New Century Care (St. Leonards) Limited

Clyde House

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Clyde House on the 7 and 9 October 2015.

Clyde House provides accommodation, personal and nursing care for up to 48 older people, some of whom have limited mobility, are physically very frail with health problems such as heart disease, diabetes and strokes. There were people at Clyde House also living with dementia and receiving end of life care. There were 34 people living at the home at the time of our inspection. Accommodation is arranged over three floors and each person had their own bedroom. Each floor has lift access, making all areas of the home accessible to people. The top floor known as Tay Wing provides care and support for up to 14 people who live with dementia and there were currently 11 people on Tay Wing.

Clyde House is a large detached house in a residential area of St Leonards on Sea, close to public transport, local amenities and some shops. The service is owned by New Century Care (St. Leonards) Limited and is one of six homes in the South East.

Summary of findings

People commented positively about the care and support received and their experience at Clyde House. However, the inspection highlighted significant shortfalls that had the potential to compromise the safety of people in the service.

A manager has been recruited following the resignation of the registered manager in July 2015. The manager had submitted an application to the CQC to be registered. 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 and associated regulations about how the service is run.

Care plans did not all reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as wound care did not have sufficient guidance in place for staff to deliver safe care. Not everyone had risk assessments that guided staff to promote people's comfort, nutrition, skin integrity and the prevention of pressure damage. This had resulted in potential risks to their safety and well-being. Staffing deployment had impacted on people receiving the support required to ensure their nutritional needs were met.

The delivery of care suited staff routine rather than individual choice. Care plans lacked sufficient information on people's likes, dislikes, what time they wanted to get up in the morning or go to bed. Where people's health needs had changed, such as not eating and drinking, care plans did not reflect the changes and therefore staff were uninformed of important changes to care delivery.

Information was not always readily available on people's life history and there was no evidence that people were involved in their care plan. The lack of meaningful activities for people, specifically those who remained on bed rest or lived with dementia, at this time impacted negatively on people's well-being.

Whilst people were complimentary about the food at Clyde House, the dining experience was not a social and enjoyable experience for people. People were not always supported to eat and drink in a dignified manner.

Quality assurance systems were in place, however there were areas that had lapsed and had not identified some of the shortfalls found at this inspection.

Arrangements for the supervision and appraisal of staff were now in place. It was acknowledged there were gaps in supervision for staff due to the changeover of managers. Staff told us that meetings now took place and they felt supported by the organisation.

People we spoke with were complimentary about the caring nature of some of the staff. People told us care staff were kind and compassionate. However we also saw examples where staff were not treating people with respect when delivering care. We also saw that some people were supported with little verbal interaction and some people spent time isolated in their room.

People had access to appropriate healthcare professionals. Staff told us how they would contact the GP if they had concerns about people's health.

People were protected, as far as possible, by a safe recruitment system. Each personnel file had a completed application form listing their work history as wells as their skills and qualifications. Nurses employed by Clyde House all had registration with the Nursing and Midwifery Council (NMC) which was up to date.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures will be inspected again within six months. The service will be kept under review and if needed could be escalated to urgent enforcement action.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Clyde House was not safe. Risk assessments were devised and reviewed monthly. However, management of people's individual risk assessments to maintain their health, safety and well-being were not in place for everyone and therefore placed people at risk.

People were placed at risk from equipment which was not suitable for their needs and we observed poor moving and handling techniques.

There were not always enough suitably qualified and experienced staff to meet people's needs. People's needs were not taken into account when determining staffing levels.

The management, administration and storage of medicines was safe.

Staff had received training in how to safeguard people from abuse and were clear about how to respond to allegations of abuse. Staff recruitment practices were safe

Is the service effective?

Inadequate

Clyde House was not effective. Meal times were solitary and inefficient service with food being served without the support required. We also saw staff did not always follow good practice guidelines while assisting people to eat. There was no dining experience offered. Senior staff had no oversight of what people ate and drank as not all records were accurate or completed correctly.

Not all staff received on-going professional development through regular supervisions, and essential training that was specific to the needs of people had not been undertaken. Lack of end of life, diabetes and dementia care guidance and training was a particular concern.

Staff had some understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. However, the use of mental capacity assessments for people who had limited capacity were not always followed or reflective of individual needs.

Is the service caring?

Requires improvement

Clyde House was not consistently caring. People and visitors were not always positive about the care received. This was supported by some of our observations.

Care mainly focused on getting the job done and did not take account of people's individual preferences or respect their dignity.

People who remained in their bedroom received very little attention and at times people in the communal areas were left unsupervised.

Summary of findings

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks with no verbal interaction with the person involved. We saw staff talk about people without including the person.

However we also saw that some staff were kind and thoughtful and when possible gave reassurance to the people they supported.

Is the service responsive?

Inadequate

Clyde House was not responsive. Care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

The delivery of care was not person focused and people were left for long periods of time with no interaction or mental stimulation.

People told us that they were able to make everyday choices, but we did not see this happening during our visit. People were moved from communal areas without being consulted. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

A complaints policy was in place and complaints were handled appropriately. People felt their complaint or concern would be investigated and resolved.

Is the service well-led?

Requires improvement

Clyde House was not consistently well led. People were put at risk because systems for monitoring quality were not always effective.

The home had a vision and values statement but we did not see the values acted on during the inspection.

People and visitors had an awareness of changes of management and felt that the new management team of the home were approachable. The manager has submitted their application to become the registered manager of Clyde House

Clyde House

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 took place on the 7 and 9 October 2015. This visit was unannounced, which meant the provider and staff did not know we were coming.

Two inspectors undertook this inspection.

Before our inspection we reviewed the information we held about the home. We considered information which had been shared with us by the local authority and looked at safeguarding alerts that had been made and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. Before the inspection we spoke with the Local Authority and Clinical Commissioning Group (CCG) to ask them about their experiences of the service provided to people.

We observed care in the communal areas and over the three floors of the home. We spoke with people and staff, and observed how people were supported during their lunch. We spent time looking at records, including eight people's care records, four staff files and other records relating to the management of the home, such as complaints and accident / incident recording and audit documentation. Some people were unable to speak with us. Therefore we used other methods to help us understand their experiences. We used the Short Observational Framework for Inspection (SOFI) during the morning on the reminiscence Neighbourhood. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with 11 people living at the service, four visiting relatives, ten care staff, the chef, the activity co-ordinator, two housekeeping staff, two registered nurses, the area manager and the manager.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Clyde House. One person told us, "I know I'm safe, I get everything I need." Another person said, "I have no complaints really but would like more company." One relative told us, "I have had concerns about staffing levels at meal times." A visitor said, "Excellent care." However we found there were shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments were not all up to date and some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. They looked at the identified risk and included a plan of action to promote safe care. However not everyone's health, safety and wellbeing was assessed and protected. For example, the management of two peoples' pressure ulcers were inaccurate and poorly documented. The organisation's policy for wound management had not been followed. There were no wound care plans, or photographs of wounds for staff to monitor improvement or deterioration. Additionally advice for one person had not been sought from the GP or tissue viability nurse (TVN) in a timely manner. One person's wound was seen by the TVN during the inspection but the documented stage and appearance of the wound was very different from what staff had documented 12 hours previously. The documentation from the staff of Clyde House stated a stage 1 superficial pressure ulcer whereas the TVN examination graded this new breakdown as a stage 4 due to the previous history and skin damage. The difference between a stage 1 and stage 4 pressure ulcer is considerable and the management of the wound very different. This person was at risk from inappropriate care.

Following admission to Clyde House people's needs were assessed and a plan of action put in place to keep them safe. We found that for one person had been in the home for two months and this had not been undertaken. The lack of risk assessments had potentially placed this person at risk. This person was unwell and not eating or drinking. Staff had not undertaken a nutritional assessment and had no baseline to monitor and mitigate risk to the person's health and well-being.

Risk associated with the use of pressure relieving equipment and the use of bedrails had not always been assessed and used appropriately. For example, six pressure relieving mattresses were found to be set on the wrong setting for individual people. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses being incorrect is that it could cause pressure damage. We also found bed rails that had been used with pressure relieving mattresses. The risks associated with their use had not been assessed as recommended by The Health and Safety Executive. People were therefore potentially at risk from falling from bed. These were discussed with the registered nurse who told us they would check them immediately. On the second day of the inspection checks on the settings of mattresses were being undertaken. However we have been contacted by an external health professional to inform us that settings were still not correct despite this being highlighted.

We looked at people's food and fluid records. The care plans directed staff to monitor people's fluid intake when it had been identified the person was at risk from drinking. Some records were incomplete and not added up to provide the total amount of fluid taken. Therefore the records would not be an effective way of monitoring how much they had drunk. We identified two people whose records indicated a fluid intake of less than 250 mls in 24 hours on three consecutive days. The amount recommended by nutritional guidance for the weight of the person stated 1100 mls in 24 hours. Staff had not recorded if a refusal had been followed up or whether it had been identified to the RN. We looked at the handover sheet and saw that this important information had not been handed over to the next staff on duty. The RN was not aware that two specific people had not been drinking well. This placed people at risk of dehydration. The manager took action on the day of the inspection to ensure all fluid totals where collated and checked.

One person who was on restricted fluids of 1500 mls in 24 hours for medical reasons had received in excess of 1700mls daily over the past week. Staff had not monitored fluid intake effectively. This person had also received soups which had not been included. This potentially could impact negatively on the person's health and well-being.

Accidents and incidents had been documented when they occurred however there were three months where there

Is the service safe?

was a lack of follow up or actions taken as a result of accidents and incidents. For people whose falls had been unwitnessed by staff, there was no record of an investigation and a plan to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect people from harm. The provider could not demonstrate there has been any learning from accidents and incidents in this case.

Personal emergency evacuation plans (PEEPs) were in place. PEEPs stated the number of staff required to assist each person but there was no further information to guide staff in the safe evacuation of each person. Staffing levels decrease in the evening and night time and this was not reflected in individual PEEPs. Staffing levels especially at night would not be able to respond to the actions detailed in the evacuation plan, due to the layout of the home and only four members of staff on duty. This placed people at risk from failed emergency evacuations. This meant people were potentially at risk from harm from unsafe evacuation procedures.

All of the above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were seven care staff in the morning in addition to two registered nurses (RN). The staffing levels decreased in the afternoon to five care staff with a twilight care staff on occasion and two RN's. A twilight shift is from 4pm until 8pm. The manager was supernumery to the staffing levels. Three waking care staff provided support at night with one RN. At the time of our inspection, the majority of people living in Clyde House needed support with all of their needs. People required two staff to assist them with all personal hygiene needs and assistance with moving. We were told the provider used an informal staff ratio of 1 staff member to five people, this did not accurately reflect the documented support needs of people. This meant that the delegation and number of staff was inappropriate to meet the needs of the people at this time.

We saw that staff were busy throughout the day and that care was not delivered in a timely manner. Personal care to assist people to get up for the day was still being undertaken at midday and this was not always people's individual preference. One person said, "I stay in bed so it's not really a problem." Another said, "I have to wait for staff but its ok as nothing really happens till later on." One staff member said, "Its busy today and so we are struggling a bit." Another staff member said, "Staff on other floors help out because we are really heavy on this floor."

Care delivery records told us that people were not receiving baths or showers as their preferences stated. For some people there was a week where they had received a wash but no offer of a shower or bath. One person said, "A bath would be nice but I understand staff can't always do it." Another said, "Quick wash and off we go, I feel a nuisance to ask for a shower."

Staff struggled to provide care and to supervise people in communal areas. We observed people were left for up to 45 minutes in the lounge area without interaction. We also noted that people did not have access to a call bell, which isolated them further. Staff were not always able to offer assistance to meet people's individual needs.

We observed the midday and evening meal service and saw there was insufficient staff deployed to give the support people required. We saw that meals were left in front of people and some people resorted to eating with their hands due to lack of staff support.

Accident and incident reports recorded a number of unwitnessed falls of people in communal areas and bedrooms, this indicated that staff were not present and people were therefore not adequately supervised.

These issues were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were systems in place to manage medicines safely. Medicine administration record (MAR) charts clearly stated the medicines people had been prescribed and when they should be taken. MAR charts included people's photographs, and any allergies they had. The MAR charts were up to date, completed fully and signed by staff. We observed staff when they gave out medicines. We saw medicines were given to people individually, the trolley was closed and locked each time medicines were removed, and staff signed the MAR only when people had taken the medicine.

Medicines were kept in locked trolleys, which were secured in a locked room. Staff followed the home's medicine

Inadequate

Is the service safe?

policy with regard to medicines given 'as required' (PRN), such as paracetamol. However records had not always been completed with details of why they had been given or accompanied by pain charts.

People were protected, as far as possible, by a safe recruitment system. Staff told us they had an interview before they started work, the provider obtained references and carried out a Disclosure & Barring Service check. We checked three staff records and saw that these were in place. Each file had a completed application form listing their work history as well as their skills and qualifications. Nurses employed by the provider of Clyde House and bank nurses all had registration with the Nursing Midwifery Council (NMC) which were up to date.

There were a number of policies to ensure staff had guidance about how to respect people's rights and keep them safe from harm. These included clear systems on protecting people from abuse. Records confirmed staff had received safeguarding training as part of their essential training at induction and that this was refreshed regularly. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. One staff member said "I have raised concerns before and the previous manager sent an alert to social services, I wouldn't hesitate to do it again, people need us to be alert and knowledgeable."

Inadequate

Is the service effective?

Our findings

People spoke positively about the home. Comments included, "It's a nice place to live." "The staff are usually kind." However, we found Clyde House did not always provide care that was effective.

The meal service at Clyde House was not a shared experience or made to feel like an enjoyable event for people. It had become a task rather than something to be looked forward to. Whilst there were dining tables available on the first floor for people to eat at, no-one was offered the choice. On Tay Wing people either ate in their room or from a small table in front of their lounge chair. The dining table was not used. We did not observe staff ask people where they wanted to sit and eat lunch.

Lunch was served in the main lounge at 12:10pm and nine people remained seated in their lounge chairs and had small tables to eat their meal from, or received support to eat from a wheelchair. Three people initially received their meal, this was done in a perfunctory manner with no eye contact or conversation. Peoples' food was cut up by staff without being asked if that was what they wanted. Staff left the lounge and there were no staff present until 12:20 pm when a staff member offered a fourth person their meal. At 12:30pm meals were given to four further people and left in front of them with no interaction. One person said, "I've got no-one to help me" and started to eat their meal with their fingers. There were still no staff in the lounge to assist or support. People ate without aids that would enable them to eat without struggling, such as plate guards and angled cutlery. When asked staff told us it was not routinely used. Condiments such as pepper and sauces were not offered. At 12:35pm, the final person in the lounge received their meal and again received no support. It was very chaotic and poorly planned lunch service.

Whilst people were still eating care staff started to move another person with a hoist and caused distress and distraction to other people. The person being moved was taken back to another floor to have their meal. No explanation was given to people. The meal time was therefore disrupted.

There were people who ate very little, one person said, "It's not nice, that's why I've not eaten anything." One care staff member said "Ok" to the person when they told them they didn't like the food but no alternative was offered. At 12:45 pm desert was brought in for one person. Two other people were dozing and their meals were untouched in front of them. The untouched meals were removed with no offer of alternative meal. At 1pm desert was brought in for the remaining people. We asked staff why no alternatives were offered to those who had not eaten. An RN said, "As long as the person eats the pudding it's ok and they can have chocolates and cake later." We noted that there was no record kept for those people who had not eaten well. We asked staff if they told the chef or trained nurse of the food returned. One staff member said, "We tell them verbally but don't always write it down." This placed people at risk of not maintaining a nutritious diet. Weight records identified that there were people whose weight were unstable. We viewed weight records from May 2015 to September 2015. Weight records for August 2015 were missing. The records provided did not state what action staff had taken where there was weight loss. For example one person in July 2015 weighed 46.3kgs and in September 2015 was weighed as 37.4 kgs. No action was recorded in the care plan as to whether it had been referred to the GP and dietician or whether fortified food was being offered. Records for fluids were not all completed in full and did not assure us that people were receiving adequate fluids to maintain their health. One person tod us that sometimes staff forget to offer them afternoon tea and evening drinks. We saw during the inspection that drinks were left with people who needed prompting or assistance and then removed not drunk or recorded as refused.

People who ate in their rooms were checked by staff intermittently to ensure they were eating, but this was not consistent on all floors. We observed people sitting with food uncovered, waiting for staff to assist or prompt them to eat. This meant their food was potentially cool to eat. Staff assisted people in bed to eat by standing and reaching over bed rails. There was little interaction observed and it was not an enjoyable experience for people. The staff had not ensured that people received suitable and nutritious food and hydration which is adequate to sustain life and good health.

These issues were a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us that they had completed training to make sure they had the skills and knowledge to provide the support individuals needed. Some staff told us they were behind in

Is the service effective?

some areas and this was already known to the organisation. Whilst training was available it was not effective in all cases. We observed poor practice in moving and handling people, assisting people with their food and in delivering person centred care. There was also a lack of understanding shown by staff in supporting people who lived with dementia. This was observed by the lack of interaction when supporting them and not managing some behaviours effectively.

We looked at training records. The organisation had identified that the training needed to be improved. New work books were in place to support the E-Learning courses staff completed online. Training records indicated that fundamental training for all staff was up to date. For example, MCA, safeguarding, health and safety. Service specific training, such as end of life care, dementia, wound care and nutrition had not been undertaken or updated to ensure best practice was followed by all staff. We saw care delivery for people who lived with dementia was not always person focused as we saw staff make decisions for people without any involvement or discussion. People with nutritional problems were not always supported in a way that maintained their health. This impacted negatively on people's well-being.

Staff supervision was not up to date for all staff. Supervision helps staff identify gaps in their knowledge, which was supported if necessary by additional training. Staff said, "Supervision sort of stopped for a while but we are now booked up." Staff records of supervision confirmed that staff supervision had fallen behind but was now being undertaken since the new manager had started work. Staff told us they had felt unsupported due to staff changes and lack of leadership. This was reflected in the unsafe practices we observed.

The provider had not ensured that staff had received appropriate training, professional development and staff supervision to meet the needs of the people they cared for.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). Staff told us most people would be able to consent to basic care and treatment, such as washing and dressing. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity did not record the steps taken to reach a decision about a person's capacity. Staff told us, "It's about asking them and making sure it is what they want." Staff however were unable to tell us about how certain decisions were made such as, where people spent their time, consenting to photographs or about whether people could use a call bell. One person was able to tell us clearly how they wished to spend their time but the documentation stated that that they did not have the mental capacity to make that choice. The staff said, "Well they will forget in a few minutes because their short term memory is very bad." We found that this person was consistent in their wishes throughout our inspection and they felt that they were prevented from living their life as they wished. Another person was not supported to attend activities as they were identified as disruptive. This was not reflected as a decision made in respect of the mental capacity assessment. This person when interacted with was humorous and enjoyed interaction and had not been supported to undertake any social activity. This told us mental capacity assessments whilst undertaken were not decision specific and were not recorded in line with legal requirements. This was an area that requires improvement.

Staff had attended training in Deprivation of Liberty Safeguards (DoLS), which is part of the MCA framework. The purpose of DoLS is to ensure someone, in this case, living in a care home is only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interest of the person, and has been agreed by relatives, health and social care professionals and there is no other way of safely supporting them. Staff were aware that the locked front door, which prevents people entering and leaving the home was a form of restraint and applications had been made to the local authority under DoLS about this. We also found that the people who lived on Tay Wing, where key pads prevented people leaving had been included in the DoLS referrals.

People did receive effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the TVN and speech and language therapist as required. It was however identified during our inspection that referral to external health professionals was not always done in a timely manner.

Requires improvement

Is the service caring?

Our findings

There was inconsistency in how people were cared for, supported and listened to and this had an effect on people's individual needs and wellbeing. Staff did not always focus on people's comfort, there was a risk of people receiving inappropriate care, treatment or support. We observed people who found it difficult to initiate contact were given very little time and attention throughout the day. People spoke positively of care staff, but a visitor expressed some concern about lack of communication between staff and the people who lived at Clyde House. Comments included, "I visit and sometimes I do not see any staff at all," and "I see staff ignore people when they call out, and worry that people might not get the care they need." We were also told, "Very nice staff, they are kind."

Staff were task focused and did not always treat everyone with respect, kindness and compassion or maintain people's dignity. We undertook a SOFI which identified some staff were not interacting with people in a way that was respectful. Staff talked over people and referred to them in the third person. One member of staff said, "Which one hasn't been fed?"

On Tay Wing one staff member told us that a person liked to move things and it was thought they might have moved the white aprons. Another staff member came into the lounge and couldn't find the aprons, and was told they thought the person had moved them. The staff member came over to the person said, "What have you done with them?" and then lifted the blanket on their legs to see if they were in their lap. There was no explanation of what the staff member was going to do before they did it, there was no eye contact made with the person and no recognition that this was uncaring and did not support the person's dignity.

People's dignity was not always promoted in the communal lounge when they were helped to move, One person's legs and underwear was displayed whilst being supported in a moving and handling hoist. No attempt was made to offer privacy during the procedure. One person was hoisted whilst other people were eating lunch which impacted on both people in a way that was undignified.

People's preferences for personal care were recorded for each person but not always followed due to rushed staff.

One person said, "They snap at me sometimes if they are busy but I don't think they mean it, I missed my shower the other day, but I'm not really worried." Another person said, "I would like a bath but it's not always possible."

We also saw a person moved with a hoist (moving equipment) where the staff moved the person whilst they were distressed and refusing the manoeuvre. It was distressing to watch as staff did not consider the persons reaction and continued to proceed with the procedure. There was no rationale given as to why or what alternative could be put in to place. Staff knew this person did not like to be moved with the equipment. We shared our observations with the provider and they acted on this immediately with staff.

We observed that people's dignity was not promoted whilst receiving support for eating their meals. People were left struggling to eat without the necessary support and others were sat with their meals in front of them for up to 20 minutes without assistance.

Whilst staff told us people should be encouraged to make choices we didn't observe that people who lived on Tay wing were offered choices. For example at breakfast or what they wanted to drink. A list of what people were to have for breakfast was used every morning with no choice offered. We also saw staff decided where people sat and when they were taken back to their room. We observed one member of staff entering the lounge and saying "Who you taking up first, her (pointing)?" There was no asking or involvement shown by staff.

People were not always supported to be independent and make day to day decisions. We saw that people were moved to different lounges in the home without being asked. One person was moved in the middle of the lunch service with no explanation. We spoke with one person on Tay Wing who said, "They don't ask me so I stay up here now and eat in my room usually, I used to go downstairs to the big lounge, but not anymore." Some people told us they did not feel listened to. One person said "I have gone to the office to complain about one carer, but they are still rude to me." Another person said, "I think I am forgotten sometimes because I get my food late, one day my supper didn't arrive until nearly 7 pm." We asked staff how they supported people to make choices and remain independent and were told, "We offer residents choices about want they want to do with their day all the time." However people were not supported to make choices

Requires improvement

Is the service caring?

about how, where and what they did on a day to day basis. We spent time observing the lifestyle within the home. People were not offered choices and people sat for long periods of time dozing in chairs or walking around the corridors. People were taken back to their room with no consultation and little conversation.

We also saw that choice and independence were not fully reflected in people's care plans and risk assessments. There was no reflection of conversations between staff and people about what they want from life whilst living at Clyde House, such as their social aspirations.

The environment on Tay Wing which is specifically for those people who live with dementia was not dementia friendly or homely. There was limited sign posting to promote independence. For example signage for people to recognise the lounge and bathrooms. There were some animal pictures on people's bedroom doors but staff and people could not tell us the relevance or how it encouraged independence or recognition from people. The lounge was formal in décor and not set out to be comfortable and relaxing for people. There was no sensory equipment for people to prompt memories or encourage mental stimulation. It was not seen as caring and stimulating environment for people who live with dementia. The management team were aware there was work to be undertaken and discussed their future plans for the dementia wing.

People were not consistently treated with dignity and respect and they were not encouraged to be independent or to live a life of their choice. These issues were a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. The manager told us, "There are no restrictions on visitors". A visitor said, "I visit every day and can't fault them."

Inadequate

Is the service responsive?

Our findings

Whilst some people told us they were happy with the standard of care provided and that it met their individual needs, our observations identified that staff were not responsive to individual needs.

Communication and social well-being was an area that we identified as a concern as a large amount of people were isolated in their bedrooms and in the lounge areas with little interaction from staff. During our inspection we noted at times there were no staff in communal areas and people were left with the television and radio on in the background. There was no rationale given by staff or any evidence this was people's choice. One person said, "I rely on my newspaper to know what day it is, the days just seem to blend into each other." There were also people whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed the tasks but did not use this one to one time to chat or offer reassurance. The SOFI identified that there was little empathy shown by staff to people and very little positive conversation.

We visited three people regularly throughout our inspection and saw they received little social interaction from staff apart from being given drinks and their midday meal. We observed staff waking one specific person for their lunch meal and they soon dozed off again without eating. When engaged with, the person was bright and mobile. We looked at their care plan which did not contain any information of their hobbies and interest?

Care was not always personalised to the individual and did not include important changes to their health. For example, reduced mobility and communication and behavioural problems. Staff described how one person had taken apart their room and ensuite. This had meant the room was odorous as the toilet was not functioning and was still being used and the person's independence was reduced as the taps had been dismantled. We were told this was to stop them being left on. There was no detail in the persons care plan to offer meaningful activities as diversional management or how to manage the person's behavioural traits.

People's care plans included risk assessments for skin damage, incontinence, falls, personal safety and mobility and nutrition. However some peoples care plans lacked details of how to manage and provide specific care for their individual needs. For example people's continence needs were not always managed effectively. Care plans stated when a person was incontinent, but there was no guidance for staff in promoting continence such as taking to the toilet on waking or prompting to use the bathroom throughout the day. One person had a tendency to use alternative objects as a toilet and there was no plan in place to manage this pro-actively.

Care plans reflected some people's specific need for social interaction, but these were not being met. There were times when we saw that people were isolated and staff interaction was minimal due to other tasks being undertaken. The activity person was enthusiastic about their role, but told us that it was difficult to ensure everyone received an opportunity for activities due to the high percentage of people who remained in their room. Staff said people preferred to stay in their room and so no longer offered to take them to the communal lounge. Staff said one person on Tay Wing could not attend group activities as they were at times destructive, however no alternatives for engagement had been made. This meant this person was isolated. One person who lived on Tay Wing enjoyed gardening and being outside but this did not happen very often. No alternatives for gardening had been explored by staff. The person told us, "I am bored and becoming less interested in things."

The records showed us that the activity co-ordinator spent time on one-to-ones sometimes but this was not regular. This also meant if the activity co-ordinator was visiting people in their room, the people in the communal areas were left watching television.

Activities promoted were not reflective of people's individual interests and hobbies. One person told us that trips out would be good, especially Christmas shopping. It was not clear from talking to staff if outings were offered or planned on a regular basis.

The evidence above demonstrates that delivery of care in Clyde House at this time was seen as task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

We saw photographs that showed people enjoying visits from outside entertainers and visitors. We also saw that people's birthdays were celebrated. One person had recently celebrated their 100th birthday and the activity co-ordinator had baked a cake and decorated the person's room. On the afternoon of the inspection people enjoyed poetry and singing session presented by an external entertainer.

A complaints procedure was in place and displayed in the reception area of the home. However, this was not displayed elsewhere in the home or provided to people on Tay Wing in an accessible format. One person told us "I have been to the office and they are very kind and I would tell them again if I had a complaint." Most people told us they felt confident in raising any concerns or making a complaint. There had been a number of complaints received in the past few months and documentation confirmed complaints were investigated and feedback was given to the complainant. We were also told by one person that they had gone to the office to complain and felt it was handled appropriately.

Requires improvement

Is the service well-led?

Our findings

People, friends and family described the staff of the home to be approachable and helpful. People told us; "They listen and are friendly." A relative said; "I think the new manager is calm and approachable." A staff member commented; "The new management team are supportive, and things are much better."

There was no registered manager in post. The registered managers' post has been vacant since July 2015. A manager had been recruited and has submitted an application with CQC to be the registered manager of Clyde House.

The provider had begun to put into place a new senior new management team in January 2015 and were undertaking organisational audits which had identified some of the shortfalls we found but work to improve had not progressed sufficiently.

The new management team said that they had already identified a change in culture and practice was needed in the home which was currently being supported by a Home Improvement Action Plan. This work was still on-going at the time of the inspection

Quality assurance systems were in place, however they were not all fully completed and had not identified the shortfalls we found. We found gaps in audits from when the last manager had left and when the new manager started their role.

We found that people's safety was potentially at risk as some care plans were lacking in specific information that had the potential to cause harm to the individual. We identified throughout the inspection that many people were unstimulated and isolated at times and that staff did not actively engage with them due to time constraints and lack of understanding of person centred care. We also found that people's nutritional needs were not being managed effectively to enjoy the meal time experience or monitored to ensure that people had enough to eat and drink. The care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example the management of wound care, dementia and continence. The environment and equipment for people who lived at Clyde House was not suitable to support people safely and ensure people's individual needs were met.

People had not been protected against unsafe treatment by the quality assurance systems in place. This was a breach of Regulation 17 of the Health and Social Care Act 2014.

The culture and values of the home were not embedded into every day care practice. Staff were able to tell us, "Things are better, we are receiving support to be able to put the residents first." Staff we spoke with did not yet have an understanding of the vision of the home and from observing staff interactions with people; it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. We saw poor practices which were undertaken by a small percentage of staff but not challenged by other staff observing. This told us that the culture of the home had still to change to ensure person centred care delivery. Staff however spoke positively of how they all worked together as a team. They said they supported each other and helped each other when things were busy.

People, staff and visitors said that communication and leadership had improved within the home and the atmosphere was pleasant. Staff and visitors had an awareness of the management team and felt that the morale of staff had improved. However due to staff deployment we saw that poor practice was accepted by staff. We also saw shortcuts in care delivery such as moving and handling and support with meals and drinks shortcut were noted due to time constraints and staff deployment. People therefore did not always receive the care they wanted and required.

The area manager told us one of the organisational core values was to have an open and transparent service. The provider was supporting staff, visitors and the people who lived at Clyde House to share their thoughts, concerns and ideas with them in order to enhance their service. Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I have been worried because there seemed to be a lot of changes, but things seem to be going forward, I have met the new manager who seems very open." Another said, "We have seen some positive changes."

Staff meetings had been held regularly over the past two months, and we were assured that regular meetings would

Requires improvement

Is the service well-led?

be held whilst changes to the management structure continued. The manager said, "There is a lot to change, such as the culture, but I have confidence that we will get there. There is a strong organisational team that are working with us to improve the service."

We spoke with staff about how information was shared. They told us they were given updates but felt they "were too quick and didn't really tell them much." They were not informed of the status of wounds, blood sugar irregularities and which people had not been drinking and eating enough. The management had identified this as an area that required improvement and were dealing with this through meetings with staff, investigations and supervision. We saw evidence of this during our inspection.

One staff member said that the culture in the work place was better, there were times in the past that they had felt their suggestions to improve care were not acknowledged and had felt unsupported. Another staff member said, "We are involved in improvements, the training and supervision are helpful and I feel listened too."

The service had notified the Care Quality Commission (CQC) of all significant events which had occurred in line with their legal obligations.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 (1) (a) (b) (c) 3 (a) (h) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider had not ensured that service users received person centred care that reflected their individual needs and preferences.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Regulation 10 (1) (2) (a) (b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider had not ensured that service users were treated with dignity and had their privacy protected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 (1) (2) (a) (b) (4) (d) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider had not ensured that the nutritional and hydration needs of service users were met**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Action we have told the provider to take

Treatment of disease, disorder or injury	Regulation 17 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that service users were protected from unsafe care and treatment by the quality assurance systems in place.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (a) (b) (e) (g) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured the safety of service users by assessing the risks to the health and safety of service users of receiving the care or treatment and doing all that is reasonably practicable to mitigate any such risks.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 (1) (2) (a) (b) (c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not ensured that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in the service to meet service user's needs. Staff had not received appropriate training, professional development and supervision.

The enforcement action we took:
Placed in special measures.