Care Quality Commission

# Meridian Healthcare Limited

# Hyde Nursing Home

## Inspection report

Grange Road South
Gee Cross
Hyde
SK14 5NB
Tel: 0161 367 9467
Website: www.meridiancare.co.uk

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## Ratings

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

## Overall summary

This was an unannounced inspection which took place on 11 March 2015. The service was last inspected in November 2013 when it was found to be meeting all the regulations we reviewed.

Hyde Nursing home is a purpose built care home and is registered to provide accommodation for people who require nursing and personal care. There are 100 beds in total, 60 of the beds are in use by Hyde Nursing Home. Godley Court and Newton units provide general nursing care for up to 35 people in total. Werneth is a unit providing care for up to 25 people living with a dementia. There were a total of 53 people using the service at the time of the inspection.

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

# Summary of findings

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which correspond to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing, management of medicines, supporting workers, care and welfare of people who used the service and the systems for assessing the quality of the service provided. You can see what action we told the provider to take at the back of the full version of the report.

Staff had been safely recruited. However, we found there were not enough staff to meet people's needs in a timely manner, particularly over the lunchtime period in all three units. We also noted shortages of staff throughout the inspection on both Werneth and Newton units. This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people told us they felt safe in the service and staff had received training in how to protect people from the risk of abuse, we were made aware of one incident which had not been reported as required. This meant there was a risk people were not adequately protected from potential abuse.

There was a policy in place to support the safe administration of medicines. However, we noted this policy did not contain adequate information about the process staff should follow if a person refused to take their medicines and it was considered necessary for the medicines to be given covertly, i.e. administered in food or drink without the person's knowledge. Adequate systems were also not in place to record when people should be offered 'as required' medicines. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

All the staff we spoke with demonstrated a good understanding of people's needs. However, when we asked staff about the induction, supervision and training they received we received conflicting information. Some staff told us they felt they received good training and support while other staff told us their induction had not been sufficiently robust to prepare them for their role in the service. They also told us they had not received any supervision since they started work in the service. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

The service was meeting the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS); these pieces of legislation are designed to protect people who may be unable to make their own decisions. We saw that appropriate arrangements were in place to assess whether people were able to consent to their care and treatment in Hyde Nursing Home and to ensure any restrictions assessed as necessary were legally authorised.

We found improvements needed to be made to the care people received in Hyde Nursing Home, particularly in relation to the management of wounds and pressure relief. Nursing records were not accurately completed regarding the wound care people required and poor communication between nurses meant some people who used the service had not received effective care. One person had been provided with a specialist mattress to help ensure they received the pressure care they needed but staff were not aware of how this equipment should be correctly installed and used. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where they were able to tell us about their experiences people who used the service told us staff were kind and caring. Positive feedback was also given by relatives about the attitude and approach of staff. During the inspection we noted a lack of positive interaction between staff and people who used the service on Werneth and Newton units. Staff on Godley Court were observed to offer support and reassurance to people throughout the inspection.

We found systems were in place to provide people with an opportunity to comment on the service they received. People told us they would feel able to raise any concerns they might have with staff or the registered manager and

# Summary of findings

were confident they would be listened to. A log of complaints was maintained by the service and we saw evidence that action had been taken to investigate any concerns raised.

Although a programme of activities was provided in the service, people had mixed views about the opportunities available to them. We noted there were missed opportunities to involve people who used the service in 'homely tasks'; the engagement in such tasks can help evoke meaningful memories for people.

Although some staff told us they enjoyed working in the service other staff told us they felt the culture was not transparent and they felt unable to raise any concerns with the registered manager. However, from the records we reviewed and our discussions with the quality assurance manager we noted staff did have opportunities to speak with other representatives from the company who were regularly on site.

There were a number of quality assurance systems in place in the service but these were not sufficiently robust to identify the shortfalls we found during the inspection. This was a breach of Regulation10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

# 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?**

Requires improvement 

Some aspects of the service were not safe.

Although people who used the service did not express any concerns about their safety, there were insufficient numbers of staff available to always meet their needs in a timely manner.

Recruitment processes were sufficiently robust to protect people who used the service from the risk of unsuitable staff.

Staff had received training in how to protect people who used the service from the risk of abuse. However, we were made aware of one incident which had not been reported as required.

Systems for the administration of medicines required improvement to ensure people's rights were always protected.

**Is the service effective?**

Inadequate 

The service was not effectively meeting people's needs.

Although care staff demonstrated a good understanding of people's needs we found the induction and supervision they received needed to be improved to help ensure they were able to deliver effective care.

Staff had received training in the Mental Capacity Act 2005; this legislation is designed to protect people who may be unable to make their own decisions. Appropriate arrangements were in place to ensure any restrictions on people were legally authorised.

Improvements needed to be made to the way care was planned and delivered to help ensure people always received the care and treatment they required.

**Is the service caring?**

Requires improvement 

Improvements needed to be made to ensure the service was always caring.

Although some people told us they considered staff were kind and caring, our observations showed that, on two of the units, interaction between staff and people who used the service was limited.

People had opportunities to comment on the service they received.

**Is the service responsive?**

Requires improvement 

The service was not always responsive to people's needs. This was because staff did not always respond to people's requests for assistance in a timely manner.

# Summary of findings

Some activities were offered to people who used the service but improvements could be made to how people were supported to engage in meaningful tasks.

A system was in place for recording and managing complaints received in the service.

**Is the service well-led?**

The service was not always well-led. This was because improvements needed to be made to the culture of the service so that staff would feel confident to raise any concerns they might have with the registered manager.

Systems were in place to monitor the quality of the service people received. However, these systems had not been effective in protecting people against the risks of unsafe or inappropriate care.

**Requires improvement**

# Hyde Nursing Home

**Detailed findings**

## Background to this inspection

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

This inspection took place on 11 March 2015 and was unannounced.

The inspection team consisted of two adult social care inspectors, a specialist advisor in the care of people with a dementia and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of residential and nursing care services.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service including notifications the provider had made to us and feedback we had received from the relatives of people who used the service. Concerns people had reported to us related to the culture of the service, staffing levels and the standard of care. People had also made positive comments to us about the caring attitude of staff and the quality of food.

We contacted the Local Authority safeguarding team, the local commissioning team, the Clinical Commissioning Group for the area and the local Healthwatch organisation to obtain their views about the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We were told there had been serious safeguarding concerns raised at the service regarding the management of wounds. We were also told the number of falls experienced by people living on the specialist unit for people with a dementia was of concern.

During the inspection we spent time speaking with 20 people who used the service, however not all of them were able to tell us about their experiences. We also spoke with four relatives, the registered manager, two nurses, seven care staff, the activity coordinator and the chef.

At the time of the inspection there were a number of professional visitors to the service. These included the clinical lead and the quality assurance manager from Meridian Health care, both of whom we spoke with during the inspection. Two nurses from the Clinical Commissioning Group were also present during the inspection to review the care records of those people who were in receipt of fully funded nursing care; their presence was as a result of the serious concerns raised about the management of wounds in the service.

During the inspection we carried out observations in each of the three units in the service and undertook a Short Observation Framework for Inspection [SOFI] observation during the lunchtime period on the unit for people with a dementia. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care records for nine people who used the service and medication records for a further eight people. We also looked at a range of records relating to how the service was managed; these included seven staff files, training records, quality assurance systems and policies and procedures.

Requires improvement

# Is the service safe?

## Our findings

People we spoke with who were able to tell us about their experiences had no concerns about their safety in the service. One person told us, "Oh I get well cared for and yes, I do feel safe here, the staff make sure we are kept safe." Another person commented, "I do feel safe here." None of the relatives we spoke with expressed any concern about the safety of their family member in Hyde Nursing Home.

We looked at how staff were recruited and whether staffing levels were sufficient to ensure people were provided with safe and appropriate care. We noted the recruitment processes in the service were robust enough to ensure people who used the service were protected from the risk of unsuitable staff. Staff files we looked at provided evidence that the required pre-employment checks had taken place before staff were allowed to work without supervision.

The registered manager told us there were four care staff and one nurse on each of the three units. However, we noted two of the three units were split over two floors which meant there were sometimes only two staff available to meet people's needs. We were told that the dependency levels of people who used the service had been assessed and staffing levels set accordingly.

We noted one of the nurses on duty was a bank member of staff who had not been on duty for some time. We observed the registered manager provided a quick verbal handover of the needs of people on the unit where they would be working but there was no written record of this maintained. We also noted that the nurse on another unit was from an agency and, from our discussions, did not know how the unit was run or where documentation was kept.

During the inspection we noted a lack of staff to be able to respond to people in a timely manner. On the morning of the inspection we observed one person on Newton unit repeatedly ask staff for assistance to move from their wheelchair into a more comfortable chair but, due to being busy on other parts of the unit, staff did not acknowledge her request for some time. Another person on Newton unit told us they had been waiting for staff to get them up for some time.

We observed lunch in three different areas of the service and found there were insufficient staff to be able to provide the assistance people required to eat their meals. On Werneth, the unit for people who were living with a dementia, we noted there were only two staff available to support the 10 women using the service at lunchtime. We saw that staff provided individual attention to people who required assistance to eat but this meant that the lunch period took over one and a half hours to conclude; this meant some people had to wait for their lunch which had to be reheated for them. On the floor of Werneth unit, where care was provided for men living with a dementia, we noted the dining area was left unsupervised for 15 minutes as staff were providing care to other people; this meant there were no staff available to provide support or encouragement for people to eat their lunch.

Our observations on Godley Court also provided evidence that staffing levels at lunchtime were insufficient to meet people's needs in a timely way and ensure the mealtime was a relaxing and enjoyable experience for people who used the service. This view was confirmed by one relative we spoke with on Godley Court who told us, "The staff get really pushed at times, especially at meal times." However, another relative commented, "One thing I have noticed is the staff here – they are very patient and always find time for everyone; it must be hard at times."

Staff we spoke with on Werneth told us they considered staffing levels were insufficient, particularly during mealtimes. They told us they had not raised this issue with senior staff due to a lack of staff meetings. Staff also told us they were concerned that they were often unable to take their breaks while working due to the needs of people who used the service.

The lack of sufficient staff to meet people's needs was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the procedures for the administration of medicines in the service. We noted seven of the eight medication administration record (MAR) charts had been fully completed. One of the records had not been signed to confirm the person concerned had received their prescribed medicines on the morning of the inspection. We discussed this with the nurse concerned who told us the

# Is the service safe?

person had received their medicines but they had forgotten to sign the administration record due to the numbers of external visitors on the unit and the distractions they had faced as a result.

We were told by the registered manager one person was being given medicines covertly, i.e in food or drink without their knowledge. We looked at the medication policy for the service and noted it did not provide any information about the process to be followed should the covert administration of medicines be considered necessary. When we looked at the care record of the person concerned we saw that a GP had advised in April 2014 that medicines could be given covertly. However, we did not see any evidence that an assessment had been undertaken of the person's capacity to consent to take their prescribed medicines or that a best interests meeting had taken place to ensure the person's rights were protected. We noted a risk assessment had also not been completed to inform staff of what action they should take should the person not eat or drink all of the food in which the medicine had been administered.

We noted there were no individualised protocols in place to advise staff of the appropriate action to take when people had been prescribed 'as required' medicines. This meant there was a risk that staff would not recognise when people might need their medicines. During the inspection we noted one staff member gave a person their pain relief medicine which was prescribed 'as required' without first checking with the person that they were in need of the medicine. They told us this was because the person always wanted the medicine at that time. However, it is good practice to always ensure that people are given the opportunity to decide whether they are in need of 'as required' medicines.

The lack of appropriate systems in place for the safe administration of medicines was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with told us they had received training in the safeguarding of vulnerable adults. This was confirmed by the records we reviewed. One staff member commented, "We do safeguarding training when we first start on our induction and then we have refreshers now and again."

All the staff we spoke with told us they understood the correct procedure to follow should they have any concerns about a person who used the service. However, one of the staff we spoke with disclosed an incident they had witnessed which should have been reported as a safeguarding concern. They told us they had not felt confident to report their concerns to senior staff in the service as they were concerned about the repercussions they might experience as a result due to the lack of confidentiality in the service. We had noted during review of the safeguarding policy for the service that staff were able to raise any concerns anonymously via a safeguarding telephone line provided by the company but the staff we spoke with told us they were unaware of this provision.

We spoke with the group quality assurance manager regarding the concerns staff had raised with us. They told us immediate action would be taken to report the allegation of abuse to the local authority; this was subsequently confirmed following the conclusion of the inspection. Both the quality assurance manager and the registered manager told us information was available on all the units and on the company's website regarding the safeguarding line and were disappointed staff had not been aware of this provision. They told us staff were also asked regularly about their knowledge of safeguarding procedures and this was confirmed in the monthly compliance audits we reviewed. They told us they would ensure all staff were reminded about the procedure they should follow for reporting concerns or poor practice in the service.

We looked at the risk assessment and risk management procedures in the service. From the care records we reviewed we saw that assessments had been undertaken of the risks people might experience in relation to moving and handling, nutrition and falls. We noted two people on Werneth were assessed as high risk of falls but it was not evident from the care files whether a referral had been made to the falls team for specialist advice and support. When we discussed this with the registered manager they told us the local protocol was for a person's GP to make any necessary referral to the falls team and they advised us this had been completed.

We noted from the care records for one person that they were assessed as posing a risk to others if they were

Requires improvement

# Is the service safe?

provided with metal cutlery. During our observations at lunchtime we noted this person was provided with metal cutlery and not the plastic cutlery which the care plan stated they needed.

Records we looked at showed equipment used in the service was regularly checked and serviced to help ensure it was safe to be used. A fire safety risk assessment was in place and staff were involved in regular fire drills. This should help ensure staff were aware of what action to take in the event of an emergency at Hyde Nursing Home.

Inadequate

# Is the service effective?

## Our findings

Most of the people who used the service who were able to tell us about their experiences said they received the care they needed. One person told us, "I normally say when I want to get up and if I feel like a sleep in, and I do sometimes, then I tell the staff and I can have my breakfast here in my room." However, another person told us they were very unhappy with the care they received at Hyde Nursing Home and wanted to leave. We discussed this with one of the visiting professionals who told us she would arrange a meeting with the person concerned, their relative and the registered manager to discuss their concerns. We also discussed the person's comments with the registered manager and quality assurance manager. They told us the person was subject to a deprivation of liberty safeguards (DoLS) authorisation as they were unable to consent to their care and treatment in the service. They told us they both had regular informal conversations with the person concerned, the most recent being the day before our inspection and they had not expressed any concerns about their care.

We asked the relatives we spoke with if they considered staff had the skills and knowledge they needed to provide effective care to people. One relative told us, "My [relative] has only been here a short time but the staff seem very nice and I am sure they would ring me if anything was wrong." All the staff we spoke with demonstrated a good understanding of people's needs.

Prior to the inspection we had received information of significant concern regarding the management of pressure care and wounds in the service, particularly on Godley Court. We had been told that following a safeguarding conference the service had been provided with an action plan to ensure improvements were made in the pressure and wound care delivered in the service. However, further safeguarding concerns had been raised immediately prior to our inspection; this indicated the service had not made the necessary improvements to the wound and pressure care treatment people who used the service received. As a result of these concerns two nurses from the Clinical Care Commissioning Group (CCG) had arranged to spend several days at the service to review the care planning arrangements for those people who had the most complex needs. They told us they would continue to work with the service to support staff to improve the standard of nursing care provided to people.

We looked at the care records for five people who were living on Godley Court to see whether these supported staff to deliver effective care; three of the people whose care files we reviewed were suffering from pressure ulcers. We found wound care assessment records had not been accurately completed by nursing staff and there was a lack of communication between nurses working on the unit to ensure effective wound care was always provided.

We checked the repositioning charts in people`s rooms and saw evidence that people had been turned appropriately, in line with their care plan. We noted the care plan for one person stated they needed their legs tilted at 30 degrees to help reduce the risk of any deterioration around the pressure sore area. However, staff told us there were problems maintaining this because the person's legs were contracted. We were told managers were aware of this issue and were trying to find a solution. When we discussed this situation and the more general care of pressure ulcers in Hyde Nursing Home with representatives from the Clinical Commissioning Group they told us they were concerned about the lack of leadership and ownership in the service regarding the management of pressure and wound care. Staff we spoke with on Godley Court told us they considered the lack of both regular nursing staff and a clinical lead for the service had impacted on the quality of care provided to people in Hyde Nursing Home.

We noted one person had recently been provided with a specialist pressure relieving mattress. However, none of the staff we spoke with were able to show us any instructions for its use. We asked staff why the mattress had been placed on a particular setting but they were unable to tell us who had given the instruction for this setting to be used. We noted the setting to be used on the mattress was dependent on the weight of the person for whom it had been provided. However, there was no evidence from the records we reviewed that the person's weight had been checked at the time the mattress was installed. We could also not find any evidence of a care plan which referred to how this piece of equipment should be used to meet the person's needs.

Inadequate

# Is the service effective?

Records we looked at showed one person in Godley Court had lost 5kg in weight over a period of six weeks. We noted the most recent care plan review for this person stated there were 'no changes' in relation to eating and drinking and therefore no action had been taken to address why the person was losing weight. When we raised this with the registered manager they told us they had not been made aware of the person's weight loss but made immediate arrangements for increased monitoring to take place.

The lack of appropriate arrangements to ensure people were protected against the risks of receiving inappropriate care or treatment was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection we were sent a copy of an action plan completed by the registered manager and quality assurance team on 1st February 2015 as a result of safeguarding concerns regarding wound and pressure care in the service. We noted many of the actions relied on supervision being undertaken by the registered manager with nurses to highlight improvements which needed to be made to the nursing care people received. However, records we reviewed did not provide evidence that this required supervision had taken place. This meant there was a risk that people who used the service would continue to receive inappropriate care.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). At the time of our inspection there were three people for whom applications to restrict their liberty had been authorised by the local authority. The registered manager told us they were aware of recent changes to the law regarding when people might be considered as deprived of their liberty in a residential or nursing care setting and were taking the necessary action to ensure, where necessary, any restrictions placed on people were legally authorised.

Records we looked at showed all staff had completed training in the Mental Capacity Act 2005 in May 2013; this legislation provides legal safeguards for people who may be unable to make their own decisions. The registered manager told us the training matrix did not include the training completed by staff who had been recently appointed.

Care records we reviewed showed assessments had been undertaken of people's capacity to consent to their care and treatment in Hyde Nursing Home and where necessary best interest decisions had been recorded.

The registered manager told us there was a robust induction programme in place at the service which staff were required to complete before they started to work without supervision. They told us this induction included training in safeguarding adults, moving and handling, health and safety and the Mental Capacity Act. They also told us that staff were asked to shadow more experienced staff in all areas of the service before they were allowed to work independently. We were told all care staff were required to complete an induction workbook which consisted of eight different modules within the first twelve weeks of their employment and that successful completion formed part of the probationary period staff were required to complete.

Most of the staff we spoke with told us they considered they had received sufficient training for their role at Hyde Nursing Home. One staff member told us, "I have just done my safeguarding training and lifting and handling and I have something else coming up; the training is pretty good." A further staff member who had worked at the service for many years told us that, although generally they had received good training, they and other carers would like more help in dealing with people, particularly men, whose behaviour might challenge others.

However two staff told us they had not received a proper induction. One person told us their induction consisted of, "Attending a group meeting for half a day, shown around the building and brief moving and handling training". In addition this staff member told us they were left on their own after two night shifts shadowing another carer. Another staff member told us, "My induction was a meeting and walk around the building and moving and handling." They informed us that they had been left without supervision on their first shift with no knowledge of the needs of any of the people who used the service.

One person told us they had completed their induction workbook but had not had a meeting to review their performance at the end of their probation period. The other staff member told us they were in the process of completing the workbook. Both staff members told us they had not received any supervision or support during their induction. We discussed this with the registered manager

# Is the service effective?

who told us it was the responsibility of the head of care to offer supervision and support to care staff and they were unaware of why this had not taken place. We were unable to discuss this with the head of care as they were on leave at the time of the inspection.

We looked at the files for six members of staff. We noted that only one person had received any form of supervision in 2015. The most recently recorded supervision for any of the other five members of staff whose files we had reviewed was in July 2014. Records we reviewed showed the monthly quality assurance audit undertaken in the service included the need to check with staff that they were receiving regular supervision but this had not been completed on the most recently completed audits in November 2014 and January 2015. We also noted the company's quality assurance report for the service had identified a major concern in August 2014 that supervisions had not been carried out for a significant amount of time. We discussed the lack of supervision with the registered manager. They told us this was due to the fact that the clinical lead had left the service in January 2015 and had not been replaced as yet.

We saw that appraisals had been completed with staff in September 2014 and that, following this process, an individual learning plan had been created in order to support staff to continue with their professional development.

The lack of effective induction and supervision for staff meant there was a risk people might not receive the care they required and was a breach of regulation 23 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw there were systems in place to monitor people's nutritional needs. However the fluid monitoring records we looked at were lacking in detail; this meant it was difficult to monitor whether people were adequately hydrated.

We asked people about the food provided in Hyde Nursing Home. One person commented, "The food is really nice, sometimes it`s too much for me, but I do enjoy it and we get drinks during the day, hot or cold." When we observed the lunchtime period on Newton and Werneth units we noted people were given meals which had been plated up by the kitchen and that the portion sizes were large. We noted there were no menus on display, none of the tables were set and people were not offered a choice of meal. We asked one member of staff on the unit for people with a dementia how they ensured people were offered a choice of meal. They told us people on the unit were not able to choose for themselves so staff would make a choice for them. In contrast we observed that people living on Godley Court were offered a choice at mealtime and there was good interaction by staff to promote people's independence when eating.

Our observations during the lunchtime period on the unit for women living with a dementia showed that staff were supporting most people to eat in the lounge rather than the dining room. We asked one staff member about this and were told it was because it was difficult for many of the people who used the service to sit upright in the dining chairs. When we raised this with the registered manager and quality assurance manager they told us this should not be the practice as anti-slip mats had been purchased for the unit to assist people to sit in the dining room.

On the unit for men living with a dementia we noted that at lunchtime one person was shouting for ice cream but as the unit was unsupervised for much of the time they got up and walked away. We also noted a lack of interaction between staff and people in the dining area, due mainly to the fact that staff were providing assistance to people to eat who were in bed.

We discussed with the registered manager that our observations over lunch in two of the units had raised concerns that people were not supported to have a relaxed, enjoyable and social experience during this important time. This had the potential to impact negatively on the amount of food and drink people consumed. The registered manager told us this was unacceptable and action would be taken to improve the situation.

Records we looked at showed staff would contact healthcare professionals if they had any concerns about a person's health. We saw evidence that advice given had been documented in care records.

People who used the service did not express any concerns about the environment of the service. However, we noted a strong malodour at the entrance to the unit for people living with a dementia. We were told arrangements had been made for the flooring to be replaced as a matter of urgency in order to improve the environment.

Inadequate

# Is the service effective?

We observed that improvements could be made to the signage in the service to make it more 'dementia friendly'. We noted that pictures had been used to indicate communal toilets and bathrooms. However bedroom doors need to be personalised to aid individuals living with a dementia to recognise their rooms. We also observed there were sensory displays in place on the unit for people with a dementia but we did not see any staff members encourage people to engage with the sensory objects.

Requires improvement

# Is the service caring?

## Our findings

Although most people we spoke with were unable to tell us whether staff were kind and caring towards them, we observed most staff speak kindly with people during the inspection. Two people who used the service were able to tell us, "There`s no problems with the staff. You could not ask for more from them; they are always there for you" and "The carers here are all very good to me; I get cared for really well and I am happy here." One relative also commented, "If ever I need to go into a care home then I would choose to come in here."

Our observations on both Werneth and Newton units showed that staff had limited interaction with many of the people who used the service and were mainly task-focused in their interventions. We noted one staff member supported a person to eat but they had little meaningful conversation with the person. We also did not observe them interact with anyone else in the lounge area where they were sitting.

Our observations on Godley Court showed that staff knocked before entering people's rooms and ensured people had the privacy they required when personal care was being provided. Interaction between staff and people who used the service was positive. We also noted that one staff member on Godley Court provided good support and reassurance to a person who had become agitated while waiting for a family member to arrive.

Staff told us they would always take the time to listen to people to ensure they were delivering the care they wanted. Comments staff made to us included, "I always ask people before I help them and even then I still talk to them about what I am doing, especially if we are hoisting someone, they may be a bit scared so I talk to them while we are doing it" and "If someone new comes on the unit, then it can take a while to get to know them really well but after a while we get to know all their likes and dislikes."

We asked the registered manager how people were involved in reviewing the care they received. They told us regular review meetings took place which involved people who used the service, their family members if appropriate and representatives from the Clinical Care Commissioning Group (CCG). We noted a review meeting was taking place on the day of our inspection and we were told the views of the person who used the service had been sought in advance of the meeting.

We noted regular meetings took place between people who used the service, their relatives and the activity coordinator to discuss the care provided in Hyde Nursing Home. We saw that positive comments had been made during these meetings.

Requires improvement

# Is the service responsive?

## Our findings

Prior to people moving into the service we were told that assessments were carried out to gather information about people and whether their needs could be met at the home. Records we looked at showed that these assessments had been completed.

We looked at people's records to check their needs, wishes and preferences were taken into consideration when planning their care. We found that whilst people's needs were documented in the care records we reviewed, we found limited information about how they wished their care to be provided.

During the inspection we noted, in some parts of the service, staff did not always respond to people's requests in a timely manner. At the start of our inspection we noted on person on Newton unit was still in bed at 10.30am and unable to reach their call bell. They told us they would like to get up and that they had not yet had a drink. We asked a member of care staff about this who told us this person did not like to get up for breakfast and that they had been checked a few times that morning but had always been asleep. We noted the person was supported to get up as soon as we had raised this with staff. We sat with the person while they had their breakfast and medication. They did not raise any concerns about the care they received.

On the morning of the inspection we observed one person on Newton unit repeatedly ask staff for assistance to move from their wheelchair into a more comfortable chair but, due to being busy on other parts of the unit, staff did not acknowledge their request for some time. We also observed that one person who used the service on Newton had been taken back to their room by staff after lunch but was sitting in their chair in a very distressed state and was calling for staff because they wanted to get into bed. When we brought this to the attention of staff we were told the person would be supported into bed immediately.

Our observations on Godley Court showed us that call bells were answered promptly and staff responded to people's requests for assistance without delay. One of the people living on Godley Court told us, "The staff don`t really get the time to sit down with you and talk, but if I need them they are straight in to see me."

We spoke with the person responsible for organising activities in the service. They told us that activities were provided in the pavilion (the central entrance area to the service) and that people from across all three units were supported to attend. The activity coordinator told us a range of activities were provided including armchair aerobics, aromatherapy, sing songs and bingo. On the day of our inspection we noted 14 people were playing bingo in the pavilion.

People who used the service expressed differing views about the activities provided in Hyde Nursing Home. One person told us there were not enough activities while another person commented that they really enjoyed the singing and hand massage sessions.

During the inspection we did not see anyone who used the service supported by staff to undertake 'homely tasks' such as setting or wiping the dining tables; the involvement in such tasks can help evoke meaningful memories for people.

The registered manager told us that arrangements were made to ensure people's religious needs were met and that leaders from several different faiths visited the service on a regular basis. They also told us that regular visits were arranged to the service by local schools and community groups.

We looked at the way complaints were managed in the service. We noted a log was maintained of any concerns or complaints received regarding Hyde Nursing Home. The log also provided evidence of the action taken to address the concerns. The quality assurance manager told us all complaints were recorded centrally to ensure any themes and trends could be identified.

People we spoke with told us they felt able to raise concerns with staff or the registered manager. Comments people made to us included, "If there is something wrong I just talk to one of the staff but if I needed to see the manager I know I could and she would come to see me" and "I have been here a couple of years now so all the staff know me and I have spoken to the manager many times when I see her around; they are all very nice."

We saw that the service was completing an annual customer satisfaction survey. We were shown the summary of the most recent survey conducted in 2014. We noted that 100% of people who responded to the survey were satisfied to some degree with the service they received. The summary highlighted that to improve satisfaction levels the service needed to increase the level of activities available.

Requires improvement

# Is the service responsive?

The need for staffing levels to be reviewed to ensure staff were consistently delivering good quality care and had sufficient time to spend with people to meet their individual needs was also documented. The quality assurance manager told us the results of the survey had only just been made available to them so as yet there was no action plan in place to take into account the comments raised.

Requires improvement

# Is the service well-led?

## Our findings

The service had a manager in place who was registered with the Care Quality Commission (CQC) as required under the conditions of their registration.

Although people who used the service and their relatives were confident about the leadership in the service, we found some staff were less confident. Some staff told us they felt unsupported by the registered manager and did not feel able to approach them with any concerns. Some staff were also reluctant to speak with us during the inspection due to concerns about how they might be treated after we had left the service. We were told several staff were actively seeking alternative employment due to the culture in the service. We discussed this with the registered manager and quality assurance manager who told us they were disappointed that staff had not felt able to speak with us as an open and transparent culture was encouraged in the service. The quality assurance manager told us they often spent time on the units and that staff were aware they were able to raise any concerns they might have about the service with them.

In contrast some staff told us they enjoyed working in the service and felt they received the support they needed from the registered manager. We observed that staff worked well together as a team during the inspection, particularly on Godley Court. Comments staff made to us included, "I have been here over ten years and I do enjoy working here; we are a good team and work well together" and "There have been a few things in the past I would have liked to talk about, but then I leave it; I don`t bother."

We asked staff about opportunities to discuss the service provided in Hyde Nursing Home and any suggestions they might have to improve practice. Most staff told us meetings were not held regularly and they did not feel they had the opportunity to raise any issues of concern. However, one staff member on Godley Court told us, "We have staff handovers at the end of each shift and we have regular meetings; I think they are good."

Following the inspection we were sent copies of minutes from the most recent staff meetings held in the service in January and February 2015. We noted the most recent meeting with registered nurses in the service had been held in October 2014 and that none had been held to discuss the recent safeguarding concerns raised regarding wound and pressure care in the service and subsequent action plan. However we saw that wound care had been discussed at the meeting in October 2014.

We asked the registered manager about the quality assurance systems in the service. They told us they completed regular audits with the quality assurance team; these included medication audits and monthly audits undertaken to assess the compliance of the service against the current regulations. We saw an action plan was produced following each compliance audit. We noted the required action from the most recent audit in January 2015 was recorded to be in relation to the supervision of staff. However, there was no record of how compliance was to be achieved or the timescale for completion.

We asked the registered manager why the shortfalls identified regarding wound and pressure care had not been identified through the quality assurance systems. They told us this was because there had been no clinical lead in the service since January 2015. However, they acknowledged they were ultimately responsible for the care provided to people in Hyde Nursing Home.

The lack of effective systems to monitor the quality of care people received was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The registered person had not taken the appropriate steps to ensure that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced staff to meet the needs of people who used the service.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**People were not protected against the risks associated with the unsafe management of medicines.** |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**The provider did not have suitable arrangements in place to ensure that people employed for the purposes of carrying on the regulated activity are supported by receiving appropriate induction, training and supervision** |

| Regulated activity | Regulation |
|---|---|
| Accommodation and nursing or personal care in the further education sector<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>**The registered person had not taken proper steps to ensure care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.** |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Action we have told the provider to take

| | |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**The provider did not have an effective system to regularly assess and monitor the quality of service that people received.** |