed they understood the meaning of mental capacity and were able to give us examples of when people were able to make decisions about their care. They recognised the importance of allowing people to make those decisions. We were satisified that the provider had taken action since the last inspection to achieve compliance in this area.

Staff knew how to maintain people's dignity and respect their privacy although some care practices of staff and other health professionals compromised this.

People had access to activities, however we received mixed feedback with regards to the activities provided. People were not always protected from social isolation.

People told us they knew how to complain if they were unhappy and records showed the service responded appropriately to complaints they had received. We saw evidence of compliments received by the service in the form of thank you cards from family members of people who had used the service.

Audits to measure the quality of care provision had been introduced but were not always completed or acted upon. Completed questionnaires and surveys were on file but there was little evidence to show this information had been used to improve the provision of care at the home.

We saw no evidence of regular staff meetings and there had been no resident or relative meetings for over six months.

Staff felt supported by the registered manager however the residential and nursing aspects of care were run

very separately and there was no overarching management of these to align the two.

We found the home in breach of the regulation in relation to good governance as there were not effective systems in place to monitor the quality of the service.

The overall rating for this service is 'requires improvement'. During this inspection we found three breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe

People told us they felt safe and family members stated they had no concerns about their safety.

There was a process for recording accidents and incidents. Body maps were not always completed following falls.

Staff practices did not promote the effective prevention and control of infections.

Parts of the building were in need of repair and a loose carpet posed a potential trip hazard.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was meeting the legal requirements relating to the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). Best Interest decisions were recorded however care plans had not always been updated to reflect these decisions.

Some improvements had been made to the environment but more could be done to assist people with a diagnosis of dementia.

People had access to a range of health professionals who had input with people's care and welfare. Healthcare professionals we spoke with were complimentary of staff.

Is the service caring?

Requires Improvement

The service was not always caring

Staff knew the people using the service well as individuals. Care workers were able to understand the interests and experiences of the person they were supporting although this was not always reflected in the care plans..

Some working practices of staff and other health professionals did not promote the privacy or dignity of individuals.

People were treated with kindness. We saw and heard friendly interactions between people and staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People who were up early confirmed this was by choice although individual care preferences were not always recorded in care plans.

People received support with pressure relief to reduce the risk of developing pressure sores. Updated regimes of care were not always transferred to care plans in a timely manner.

Complaints were handled within appropriate timescales and the outcomes of complaints were documented.

Is the service well-led?

Inadequate

The service was not well led.

A selection of audits had been introduced by the service however these were either not fit for purpose or had not been completed regularly. Areas identified during audits as requiring improvement had not always been acted upon.

It was not clear if feedback had been acted upon. Surveys and questionnaires were not monitored and action plans were not developed from them.

Despite the additional support provided for the registered manager the two elements of care functioned very separately. We saw little evidence of someone being in overall charge and bringing together the nursing and residential staff.

Clyde Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9,11 and 16 November 2016, with the first day being unannounced. This meant the people who lived at Clyde Court and the staff who worked there did not know we were coming. The inspection team consisted of one inspector and an 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. On the second and third days of the inspection one inspector from the inspection team wason site.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service, including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.
We contacted the local Healthwatch organisation and the local authority commissioning team to obtain their views about the provider. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We liaised with other professionals involved with the service at the time of our inspection and received feedback about the management of the service.

We spoke with10 people who used the service, six visiting relatives, three visiting healthcare professionals, a volunteer and 10 members of staff, including the registered manger, the quality administrator and the cook. We observed the way people were supported in communal areas and looked at records relating to the service.

Some people who used the service were unable to tell us about their care therefore we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who cannot tell us about their care. We observed care and support at

lunch time in the dining room and also looked at the kitchen, the laundry, lounge areas and a number of people's bedrooms.

We reviewed five people's care records in detail. We looked at five staff recruitment files and records in relation to staff training, supervisions and appraisals. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. Appraisal is a process involving the review of a staff member's performance and improvement over a period of time, usually annually.

We looked at the systems and processes in place for monitoring and assessing the quality of the service provided by Clyde Court and reviewed a range of records relating to the management of the service; for example medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures, complaints and compliments.

Requires Improvement

Is the service safe?

Our findings

All the people we spoke with in the home said they felt safe. People told us, "Oh yes. I feel I am in a safe place," and, "I feel safe as there are people around me who can help me." One relative we spoke with also told us, "I prefer it here than the other two homes [my relative] has lived in." However, during our inspection we assessed that people living at Clyde Court were not always kept safe.

At the last inspection we assessed that the provider was aware of the need to prevent infection from spreading and was taking the necessary steps. The registered manager was the nominated Infection Control Lead and had allocated infection control champion roles to two members of the care team. An infection control audit undertaken by the council in July 2016 had given the home a "red" rating, due to issues identified at this time. Another external audit was undertaken in October 2016 prior to our inspection. The council judged that the home had made some improvements in this area and were at this point awarded an "amber" rating. At this inspection however we found some current practices did not promote good infection prevention and control.

We spoke with people who preferred to stay in their room. Whilst speaking with them we noted that their commodes had been used and were nearly full. We checked on these commodes two hours prior to lunch being served. When we checked these commodes again at 3pm they were still full and had not been emptied. This meant those people who remained in their rooms for their lunch had eaten their meals with a full commode in their room. We made one of the managers aware of this immediately after our first day of inspection, in the absence of the registered manager.
Lunch time pots had not been removed from a person's bedroom when we were speaking to them at 3.00pm. We were told this happened regularly and were often removed by staff bringing the tea time meal up to the room. We saw that a toilet in the bathroom on the top floor was soiled for the majority of the first day of our inspection. We were told that this toilet was used by one independent person living on the top floor, however we also noted that on the first day of inspection there was no access to toilet paper in this bathroom. This would increase the risk and potential spread of infection.
We saw that documentation to record monthly mattress checks was in place however these had last been carried out in April 2016. During the lunch time service on the first day of inspection we saw staff exiting the dining area for a period of time. It was not clear what tasks they were carrying out however they were entering other areas of the home, some of which required redecoration and improvement works. We saw staff return to the dining area and continue to serve food with the same plastic apron in place and without any hand washing having been carried out.
We viewed a record from a visiting healthcare professional, who had visted Clyde Court prior to our inspection They had noted staff had poor hand hygiene at the time of a diarrhoea and vomiting outbreak. At our inspection we noted that in a bathroom on the first floor unused incontinence products had been removed from the packet and were being stored on top of a bin containing rubbish.
We found working practices poor in relation to the control of infection. Checks to prevent the spread of infection were not fit for purpose. We found this was a breach of Regulation 15 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
On the first day of inspection we arrived at the home at 8.30 am. Care staff on duty included the Clinical

Lead, one nurse, a deputy manager and six care workers. A second deputy manager was covering the role of cook due to annual leave. The registered manager arrived around 9am and was in the home for the morning of the first day of inspection. We spoke with a member of the owner's family who was on site for most of the inspection and was involved with day to day aspects of the home.
We asked people if they thought there were enough staff to meet their needs. People living at Clyde Court told us they did think there were enough staff. We saw no evidence that people were not attended to within acceptable timescales. Everyone we spoke with had call bells in their rooms and five people we spoke with knew what they were for and how to use them. One person told us, "Staff do answer but not always straight away." Staffing levels for Clyde Court were adequate for the needs of the people living in the home. The atmosphere during the three day inspection was on the whole relaxed and pleasant. We heard no one calling or shouting for help. Call bells, when rang, were attended to and staff did not appear hurried or under pressure when undertaking care duties.

At this inspection we looked at a sample of medicine administration records (MARs) and found charts had been completed. We did see two MAR charts with one gap each in administration records noted. We were able to sample people's medicines and saw from blister packs that these medicines had been administered but not signed for. We were told these anomalies would have been picked up and addressed after the monthly medicines audit. Whilst in this case this was a recording error there should be a system in place that picks up errors in a more timely manner to minimise any risks to the health and wellbeing of residents.

We looked at how medicines were monitored and checked by management to make sure they were being handled properly and that systems were safe. As the home was dual registered the nursing staff checked in medicines for those people with nursing needs. Other senior staff checked in medicines for those people with residential needs.
Each MAR contained a photograph of the person, as well as information about any allergies and details about how the person liked to take their medicines was recorded. Systems were also in place to record fridge temperature checks; medication returns and any medication errors. We saw people's names were added to medicines stored in boxes and bottles along with the date that the medicine was opened, which is good practice. We saw there were good 'when required' (PRN) protocols in place to help guide staff as to when they should administer these medicines. These protocols advised staff of maximum doses within a 24 hour timescale and of other medicines and certain foods to be avoided if administering the "when required" medicine. We saw medicines that were controlled drugs were stored and recorded correctly and a weekly stock check was carried out. Controlled drugs are drugs which by their nature require special storage and recording as they can be subject to misuse.

We checked the safeguarding records in place at Clyde Court. Staff told us and the training matrix evidenced that they had completed training on safeguarding adults from abuse, undergoing refresher training every twelve months. Staff were able to describe different types of abuse, and the action they would take if they became aware of an actual or potential incident of abuse. Staff told us that they would report any concerns to the registered manager or a senior member of staff and were also confident about using the whistle blowing procedure. They were certain they would be listened to and that appropriate action would be taken.

We reviewed records to ascertain how the home managed accidents and incidents. We saw that accidents and incidents occurring within the home were logged and documented accordingly. We saw examples of when observations had been done on people after having an accident. These were recorded and contained within care plans. However we saw that body maps were not always completed following an individual having a fall. We brought this to the attention of staff receiving feedback after the inspection. There was a process in place for identifying and monitoring people having frequent falls and other accidents such as

scalds or fractures.
Risk assessments had been completed for any areas that were considered to be of concern. We saw risk assessments for malnutrition, skin integrity, medication, mobility and the risk of falls. The risk assessments we saw in care plans had been reviewed on a regular basis to ensure they remained relevant and up to date.

Through discussion with staff and examination of records we were satisfied that there were satisfactory recruitment and selection procedures in place. During the inspection we looked at the records of four staff members, including staff newly recruited to the service, to check that the recruitment procedure was effective and safe. Recruitment procedures were in place and being followed to ensure only suitable staff were employed by the service.
Pre-employment checks had been carried out, including Disclosure and Barring Scheme checks, health clearance, proof of identity documents, including the right to work in the UK, and two references, including one from the previous employer when possible. DBS checks help employers make safer recruitment decisions to minimise the risk of unsuitable people from working with people who use care and support services. This meant that people who used the service could be confident that staff appointed were suitable to work with vulnerable people.

The service had a Whistleblowing policy that was available to staff. Whistleblowing is when a person tells someone they have concerns about the service they work for.
We looked at service certificates to check that the premises were being maintained in a safe condition. There were current maintenance certificates in place for the electrical installation, the passenger lift, mobility and bath hoists, gas equipment and fire extinguishers. We saw that weekly, monthly and three monthly checks on equipment and fittings in the home was carried out, for example we saw records relating to water, fire door closure mechanism, bed rails, emergency lighting and call points checks. Weekly fire bell checks were undertaken and documented. Two stair lifts situated on the top floor of the property had also been serviced in September 2016. These were not used currently by the two people living in the rooms at the top of the stairs, however we were assured that if people chose to use these in the future they were safe to do so.

Clyde Court is a large detached property in its own grounds. Rooms were spacious and we were informed of the improvements to the décor that had been carried out since our last inspection. However, during the inspection we found that parts of the building were in need of repair with a piece of exposed brickwork in one corridor on the first floor. A carpet was loose in one corridor outside a person's room and potentially posed a tripping hazard. We discussed these potential hazards with the provider who confirmed work was ongoing in the home to replaster and decorate this area and the carpet would be replaced.

When the inspector arrived for the second day of inspection, they found the front door to the home was not closed and had been left on the latch. This was to allow staff coming on to the day shift easy access in to the home, when night staff might otherwise be engaged providing personal care to people wanting to get up for breakfast. The inner porch door had no locking mechanism fitted, therefore the inspector was able to access the home without alerting staff to their presence and access to the home and main staircase was possible. We informed the owner and other members of management about this as part of the inspection feedback process. They assured us that they would rethink the security arrangements given that this poor practice could promote unwanted visitors to the home and put people living at Clyde Court in danger.

Requires Improvement

Is the service effective?

Our findings

People spoke positively of the staff working at the home. A person we spoke with told us, "They look after you well; I am fine." Another person said, "All the staff are brilliant," and a third told us, "It takes a very special person to do their job."

We spoke to five members of staff during the inspection who confirmed they had access to a range of induction, mandatory and other training relevant to their roles and responsibilities. Examination of training records confirmed that staff had completed key training in subjects such as moving and handling; health and safety; fire safety; food hygiene; safeguarding; administering of medicines; infection control and mental health and dementia.

We noted that the registered provider had systems in place for new staff to complete the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standards that should be covered as part of induction training for new care workers. We saw that one care worker had achieved the full care certificate during the time of our inspection, having achieved over 80% in all units.

The provider information return stated that supervision meetings and daily handovers supported staff to question practice. We saw evidence of a number of supervisions within the personnel files we looked in. We were satisfied that staff were receiving supervision according to company policy and staff we spoke with told us they felt supported in this area.

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.
We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS with the registered manager on the first day of our inspection. Discussion with the registered manager showed they had an understanding of the principles of the MCA and DoLS, and we saw that if it was considered that people were being deprived of their liberty, the correct authorisations had been applied for.

The registered manager maintained a record of people subject to a DoLS, together with the type (standard or urgent) and expiry date. They made us aware of the delay this were experiencing with regards to receiving

authorisations from the supervising authority in relation to DoLS applications.

We saw that there were policies in place relating to the MCA and DoLS. Where people did not have the capacity to make decisions about their care, meetings were held with people, their relatives and health and social care professionals to help ensure any decisions made were in the best interests of people using the service.

We saw two examples of best interest decisions recorded in relation to the administration of medicines covertly and the use of crash mats. We saw that following one best interest decision involving a family member of a person living at Clyde Court the care plan had not been updated to reflect this decision and we spoke to the clinical lead about the importance of this. We were assured that changes to care plans would be done in a timely manner to reflect any best interest decisions made on behalf of people who were deemed to lack capacity to make specific decisions.

Staff we spoke with confirmed they understood the meaning of mental capacity and were able to give us examples of when people were able to make decisions about their care. They recognised the importance of allowing people to make those decisions. We were satisfied that the provider had taken action since the last inspection to achieve compliance in this area.

During this inspection all the people we spoke with told us the food provided was good. We asked people what they thought of the food at Clyde Court. One person told us, "It has improved and we get choices." A second person said, "I enjoy the food; I don't eat a lot," and a third person described the food as 'very good.'

We saw a whiteboard in the kitchen that indicated the dietary requirements of individuals living in the home. Care staff covered the role when the cook was absent. The kitchen assistant had previously been a cook but had stepped down from the role. They had the relevant skills to assist in food preparation. We saw no menus on tables however the daily meal was displayed on a large whiteboard situated outside the dining room. We saw large stocks of food items in fridges and freezers and a good selection of dry goods in a dedicated store area.

A rolling menu plan was in operation, which offered people a choice of meals and was reviewed periodically. People were offered a range of options at breakfast and we heard people being offered breakfast choices following our early arrival at the home. We spoke with the cook and the kitchen assistant about the dietary needs of the people living at Clyde Court and found they were aware of which people had specific needs, such as diabetes. They were knowledgeable about how to prepare foods for those with swallowing problems and how to fortify food and fluids for those individuals who needed to gain weight. The cook also knew the food preferences of each person and we saw this was documented by the home. The kitchen area was clean and tidy and we saw the service had been awarded five stars out of a possible five during their most recent food hygiene inspection.

We checked to see that the environment had been designed to promote people's well-being and ensure their safety. We found some signage was now available in the form of people's profiles on some bedroom doors, although we did not see these on bedrooms on the first floor. We saw one profile that indicated the person liked to go fishing and enjoyed reading a newspaper. Having such distinctive indicators in place mean that people with dementia might recognise their bedroom more easily, however these need to be replicated on all bedrooms.

There was some signage on toilet and bathroom doors to assist people with dementia. We saw that toilets on the ground floor had large red signs indicating whether the toilet was designated for ladies or gentlemen.

They also had small metal signs which indicated toilets were for communal use which might cause confusion for some people, especially people with a diagnosis of dementia. We saw that people's bedrooms were personalised with family photographs, ornaments, cuddly toys and small items of furniture, such as a favourite chair.

We saw from observation and from support plans that some people who used the service had complex health needs which required input from a range of healthcare professionals. In the five support plans we looked at we noted individuals had been seen by a range of health care professionals including GPs, dietician, tissue viability nurse and other specialist healthcare professionals. Visits were recorded in the daily records for each person and upcoming appointments were recorded in their care files.

People's care records showed that their day to day health needs were being met. People had access to a GP and we saw during our inspection that district nurses visited the service on a regular basis to undertake routine treatments, such as administer insulin, change dressings and take bloods. Clyde Court staff also received support from the area Nursing Home Team. This team made regular visits to the home to carry out clinical and medicine reviews. The Nursing Home Team could also issue prescriptions when this was deemed necessary to treat a person presenting with any symptoms of infection or illnesses. Any identified infections or illnesses were addressed promptly in the best interests of the person. This meant that people received regular health checks and medicine reviews that promoted their wellbeing and helped improve their quality of life.

The home intended to work towards the End of Life Six Steps Programme and had nominated a nurse to lead on this. People at end of life were able to remain in the home as staff received ongoing support from other professionals, for example district nurses and members of the nursing home team.

A health professional we spoke with told us that the service had made improvements in the three months prior to the inspection. In their opinion there was a better atmosphere in the home and they complimented staff on their professional conduct. They implied further improvements could be made by the provision of a designated treatment room.

Requires Improvement

Is the service caring?

Our findings

We asked people who used the service if the staff were kind and caring to them and people said they were. People were complimentary about the staff. One person told us, "They know me and are very good. They look after me. I can talk to them and I can go out when I want." Another person commented, "The staff call me by my first name. They are all friendly. I can ask any of them to help me and they do help."

We observed that the dining room experience was not a pleasant experience for some people. There was no structure to the meal time service and the environment was chaotic, especially on the first day of inspection. Care workers were very busy serving and did not always provide support in a caring way.

On the second day of the inspection we saw a lady brought into the dining area in a wheelchair. She was placed on her own at a small table, facing the busy kitchen and unable to see other people in the room. The table was cluttered and was being used to store condiments removed from other tables and empty drinks bottles. It transpired that it was this person's birthday and a celebration cake was later brought out. Whilst the person did not appear distressed and was smiling we judged that this was not a pleasant environment in which to eat lunch.

We saw that some residents had plastic aprons on during meal times whereas others were given material clothes protectors, which were more dignified. There was very little support offered to residents in way of assistance, for example help with cutting up food, or providing equipment initially to help people do this independently, as all staff were busy serving food. When help was offered to a person their meal had been served approximately 10 minutes before and was possibly cold.

We spoke with two care workers about people who used the service. Both care workers knew information about people's life histories, their likes and dislikes. This showed us that staff knew the people using the service well as individuals. Care workers were able to understand the interests and experiences of the person they were supporting although this was not always reflected in the care plans.

A member of staff we spoke with explained how they maintained people's privacy and dignity and told us, "I always treat people with dignity and respect. If I saw a member of staff not doing this I would report it to the manager." We observed that people were clean and were supported to maintain their personal hygiene needs. We saw staff were discreet when discussing people's personal care needs with them and other professionals. We observed staff knocking on people's bedroom doors and waiting before entering.

Although we saw and heard polite and dignified interactions between staff and people living at Clyde Court some working practices did not promote the privacy or dignity of individuals. For example not emptying commode pots in a timely manner meant that people were not always treated in a dignified way. On the third day of our inspection we saw that people were being weighed in the main lounge area of the home in front of other people. We saw a health professional supporting two people at the same time in a quiet lounge and another taking blood sugars from a person in the lounge area. As staff at the home did not object it highlighted to us that these were common practices, which are not private or dignified for those

people concerned.

We concluded this was a breach of Regulation 10, (Dignity and respect); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed some really positive interactions between people and staff. We observed one care worker assisting someone to eat their lunch time meal. Even though verbal communication with the person being assisted was limited the care worker made conversation, offering words of encouragement to the person eating the meal. The person was not rushed but was given lots of time to eat their meal.

Requires Improvement

Is the service responsive?

Our findings

Since our last inspection concerns had been raised by other professionals about the timings of people rising in a morning. There were reports that people were being woken early in a morning and not choosing to get up at that time. On the second day of inspection we arrived at the home prior to 8 am. We saw that four people were in the lounge, dressed and waiting for breakfast. People confirmed that they had requested to get up. One person told us, "I always wake up early."

We heard staff offering people breakfast choices and appropriate music was then turned on. We were assured that people were up early because it was their choice. We did not see people's preferences regarding waking and retiring to bed recorded in individual care plans, although two care plans we saw indicated that female carers were preferred when receiving personal care. Person centred information should be documented so that staff are aware of these, particularly if staff are new to the service or when agency workers are used.

At this inspection we found activities were still limited. There was an activity co-ordinator in post employed for three days per week. On our first day of inspection they told us that they also covered care shifts and were on shift as a carer so we saw no entertainment provided on that day.
We asked the people living at Clyde Court what they thought about the daily activities and we received mixed feedback with regards to the activities and entertainment on offer. Three people we spoke with said they enjoyed the singers that came into the home 'especially the Elvis impersonator.' Another person said they would welcome more organised entertainment.

We did not see a timetable of activities displayed around the home but there was a notice board to advertise any booked entertainers. The coordinator told us their role involved more one to one activities, for example nail and hand manicures and taking people shopping. People told us they enjoyed the bingo activity. Our second day of inspection coincided with Remembrance Day and the two minutes silence was observed by both residents and staff in the lounge and dining area. However there were no decorations or other activities done in respect of this day.

We saw a form that documented activities undertaken and recorded which people had participated. Other activities on this form listed watching films, chair exercises and sing-a-longs. We saw five ladies participating in light exercises in the lounge on our second day of inspection. One person we spoke with chose to stay in her room for the day and meals were taken to them. There was limited interaction with staff at these times and this person was in danger of being isolated. We spoke with them about a sing-a-long that was taking part in the home and they told us, "No one has told me there's a sing-a-long." The service must ensure that all residents are kept informed of activities and involved as per their choices. We informed the provider and other members of management about this person's feelings of isolation in the absence of the registered manager.

Since our last inspection concerns had been raised by other professionals regarding how staff at the home managed pressure care and how people identified as having pressure areas were managed. We saw records

of pressure relief were updated. These records indicated people received support with pressure relief to reduce the risk of developing pressure sores as frequently as their care plans directed. There was input from the nursing home team who also reviewed and updated pressure care regimes and provided instructions for staff on how best to manage individual's needs. We noted that care plans did not always reflect changes to the pressure care regime as instructed. For example, changes had been made in October 2016 to one person's dressings which were not yet updated on care plans. We checked the dressings file and saw that the correct dressings and foam adhesive were being used and this paperwork was correct. We made the clinical lead aware of the changes. They would have expected the lack of updates to be picked up on the next care plan audit but assured us the changes would be made immediately.

We identified at the last inspection a lack of person-centred information and inconsistencies with care plans not detailing aspects of risk and how to manage these risks. We saw changes had been made to care plans, initially for those people with nursing needs. We saw risk assessments in place around the use of bed rails, falls and pressure care. There was now a one page profile summary of care that included a photograph of the person and details about how they wanted to be supported. One file we looked at indicated that regular pressure relief was required and two hourly turns as the person was unable to move independently. A visitor we spoke with told us how they had been involved with aspects of their relative's care, speaking to the nursing home team and senior staff. We checked the care plan which had been updated in light of this and saw that medicines had been reviewed and increased to help with pain relief. This meant that the home responded to people's needs, involved them and their representatives and took action when necessary

Information in care plans about people's life histories and care preferences was still limited. We discussed this area with the clinical lead in the absence of the registered manager who acknowledged this observation. They confirmed the improved care plans would be completed for everyone with nursing and residential needs and aspects around people's life histories and care preferences would be captured and added to care plans. We will check this at our next inspection.

We saw some attempts had been made with personalising people's spaces with personal profiles on some residents' doors. These laminated signs included what people liked and disliked to do, and included favourite food preferences. We heard staff offering choices and alternatives to people if requested. For example staff were giving out drinks of juice but a person wanted a cup of tea. We heard the care worker offer to make the person a hot drink.

Staff were responsive to people's needs. We heard one person asking what the medicines they were being given were for. The member of staff administering the medicines took time to explain and said, "That one is for pain in your knee and that one is a tablet for your heart." Some people were not able to communicate verbally but care workers recognised their body language and what they were trying to communicate. For example one person at lunch time shook their head and turned away. The care worker assisting them noted this and asked, "Have you had enough?" and offered to wipe their mouth.

We asked care workers how they knew what people's care needs were. One care worker said that they would find out by getting to know the person and following the care plan for that person; another care worker said that the clinical lead or a deputy manager would inform the staff when needs changed and if people's care plans had been updated. We saw examples of care workers recognising people's needs and meeting these throughout the inspection. One staff member presented a person with a spoon after serving their lunch and said, "I know you like eating with a spoon so I went to get a spoon."

We saw that the service had a complaints policy and people were provided with a copy of how to make a complaint on admission to the home. People we spoke with told us they had not needed to complain but

would not hesitate to do so if warranted. One person told us, "I would go to the manager and if that didn't work I would ask my relative to complain for me." We saw examples of resolved complaints including missing laundry which had been replaced. Another complaint had been made about a member of the care team. We saw that the person had been spoken with, informed of the complaint and had received additional training in relevant aspects of care, such as person centred care and communication. We were satisfied that complaints were being recorded, addressed and resolved accordingly.

We saw a sample of returned questionnaires and feedback from people and their relatives. These questionnaires included comments about the food, activities and the home in general. Comments from people using the service included, "I would like more baths or showers," and, "I like the input from the local church." There were positive remarks about the menu which was referred to as 'varied' and the food was 'well presented.' One questionnaire deemed care staff to be 'dedicated'. We saw that the home had received compliments mainly in the form of thank you cards from relatives praising the care delivered by the service. Recent compliments were displayed on the notice board so staff were made aware of them.

Inadequate

Is the service well-led?

Our findings

The home's registered manager had been in post for over two years. At the time of our inspection the registered manager was only available for half a day on the first day of inspection due to annual leave and other personal commitments. We met with other members of the management team during the three day inspection.

Since our last inspection the provider had closed a sister home in the area and some staff and residents had transferred to Clyde Court. We saw that the registered manager was better supported with a clinical lead in post. This was a relatively new appointment at the time of our inspection but we were assured that the registered manager, who was not a registered nurse, was now receiving appropriate clinical support with regards to people living at Clyde Court with nursing needs. There was also a deputy manager and an assistant deputy manager in post with remit for those people requiring residential care. Staff we spoke with felt better supported and told us, "The home has improved. It is better with a clinical lead in place."

Staff told us that the manager was supportive and was approachable if they needed to voice any concerns. A new member of staff told us that they had received help and support in their role and another, when asked who they would go to for help said, "I would go to [manager's name.]"

At the previous inspection we saw no evidence in place of any systems or audits to allow the registered manager to effectively monitor the quality and safety of the service. At this inspection we saw that a selection of audits had been introduced which included checks on the building and environment, falls and accidents, medicines, medicines, accidents and catering. However the audits implemented were either not fit for purpose or had not been completed regularly. Additionally areas identified during audits as requiring improvement had not always been acted upon. During this inspection we identified breaches of the Heath and Social care Act 2008 which the service's internal systems had failed to pick up.

For example there was a process in place for identifying and monitoring people having frequent falls and other accidents such as scalds or fractures, however the last analysis had been completed in May 2016. This meant that if any people had had a number of falls since that time they had not been identified, nor any action taken to try and reduce the risk of further falls.

We observed lunchtime meal experience over the three day inspection. During our observations we observed that the lunch time service was chaotic and unstructured. It appeared that most staff were responsible in serving meals and therefore all accessed the kitchen to collect these. There was no lead from management to rectify this and the allocation of specific meal time duties to individual staff had not been done.

During the lunch time serving on the first day of inspection we observed a care worker checking their mobile telephone on more than one occasion. The use of a mobile phone whilst working is contrary to company policy. We saw no senior staff present at the time reprimand or correct the care worker in the absence of the registered manager.

We saw that documentation to record monthly mattress checks was in place, however these had last been carried out in April 2016. Rotas indicated when the two infection control champions were allocated infection control checklist duties with the initials IC against the staff member's shift. We found little evidence that infection control checks were being done on a regular basis despite the outcome of two recent visits and reports outlining areas of improvement from the local authority. On our second day of inspection the staff member allocated these duties had been taken off the care rota and was covering kitchen duties. This meant that they were not able to undertake the infection control checks and indicated to us that the service did not deem these to be important. Similarly a member of staff with responsibility for co-ordinating activities was also undertaking a caring role on our first day of inspection and we saw no evidence of any activities on that day. During this inspection we found Infection and prevention and control was poor and constituted a beach of the regulations.

Staff told us they felt comfortable in approaching management. They found the daily handovers useful but considered that staff meetings were not regular enough. We saw no evidence of minutes from staff meetings during our inspection.

A maintenance audit undertaken in July 2016 identified that wallpaper was coming off the wall in one bedroom and a hand basin in another required replacing as it was cracked. At the time of our inspection we checked a selection of bedrooms and found that neither of these identified improvements had been undertaken.

We saw a sample of returned questionnaires and feedback from people and their relatives. These questionnaires included comments about the food, activities and the home in general. Feedback from a relative dated February 2016 indicated that the last meeting held for relatives was over a year ago. We saw no evidence that a meeting for relatives and / or residents had taken place since. We saw a comment on a feedback form, "Commodes are often not emptied." This had not improved at the time of our visit as we saw commodes in bedrooms that had not been emptied at 3pm.

Other feedback included suggestions about how to stimulate residents by introducing painting activities, jigsaws, knitting and one to one discussions. There was nothing recorded to say any of these suggestions had been considered or tried.

We found the surveys were not monitored and action plans were not developed from them. Surveys are a tool for improvement and should be used as such. If actions are not identified from the feedback provided then the feedback has not served its purpose.

We concluded this was a breach of Regulation 17, (Good governance); of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the additional support provided for the registered manager the two elements of care functioned very separately and systems put into place to help prevent errors occurring were not always taken on board. We saw little evidence of someone being in overall charge and bringing together the nursing and residential elements of care. This was a theme noted by a relative after a tea trolley had been forgotten on one occasion. They highlighted in their feedback questionnaire it was vital that someone allocated and checked that all duties had been carried out.

The management team understood their responsibilities with the Care Quality Commission and had reported significant information and events, such as notifications of deaths, serious injuries and any safeguarding issues.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff knew how to maintain people's dignity and respect their privacy although some care practices of staff and other health professionals compromised this. We saw instances where people were not treated in a dignified way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Some working practices were poor in relation to the control of infection. Checks to prevent the spread of infection were either not carried out or not fit for purpose.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Audits were either not fit for purpose or had not been completed regularly. Areas identified during audits as requiring improvement had not always been acted upon. Surveys were not monitored and action plans were not developed from them.

The enforcement action we took:

Warning notice