Peter Allen Investments Limited

Clevedon Court Nursing Home

Inspection report

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13 January 2017

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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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on the 9, 10 and 13 January 2017 and was unannounced. Clevedon Court Nursing Home is registered to accommodate up to 50 people. It is registered to provide accommodation for persons who require nursing or personal care. On the first day of the inspection 48 people resided at the service. On day two and three of our visit 47 people were staying at the service. Eight of these people had been admitted for rehabilitation care. The local hospital was closed for refurbishment so the local authority were using eight of Clevedon Court Nursing Home beds to replace these closed beds until the refurbishment was completed.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 had an ethos of honesty and transparency and managed complaints effectively.

The provider had failed to have effective quality assurances systems that ensured the assessment and delivery of care for people was appropriate. This resulted in them failing to identify the issues we found during the inspection. For example, people's records, including risk assessments and care plans did not always accurately reflect people's needs or the care they required. They were also not always personalised to reflect the individual's needs. One staff member told us; "There is a lack of readable documents for people staying for rehab." In addition, people's end of life care was not consistently planned to reflect their needs and preferences. People did not always have personalised end of life care plans.

People living at the service were not always able to communicate their views and experiences to us due to their healthcare needs, so we observed care provision to help us understand the experiences of people who used the service. We found people did not always have their dignity respected. For example, everyone was supplied with a continence aid on their bed even if they had not been assessed as needing one.

We also found aspects of medicine management were not always safe. Their medicines were not always managed correctly and it was unclear whether people had been given all their medicines at the right time.

People who stayed for rehabilitation were cared for by a separate team of visiting professionals. Their care was discussed at regular "ward rounds" and included arrangements for external physiotherapists and occupational therapists to visit. However the staff employed by Clevedon Court Nursing Home were not included in the ward rounds and had no care plans or other information about the care of these people. Yet staff were providing day to day care for them. One staff member said; "We don't have time to go on ward rounds." Staff confirmed these people often had higher needs than they were aware of and that they did not know their full medical, health or personal history, including nutritional and social preferences. There was minimal amount of information for the transition of these people from the main hospital to Clevedon Court for onward care and rehabilitation. Pre- assessments were not always carried out to ensure people's needs

could be suitably met.

Improvements were needed to how people were kept safe in emergency situations, such as fire. For example, the service held an emergency box for staff to use in the event of an emergency and this held evacuation plans, building plans and information on people and their next of kin contact details. However, this held outdated information about who was currently residing in the service. Not everyone had an emergency evacuation plan in place to assist staff in an emergency. This could place people at risk as the emergency service would not have all the information needed to assist people who required support to leave the building safely.

People were protected by safe recruitment procedures and new staff completed an in house induction programme. Staff had undertaken training and had the right skills to meet people's needs. However, staff did not complete the Care Certificate (a nationally recognised set of skills training). People were cared for by staffing levels where they were normally good, however since the opening of the eight rehabilitation beds staff told us they had found that they did not have so much time to spend with people. One staff member said; "We seem to be doing a lot more (for people staying for rehabilitation) than we were expecting to do." Another said; "We thought they would be able to do more for themselves but the demands are high."

Improvements were needed to ensure team meetings were taking place to help inform and involve staff in decisions about the running of the home. Improvements were also needed to ensure staff received regular supervisions or appraisals to give staff an opportunity to discuss any issues or to discuss topics including how best to meet people's needs effectively.

People receiving rehabilitation care had restricted visiting times in place without explanation being given to them or their relatives. The registered manager said this was because of visits from physiotherapists and occupational therapists. However, we observed these professionals often visited in the afternoon.

People looked relaxed with the staff and there was a friendly and calm atmosphere. People chatted and enjoyed the staff's company. Comments included; "Very kind and caring staff" and "I wouldn't be anywhere else." A relative said; "Lovely lovely place."

People were supported to maintain a healthy balanced diet. People told us they enjoyed the meals, there was plenty of it and we observed people were not rushed. People had opportunities to take part in a variety of activities arranged by the services activities co-ordinator.

The service was clean, well maintained and decorated. The staff team worked hard to create a home from home environment. There were no malodours experienced throughout the service at the time of this inspection.

We found a number of breaches of the regulations. You can see what action we 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 were not always protected from risks associated with their care because their documentation did not always accurately reflect their needs.

People did not have all aspects of their medicines managed safely.

People were supported by sufficient numbers of suitable, experienced and skilled staff.

Staff were able to recognise and had a good understanding of the signs of abuse, and knew the correct procedures to follow if they thought someone was being abused.

The home was well maintained and clean.

Is the service effective?

Requires Improvement

The service was not always effective.

People were supported to maintain a healthy and balanced diet. However, documentation was not always completed to help identify if they were at risk of malnutrition.

People were cared for by skilled and experienced staff who received regular training. However staff did not receive regular supervisions or appraisals.

People had access to healthcare services which meant their healthcare needs were met. However, the care people received was not always documented.

The registered manager understood the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 (MCA).

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always promoted by the staff.

People's end of life wishes were not always recorded.

Due to lack of documentation staff were not always knowledgeable about the care people required and what was important to them.

People were treated with kindness and respect, and were happy with the support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were not always supported by good records which placed them at risk of inappropriate care.

People were supported to participate in activities and interests they enjoyed.

The service had a complaints procedure which people and their families knew how to use if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's care was not effectively monitored by a lack of appropriate quality assurance systems.

Systems and processes were not effective in identifying potential problems within the service relating to medicine management, care planning and record keeping.

There was an experienced registered manager in post who was approachable and people spoke highly of.

Clevedon 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 checked 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.

The inspection was undertaken by one adult social care inspector, a pharmacist inspector and a specialist nurse advisor. The inspection took place on the 9, 10 and 13 January 2017 and was unannounced.

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 also reviewed information we held about the service. This included previous inspection reports and notifications. A notification is information about important events, which the service is required to send us by law.

During the inspection we met or spoke with 20 people who used the service, the registered manager, the registered provider and 15 members of staff. We spoke with seven relatives and eight health care professionals who had supported people within the service.

We looked around the premises, observed and heard how staff interacted with people. We looked at 11 records which related to people's individual care needs. We looked at records which related to the administration of medicines, four staff recruitment files and records associated with the management of the service including quality audits.

Requires Improvement

Is the service safe?

Our findings

People, particularly people staying for rehabilitation, did not always have care plans and risk assessments in place to provide staff with information on the care needed to meet people's needs safely. For example, one person staying for rehabilitation had recorded on their discharge letter from the local hospital that they had an infection that needed special protection measures put into place. No risk assessment was in place to protect the staff or inform the staff of this infection. This meant the risk assessment did not reflect their condition or provide up to date guidance to staff on how to mitigate the risks to them and others. The registered manager confirmed staff were aware of this infection and managing this appropriately for example using protective items including gloves. However the registered manager agreed that this information was not documented.

People did not always have risk assessments in place to help minimise risks associated with their moving and handling. For example, one person had been admitted for rehabilitation after a recent hip fracture, but staff did not have a risk assessment recorded to follow to enable them to support the person correctly and safely. Staff were able to confirm that they were able to ask this person how they liked to be assisted and had received some information from the visiting physiotherapist to move this person safely.

Some people had risk assessments in place to reduce the risks of developing pressure ulcers; these assessments showed staff how they could support people safely. Such as, by providing pressure relieving mattresses. However, risk assessments were not always completed. For example, one person staying for rehabilitation, had a picture on their file of a pressure ulcer on their body, but no information was recorded on the management and care of this area and there was no additional risk assessment in place. This meant, staff were not fully aware of the full risks through reading records, and the records did not reflect people's current conditions or provide up to date guidance to staff about how to minimise associated risks. Staff confirmed that this person pressure area was being attended to however we could not find this information recorded.

A specialist team visited three times a week to see people who were staying for rehabilitation. However, there was no information recorded and no care plans or guidance in place for staff caring for these people on what was discussed and what plans were put into place to manage their risks and care needs. The registered manager confirmed that verbal information was at times given to the senior staff on duty. However it was not always documented for the services staff to access.

Repositioning and intake charts for people were not always being maintained. Therefore staff were not aware, through the reading of records, of the hydration and nutritional intake for people to help ensure they were eating and drinking enough to help maintain safe levels. Therefore not having fully completed care records or risk assessments in place to show staff how to meet their needs meant their potential risks of falls, skin damage or weight loss was not known to staff. We observed staff providing drinks to people throughout our visits for people with intake charts in place. However we observed intake charts were not always being completed.

The providers PIR recorded; "Pre-admission visits establish initial assessments of daily living, assessing any risks that need to be managed in line with the resident's wishes and needs. Creative risk management enables the resident to maintain their independence and continue with community links that have been a fundamental part of their everyday life prior to requiring full time care." This is not what we found. People's medicines were not always managed safely. People's MARs (Medication Administration Records) recorded people's current medicines. The service used a local pharmacy that provided people's MARs. However, some people's medicines had not been supplied by the usual pharmacy so staff had completed handwritten MARs for these people. The provider's medicines policy stated that hand written additions should be checked for accuracy and signed by a second trained staff member. In four examples, we saw staff had not followed the provider's own policy, which increased the risk of mistakes occurring. Staff signed when people had taken their medicines and recorded the reason if a medicine was not taken.

Some people were prescribed creams and ointments. These were kept in people's bedrooms and applied by staff when they provided personal care. People had care plans in place to provide guidance and direction to staff on applying these creams and ointments. Staff told us they felt confident about also asking the nursing staff for advice. However, there were no recording system available for staff to complete when they had applied people's creams and ointments. Staff told us they would record this on people's daily record. However the records did not state which creams had been applied. Therefore we could not be certain that creams and ointments applied had been prescribed for them.

Some people were prescribed medicines to be given 'when required' such as those to treat anxiety. Staff were able to explain when they would give these medicines and whether people were able to request these medicines, if they needed them. However, there was no additional written information either on people's MARs or in their care records, which would support staff to give these medicines in a consistently safe and effective way. This meant, some people may or may not get their medicines when required.

No one currently managed their own medicines, however one person looked after their own inhalers and staff confirmed they usually observed people taking them. However, there was no information about self-administration in this person's records and no risk assessment in place to make sure this person was safe.

A relative for someone staying for rehabilitation and who was preparing to go home believed the staff were supporting their relative to remain independent with their medicines. A staff member also reinforced this view, however they added that no documented plans were in place to help ensure people who self-medicated were supported to prepare them for discharge. However the service discharge policy stated; "Clevedon Court will work to ensure safe and appropriate discharge from the home."

The provider had not ensured records accurately reflected people's current needs or that gaps in records were identified. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People mostly received their medicines in a respectful way. However, staff members interrupted some people's lunch to administer their medicines. One staff member also gave a person their antibiotic with their meal when it was prescribed to be given on an empty stomach.

Medicines were stored securely, although storage areas were very small and there was no clinic room available. Medicines that needed additional security were stored safely. However, one storage area was very small which made it more difficult for staff to manage their supplies appropriately. Medicines refrigerators were also available and staff monitored the refrigerator temperature daily. Records showed this was in the safe range for storing medicines. However, staff had not checked the minimum and maximum temperatures

over the past 24 hours, as stated in the home's medicines policy. Staff were aware of what action to take if any mistakes were found, to help ensure people were protected.

The service had an emergency box which held information about what support people needed from the emergency services, if they needed to be evacuated. The box also held a current list of people living in the service, contact details of next of kin for people and plans of the building. However, the list of people living in the service was out of date and none of the people staying for rehabilitation had emergency evacuation plans in place. This could hinder the emergency service in assisting people who required support to leave the building safely. For example, it did not record it people where mobile or able to walk unaided. The registered manager had started to action this before we finished our visits.

People who were able to told us they felt safe. Comments included; "Yes I do feel safe here." Another person when asked if they felt safe said; "Yes I do." Staff said when asked if they felt people were safe replied; "Yes they are safe." A relative said; "I believe he is safe here."

People were supported by suitable staff. The service had safe recruitment processes in place. Required checks had been conducted prior to staff starting work at the home. Recruitment files included relevant recruitment checks. This ensured the registered manager could minimise any risks to people as staff were safe to work with vulnerable people. One newly employed staff confirmed their checks had been applied for and obtained prior to them commencing their employment with the service.

People were protected from discrimination, abuse and avoidable harm by staff who had the correct skills and knowledge to help ensure they helped to keep people safe. Staff received safeguarding training and had access to policies and procedures about safeguarding and whistleblowing. Staff knew what to look for and could identify abuse. They said they would have no hesitation in reporting abuse and were confident the registered manager or provider would act on issues or concerns raised. Staff said they would take things further, for example contact the local authority's safeguarding teams if this was required. However, there was no information displayed to point people, relatives or staff to what constituted abuse and where to go to seek help and advice.

People lived in an environment that was both safe and secure. It was well maintained, clean and hygienic. Smoke alarms and emergency lighting were tested. Regular fire audits and evacuation drills had been carried out. This helped ensure staff knew what to do in the event of a fire. Some care records and risk assessments detailed how staff needed to support people in the event of a fire to keep people safe. However, some people had bed rails on their beds. These did not all meet the required standard. The registered manager took action to start procedures to rectify this during our visits.

People, relatives and staff mainly agreed there was sufficient staffing numbers to help keep people safe. This included two trained staff on each shift. However, some staff said that since the admission of the eight rehabilitation beds their workload had increased due to the high needs of these people. Staff said this was in part due to not having sufficient information on how to meet those needs but also some people needed two staff to assist them. Staff went onto say that they often didn't have enough time to sit with people. The registered manager confirmed staffing numbers were reviewed and increased when needed to help ensure sufficient staff were available at all times to meet people's care needs and keep people safe. The registered manager understood the concerns from the staff and would take action to resolve these issues.

Accidents were recorded and analysed to identify what had happened and action the staff could take in the future to reduce the risk of reoccurrences. Any reoccurring themes were noted and learning from accidents or incidents were shared with the staff team and appropriate changes were made. This helped to minimise

the possibility of repeated incidents.

Requires Improvement

Is the service effective?

Our findings

People had access to healthcare professionals including GP's, opticians and chiropodists. The local GP held a fortnightly surgery in the service. This enabled staff to seek advice and support regularly. During our visit people, in particular people staying for rehabilitation, saw therapists daily. This included occupational therapists and physiotherapists. Although some of these visits and the outcomes were documented, the staff did not all have access to them. Therefore there was a risk they may not be aware of what treatment or procedures had been carried out, in particular for people staying for rehabilitation. This included the registered manager and nurse in charge not always being given a verbal handover after each visit. People had health notes held on their file. This included information on people's current health concerns and diagnosis. However, we found these had either been only partly completed or were blank, particularly for people staying for rehabilitation. These people's file also did not hold current treatment plans or care regimes forms. This meant the person in charge and staff providing care to people did not have full information on current progress or completed treatment to ensure continuity of care. However people, healthcare professionals and relatives spoken with all agreed they had no concerns about the care provided. We observed that people were well cared for by staff and people looked comfortable.

People could choose what they would like to eat and drink. Staff visited people the previous day to inform them of the choices on offer the following day to them and a menu was displayed. Some people had their specific dietary needs catered for and a menu was displayed. However, people's records gave the impression that individual nutritional and hydration were not always met. For example, care records were not always available for people staying for rehabilitation, therefore there was no or little information held to provide guidance and information to staff about how to meet individual dietary needs. For example, according to the records, one person staying for rehabilitation had not eaten or drunk properly for several days. No information was documented on what was a sufficient amount of food and fluid needed to meet this person needs. No information was recorded on what action, if any, had been taken to offer support for this person. However we did observed this person being provided drinks and food during our visit.

People who required special diets received the appropriate diet and staff were fully aware why this was needed. Some records identified what people disliked or enjoyed while others had no records, particularly people staying for rehabilitation. A nutritional screening tool was not always used to identify if a person was at risk of malnutrition. People identified at risk of malnutrition did not always have their weight recorded therefore we could not confirm it people's weight was monitored. Food and fluid charts were not always completed in full to show what people had eaten or drunk each day.

The provider had not ensured records accurately reflected people's current needs or that gaps in records were identified. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not all receive regular supervision and yearly appraisals and team meetings were not held regularly. This meant staff were not provided with opportunities to discuss areas where support may be needed or to offer ideas on how the service could improve. Staff said they would like to have more staff meetings,

including meetings for ancillary staff and care staff. Staff went on to say staff meetings would enable them to discuss people's needs, particularly for people staying for rehabilitation and would enable staff to discuss how best to meet people's needs effectively. The providers PIR stated; "Staff receives regular supervision and performance is assessed on an ongoing basis." However all staff spoken with confirmed they could speak to the senior staff for advise at any time.

Newly employed staff were required to complete an induction before starting work. This included training identified as necessary for the service, such as manual handling training. The service had not yet adopted the Care Certificate which replaced the Common Induction Standards in April 2015. It is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector. The Care Certificate should be completed within the first 12 weeks of employment. However, the induction programme which was used instead of the Care Certificate incorporated a full three day induction with a period of working alongside more experienced staff until such a time as the staff member felt confident to work alone.

People were relaxed and had staff support them during mealtimes. People who required additional assistance were given the support they needed. Nobody appeared rushed and all were able to eat at their own pace. Some people made positive comments on the food provided. However, we observed meals being plated up more than an hour and a quarter before lunch. This meant that the chips were, as described by one person as being; "soggy." Others said; "The food is very good" and "No complaints about the food." A visiting professional said they sometimes had people staying for rehabilitation wanting to stay longer as the food was very good. Though people had access to drinks and snacks 24 hours a day this was only via asking staff. No drinks or snacks were readily available around the service for people who were able to help themselves. However, we observed people being provided with regular drinks.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met.

The registered manager demonstrated understanding of, and had received training in the MCA. The registered manager confirmed additional training was planned so all staff would understand their responsibilities. However, not everyone was having their needs assessed in line with the MCA as required.

People were not always having their right to consent to their care and treatment respected. People who lived their full time and lacked capacity were having their needs assessed but not always for specific issues. For example, in relation to the use of bed rails. 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.

The records of how the service was ensuring capacity assessments were completed and best interest's decision were not always clear. This meant staff did not always know when and how they were acting in people's best interest.

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 are called the Deprivation of Liberty Safeguards (DoLS).People, when appropriate, were assessed in line with the Deprivation of Liberty Safeguards (DoLS) as set out in the Mental Capacity Act 2005 (MCA). DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. Following an

application, A Best Interest Assessor visited the service during our inspection to undertake an assessment for one person.

Where people could consent, their care plans were not always detailing where people were involved in planning their care or asked to consent to the planned care. For example, the records of people staying for rehabilitation did not evidence seeking their consent was taking place.
The registered manager confirmed some people were subject to a DoLS authorisation and some people's application was waiting approval.

Healthcare professionals visiting people who lived permanently in the service confirmed staff kept them up to date with changes to people's medical needs and contacted them for advice. Healthcare professionals also confirmed they visited the home regularly and were kept informed about people's wellbeing. This helped to ensure people's health was effectively managed.

People received effective care and support from staff that were well trained. Staff had the skills and knowledge to perform their roles and responsibilities effectively, knew the people they supported well, and this helped ensure their needs were met.

Training records showed staff were provided with regular training and updates in mandatory areas such as moving and handling and safeguarding adults. Staff had also undertaken a variety of further training related to people's specific care needs such as dementia care.

People's individual needs were met by adaptation, design and decoration of the service. The service was decorated to a high standard with colours used which provided both a peaceful and calm atmosphere for people living with dementia and helped to reduce their anxiety. Displays provided stimulation for people. The provider had plans in place to completely redesign the garden area. This would make it more accessible and designed in a way so that it could be used safely by people, with minimal support by staff. One person said; "I love it here."

Requires Improvement

Is the service caring?

Our findings

People did not always have their dignity or privacy respected. For example, we found several people's bedroom doors were wide open. People could be seen with the area below their waists exposed. The majority of people were also observed sitting on incontinence pads in their chairs. This implied everyone in the service had continence issues and the use of incontinence sheets was not specified in any care plans read. Therefore showing that people's continence needs were not being managed effectively. We also observed that in some cases over an hour before lunch was served, everyone sat in the two lounge areas on the lower floor were fitted with a clothes protector. Even if people did not need or require such protection. People were also not asked if they wished to have this protection, and some people would have been able to make that choice. We heard several staff members talking to other staff members about "feeding people" rather than "assisting people" with their meals. This was disrespectful and undignified phraseology.

We saw other examples throughout our inspection when staff did not always treat people in a dignified manner. For example, staff asked people in front of others if they "needed the toilet." Other staff did not always ask people discreetly if they required support.

The providers PIR recorded; "The home has staff who are dignity champions who act and influence others to understand and acknowledge the importance of respecting people in a dignified way, staff will also challenge any poor practice and escalate any concerns to senior staff within the home."

Visitors were observed visiting throughout our time at the service. However, a notice on the front entrance indicated that people staying for rehabilitation could only have visitors in the afternoon. This went against the provider's own policy and brochure information which stated that "visitors where welcome at any time". One relative spoke of the difficulties they experienced in trying to comply with the restricted visiting hours specified by the home, particularly as they did not drive. They referred to a period when their relative was first admitted to Clevedon Court Nursing Home for rehabilitation and they particularly wanted to visit as they were concerned about their relative's condition, and they were told by the home that they could not visit in the morning, but had to wait till the afternoon. The registered manager stated the restrictions were put in place for people staying for rehabilitation only. They went onto say this was due to planned visits by professionals including physiotherapist. However we observed professionals visiting in the afternoon.

People privacy and dignity was not always maintained. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People, mainly those staying for rehabilitation, care files did not always hold information on how people liked their morning, afternoon and evening routines to be carried out. For example what time people liked to get up or go to bed. Some records held 'do not resuscitate' information which documented people's wishes on resuscitation. Records showed that end of life care had been discussed with some people while others did not have this information recorded. This meant staff may not know what to do or what decisions to make regarding people's end of life care. In some cases where a person had been assessed as lacking capacity, involvement with family members and other professionals had been sought to ensure decisions

were made in the person's best interest.

The provider had not ensured records accurately reflected people's current needs or that gaps in records were identified. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A thank you card sent to the service recorded; "A massive thank you to you and your staff for making […] stay with you so comfortable and dignified."

People who lived in the service were supported by kind and caring staff. People told us they were well cared for, they spoke well of the staff and of the good quality of care they received. We observed positive interactions between people and staff. One person said; "Staff have been extremely kind" and "The staff are very kind and caring." A relative said; "They are so kind and caring - he is always well cared for." Another said; "Mum's always been happy here." All visiting healthcare professionals commented that staff were very caring.

During our visits we spent time in the shared areas of the service. We observed staff treating people with kindness, patience and compassion throughout our visits. We observed many positive interactions between people, care staff and management. Staff were kind, respectful and mostly spoke with people considerately. We saw relationships between people were relaxed and friendly and there were easy conversations and laughter heard throughout the service.

People were involved and asked for their views when other care was provided. Staff asked people before they provided support if they were comfortable with the support being offered. For example, if a person required assistance to move from the lounge area to the dining area. Staff were observed telling people throughout the procedure what they were going to do and tasks were completed at people's own pace.

Staff showed concern for people's wellbeing. For example, some people were now cared for in their beds due to their deteriorating health. Staff were observed providing kindness and compassion to these people. Staff informed people what tasks they were going to complete, for example if they were going to turn people. Some records showed staff recorded regular personal care was carried out including hair care.

People were supported by staff who cared. We observed people were comfortable and people all agreed they were cared for well and staff took time to assist them with all their needs. Staff were attentive and prompt to respond to people's emotional needs. For example, if people became upset or confused.

Requires Improvement

Is the service responsive?

Our findings

Staff had access to the computerised care plan system. However, they did not have access to records for people who stayed for rehabilitation as no care records were available. One staff member said they either relied on the person telling them what care they needed and if they were not able to do this then they used their own skills and experience to determine what support they required. A staff member said; "Not fully in the picture with the rehab people so not able to pass on information to them or relatives when they ask."

People's care plans recorded similar wording and generic statements, with a lack of person specific detailed information that reflected the person's current abilities or preferences. For example, one mobility care plan referred to the person standing and using the toilet. However, staff stated that this person could not weight bear and did not use the toilet and their continence was managed using continence aids. Another held conflicting information. Under the overall health section it stated that assistance was required from two staff members. However, under personal care section it stated able to manage independently.

Another person who was cared for in bed due to deteriorating health did not have a care plan in place to support their altered condition they had experienced for the past three days. Individual bedrooms held a shortened version of people's care plans. This included people's likes and dislikes and a "This is me" document. However, we found the copies in some bedrooms had not been completed or updated. Therefore staff would not have up to date information available to them in people's bedrooms.

People were cared for and supported by staff who were responsive to their daily needs. However, some people did not have pre-admission assessments completed before admission to the service. Not having pre-admission assessments in place did not ensure the service was able to meet and respond to people's needs before admission. Not all records held full details about people's health and social care needs, therefore denying staff of information about how to meet people's individual needs. One staff member said; "One person was admitted and we had no pre-admission assessments, no medical history nothing at all. So not fully in the picture of their needs." The services admission policy stated; "A full assessment will be made before a person comes to Clevedon Court Nursing Home." The service admission policy stated; "Relevant information must be gained from the person and their relatives/friends and any other source to add to the care plan if not gained during the assessment." It then highlighted the requirement of the completion of an admission checklist and new person form.

The providers PIR recorded; "A full pre-assessment is carried out either in the resident's home, or in hospital." It goes onto say; "Person centred care plans are completed and reviewed on a regular basis" and "Plans are drawn from the assessment to support the care delivery to the resident and to inform staff of resident typical day preferences."

People who moved from one service to another did not have full details about the care required to meet their needs, for example people's notes received from the service they moved from were not comprehensive.

People who had been admitted for rehabilitation had no ongoing assessment of needs, consent for treatment for clinical purposes, and no plan of care in place to reflect current needs. These individuals did not have risk assessments in place, for example waterlow assessments.

Care plans were not maintained as up to date accurate records of ongoing care needs. People's care plans held general statements and lacked the details necessary to inform staff about the care people needed. For example, one care plan read; "'Introduce a repositioning schedule that is tailored to […] current needs", but it did not record what these were. One staff member said; "There is a lack of readable documents about people, particularly people staying for rehabilitation."

Some people had information held in their bedroom to assist staff to have an overview of people's life story prior to admission. While others did not. However, assessments and care plans completed primarily focused on physical needs and there was limited information about how people's emotional and psychological needs were met.

Some people's care plans gave guidance for staff on how to manage aspects of people's health but we found these instructions were not always correctly followed. For example, one person had an infection. However, there was no care plan in place to inform staff how to manage and treat this infection and there was no evaluation of the person condition or infection in the six days since they had been started on antibiotics. So, it was impossible to determine from the records whether the individual's condition was deteriorating or improving.

Some people had a pain assessment form that would record the level of pain people may be in. However, we found these were not always been completed even though people had pain receiving pain medicines. Therefore staff did not know how to respond or if this person required assistance with managing pain. This was particularly important for people with limited communication.

One person admitted two months ago did not have any care plans forms completed. This included overall health form, treatment plan, injury risk, nutrition and hydration needs and how to manage a recently diagnosed infection. Therefore staff would not have recorded information to respond to this person. Some people had information on how staff could respond to people's emotional needs and if a person had additional needs, for example those people living with dementia and who required extra support was not always recorded. However some people did not.

The provider had not ensured records accurately reflected people's current needs or that gaps in records were identified. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The company had a policy and procedure in place for dealing with any concerns or complaints. However, the procedure was not displayed in the entrance for visitors to access. The registered manager told us that each bedroom held information about complaints for people to access. However, we found some bedrooms without this information. During the inspection the registered manager took immediate action and displayed the complaint's procedure in the main entrance. The registered manager knew the process for investigating complaints in line with the provider's policy and appropriate was action taken. Outcomes were recorded and feedback was given to the complainant and documented.

People were not all able to be involved with planning their care. Some people, whose needs had changed, had their care plans reviewed and altered to reflect this change. While others did not. For example, some people's general health had deteriorated and staff responded by contacting the GP for advise and support,

this helped ensure they remained comfortable. A relative said; "They come in to see us and update us on how mum is." Healthcare professionals agreed the service was responsive to people's needs when they became unwell and contacted them quickly and appropriately. However, this was not always documented to confirm this.

Daily records were completed even for people who may not have a care plan in place. This enabled staff coming on duty to get a quick overview of any changes in people's needs and their general well-being. The daily records also covered any social or physical activity and any visitors they may have had.

Some people had a life history completed. While others did not. A completed life history covered a person's childhood, adulthood and retirement. Therefore staff could understand a person's past and how it could impact on who they were today. This helped to ensure care was consistent and delivered in a way which met people's individual needs.

People were able to call for staff assistance at all times to respond to their needs. People had access to call bells in their bedrooms. People sat in the lower floor lounge area did not have access to a call bell. However, we spent time observing and saw that staff frequently came into the lounge to make sure people received the support they needed. We saw people who chose to stay in their bedrooms had their call bells next to them. One person said; "If I ring my bell they always come to see me."

There were two designated activities co-ordinators employed to provide a programme of events at the home, aimed at supporting people to remain active. Planned activities were provided regularly by staff and by entertainment coming into the home. People were given a list of the activities in advance to enable them to make a choice about attending. There was also a large notice board showing the activities for the coming week. Staff said people were encouraged to participate in activities of their choice. The staff understood people's individuality when arranging activities and ensured people had a variety to choose from. People said they were happy with the activities provided in the home, although some people preferred not to join in. The displayed activities list showed daily activities planned including the showing of a film club and memory club.

The service received compliments from families of people who were living or who had lived there. Comments included, "My husband and I have been told several times by independent people, including doctors, nurses, social workers and carers that in their opinion this home is the best in Clevedon." Another relative said; "I didn't want him to go anywhere but here!"

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager failed to have good systems of governance arrangements that monitored the quality of care being delivered to people. For example they had failed to have a system that monitored how people's privacy and dignity had been maintained. This had resulted in practices of leaving people's bedroom doors without considering their privacy or dignity. Their monitoring systems had also failed to identify the lack of appropriate records for people and in particular for people receiving rehabilitative care. This has resulted in people being at risk of receiving inappropriate care. There systems for monitoring had also failed to identity the inadequate recordings in care records including food and fluid records, lack of significant details in care records about people's medical needs and daily care not always being recorded. Their audits of infection control practices and audit of medicines were not always completed in line with their own policies and the audits had failed to identify problems with medicines or record keeping. For example, the services medicine policy stated that weekly medicines audits should be done. However, there were only two audits dated 2016. It was not clear from these audits, which area(s) staff had checked or how many records were looked at; and these had not highlighted any areas for improvement. In addition, quality assurance surveys had not been carried out since 2015 to obtain people's views about ongoing improvement plans for the service.

The quality of the service had not been assessed or monitored effectively or appropriately. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that the registered provider and registered manager did not hold regular staff meeting, supervisions or appraisals to enable them to be updated staff on any issues or give them the opportunity to discuss any areas of concern or comments they had about the way the service was run. For example, staff spoken with all raised concerns about the lack of information for people staying for rehabilitation and the high needs of these people.

However, staff did state that they were mainly happy working at Clevedon Court Nursing Home. One staff said of the service; "Brilliant place to work - management are great and very supportive" and another said; "Fantastic and approachable." The nurses at the service were supported with their revalidation. Revalidation is the process where registered nurses and midwives are required every three years to demonstrate to the Nursing and Midwifery Council (NMC) they remain fit to practice.

There were clear lines of accountability and responsibility both within the service and at provider level. The registered manager was supported by a deputy manager, nurses, senior care staff, care staff and a team of ancillary staff. The registered provider was also available to support the registered manager.

People and visitors spoke positively about the registered manager and felt comfortable approaching them. One person said; "I wouldn't be anywhere else." Healthcare professionals commented that the registered manager was brilliant and it was a testament to her hard work how the service is run.

The registered manager promoted the ethos of honesty, learning from mistakes and admitted when things

had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment.

The service brochure states their values are; "The well-being of our residents is always without question our utmost priority. It is our aim to provide a quality, comfortable, enjoyable, safe and homely atmosphere whilst making sure we deliver the highest individualised standard of care. There is no compromise.

The service had notified the CQC of all significant events which had occurred in line with their legal obligations.

There was maintenance staff in post with responsibility for the maintenance and auditing of the premises. Equipment such as moving and handling aids and wheelchairs were regularly serviced to ensure they were safe to use. The environment was clean and well maintained. People's rooms and bathrooms were kept clean. The provider carried out regular repairs and maintenance work to the premises. There was building work being carried out during our visit. A lounge area on the first floor was being extended to provide people with more space. The boiler, electrics, gas appliances and water supply had been tested. Fire alarms and evacuation procedures were checked by staff, the fire authority and external contractors, to ensure they worked. There was a record of regular fire drills.

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 Regulation 10 (1) People's privacy and dignity was not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) (2) (a) (b) (c) (e) The registered person did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided or mitigate the risk to people relating to their health, safety and welfare. Accurate, complete and contemporaneous records in respect of the care and treatment provided to each person were not being maintained.