Mrs Elizabeth Heather Martin

# Clyde Court Nursing Home

## Inspection report

22-24 Lapwing Lane
West Disdbury
Manchester
Greater Manchester
M20 2NS

Tel: 01614341824

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04 October 2017

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## Ratings

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

# Summary of findings

## Overall summary

This inspection took place over three days on 27, 28 September 2017 and 04 October 2017. The first day was unannounced which meant the service did not know in advance that we were coming. The second and third days' were by arrangement.

We last inspected Clyde Court Nursing Home in November 2016. During that inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service received an overall rating of 'Requires Improvement' and we took enforcement action.

Clyde Court Nursing Home is situated in the Didsbury area of Manchester. The home is registered with the Care Quality Commission (CQC) to provide accommodation to a maximum of 41 people who require nursing or personal care. At the time of our inspection, 33 people were accommodated at the home. Accommodation is over three floors and there is lift access. .

At the time of this inspection, the service had a registered manager. However, due to circumstances beyond their control, they were only present for day one of the inspection visit. For the remaining two days, the inspection was supported by the registered provider and deputy manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

During this inspection we identified four breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in respect of: safe care and treatment, consent, person-centred care, and good governance. We also made a recommendation in regards to equality and diversity. We are currently considering our enforcement options.

Not all aspects of the service were safe. For example, clinical risk assessments and guidance completed by Speech and Language Therapy (SaLT) for people considered at high risk of choking were not always followed. We also found unsafe practice which potentially left the home vulnerable to unwanted visitors and provided a route for people who used the service to leave unnoticed by staff. This was because people living at Clyde Court were able to answer the front door unsupervised.

People's medicines were managed in a safe way and we found systems in place which sought to ensure the safe storage, administration, ordering and disposal of medicines. This included medicines classed as a controlled drug.

Improvements had been made around systems for the prevention and control of infections and work had been completed to improve the physical environment.

We reviewed staffing levels and found these to be adequate to meet the needs of the people living in the home.

Policies and procedures for the safe recruitment and selection of staff were robust.

Accidents and incidents were recorded over two separate systems. This meant information was not captured consistently and it was not always clear what remedial actions had been taken to reduce the likelihood of such events occurring again in the future.

Staff received training which enabled them to carry out their roles effectively. Training included moving and handling, health and safety, safeguarding, first aid and infection control. Registered nurses had access to continuous professional development opportunities.

Mental capacity assessments had not been completed in line with the requirements of Mental Capacity Act 2005. We found examples of assumptions being made regarding people's capacity to make decisions based on people's age or medical diagnosis rather than an assessment that the person had been determined to lack capacity to make the decision independently.

The mealtime experience was pleasant and people told us they enjoyed the food at Clyde Court. All meals were freshly prepared and people were offered a variety of choices.

People who used the service and their relatives told us staff were caring. We also observed a number of positive interactions. Staff treated people with kindness and explanations were provided before undertaking care tasks with people.

The home was engaged in the 'Six Steps' End of Life Care Programme. This meant that for people who we were nearing the end of their life, they could choose to remain at the home to be cared for in familiar surroundings by people they know and could trust.

People who used the service at Clyde Court were from diverse backgrounds and the home benefited from a workforce that was representative of the local community.

We saw that a number of people were able to maintain community links by attending a local day centre and some people were regularly taken out by their family members. Communal activities within the home were provided and these ranged from armchair exercises, bingo, films nights and an entertainer who frequently visited the home. However, activities provided on a one-to-one basis were limited, particularly for people that were isolated on account of needing to be cared for in their own rooms.

People's care and support was not always delivered in a person-centred way and did not take sufficient account of their needs, likes, dislikes and personal preferences.

We looked again at systems for governance and quality assurance. We saw a new system had been established and there was a variety of audit tools in place which looked at areas such as infection control, nutrition, building maintenance, mealtimes and observational audits. There was a medicines audit tool but the template document in use was out of date and referred to the CQC's old methodology and way of inspecting pre the changes implemented in 2014. Overall, we recognised that some improvements had been made in respect of the number of audits being completed but further work was required to ensure remedial actions were clearly documented.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not consistently safe.

Care plans and risk assessments for people deemed as having an 'unsafe swallow' and at high risk at mealtimes were not consistently being followed.

The safety and security of the home was compromised and people were placed at risk due to ineffective procedures when visitors wished to gain access to the home.

People's medicines were managed safely.

Safe systems for the recruitment and selection of staff were in place.

### Is the service effective?

**Requires Improvement**

The service was not consistently effective.

Capacity assessments had not been completed in line with the requirements of the Mental Capacity Act 2005.

People's routine health needs were met and people had access to primary medical services.

The overall mealtime experience was pleasant and the food was freshly prepared.

### Is the service caring?

**Requires Improvement**

The service was caring.

Staff treated people with kindness and explanations were provided before a task was completed with people.

Feedback from people who used the service and their relatives demonstrated staff were caring.

Staff at Clyde Court were engaged in the 'six steps' programme to support the delivery of end of life care.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

Care and support was not sufficiently person-centred.

The response to people living with additional needs, such as pressure sores, was not consistent.

The activities were too generic and did not take sufficient account of people's needs and preferences.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well-led.

Systems for governance and quality assurance remained an area of concern.

Crucial information was not shared with us relating to people who used the service. This questions the transparency and openness of the service.

Investors in People accreditation had expired.

# Clyde Court Nursing Home

**Detailed findings**

## Background to this inspection

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

We last inspected Clyde Court Nursing Home in November 2016. During that inspection we identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service received an overall rating of 'Requires Improvement' and we took enforcement action.

This inspection took place over three days on 27, 28 September 2017 and 04 October 2017. The first day was unannounced, the service did not know we were coming. The second and third days' were by arrangement. The inspection team consisted of one adult social care inspector.

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 information we held including safeguarding information and notifications made to the Care Quality Commission. A notification is information about important events which the service is required to send us by law.

We contacted Manchester City Council's contracts and commissioning teams and local NHS community services for information they held on the service. We also contacted Manchester Healthwatch. Healthwatch is an organisation responsible for ensuring the voice of users of health and care services are heard by those commissioning, delivering and regulating services.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of the people who could not talk to us.

We spoke with six people who used the service and four visiting relatives. We also spoke with the registered manager, deputy manager, clinical lead nurse, three registered nurses, and seven members of staff including care staff, the administrator, cook and domestic staff.

We looked at records relating to the service including care records and associated documentation, staff recruitment files, medicines records, policies and procedures and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

We asked people whether they considered Clyde Court to be a safe place to live. Comments from people who used the service included, "I feel very safe here. I was quite unwell when I first arrived but they have looked after me and I would recommend the home to anyone."; "The staff are kind, always very busy, but they do their best."; "I sometimes panic at night if I think no one is coming when I press my buzzer but the staff do come eventually." Comments from visiting relatives included, "I would agree it's a safe place. I don't have many concerns."; "I visit every day so if I saw anything I considered to be unsafe I would defiantly raise it."

On arrival at Clyde Court for day one and two of our inspection visit, a person who used the service answered the door unsupervised and allowed us access into the building. We spoke with the registered manager about this and we were told this person frequently answered the door and it was 'just something they did'. However, we considered this to be unsafe practice which potentially left the home vulnerable to unwanted visitors and provided a route for other people who used the service to leave unnoticed. For example, people who lacked mental capacity and by law, were unable to leave Clyde Court unsupervised could easily have absconded. Further consideration needs to be given as to how this person can contribute to daily life at Clyde Court without exposing themselves others to potential risks.

At our last inspection of Clyde Court in November 2016, we raised concerns with regards to how staff at the home managed pressure area care. At the start of this inspection, we asked the registered manager to identify to us people who had a current pressure area. We were told only one person had an historical pressure area which was now 'well healed' and that no one else was being actively treated. However, after we completed our on-site inspection, the registered manager notified CQC of a person living at Clyde Court who had a grade four pressure sore. When a person is diagnosed as having sustained a pressure sore graded three or above, this is deemed a serious event that requires active nursing care and treatment. As this person's circumstances were not disclosed to us during the inspection visits, we asked the registered manager to send us all relevant documentation linked to this person's pressure care. On reviewing the documentation, we were able to confirm this person had been actively receiving treatment for a pressure sore at the time of our inspection visits. More widely, we saw a referral had been made to the NHS tissue viability nurse (TVN ) as the wound was failing to heal, the nurse then visited the home to complete a review. Records provided to us demonstrated the TVN had highlighted concerns to the management regarding inconsistencies in the recording of two hourly turns. This meant the service was unable to demonstrate effectively that safe care and treatment had been delivered in line with this persons care plan.

We also reviewed the care records of one person who was identified as having an unsafe swallow. We saw an NHS National Patient Safety Agency guidance document and a risk feeding protocol. These documents had been completed by a Speech and Language Therapist (SaLT) in respect of risks associated with eating and drinking, such as choking and aspiration. Aspiration is when food or liquid enters the lungs placing a person at risk of aspirational pneumonia and other associated complications. The guidance and protocol gave clear instructions for staff to follow when supporting this person. For example, whilst seated in their wheelchair, a cushion needed to be placed behind this person's back to aid good posture; staff must sit

directly opposite the person; and, specific assistance was required in respect of feeding and swallowing. However, during our observations at lunchtime, we saw this person was not being supported by staff as per SaLT instructions. The care assistant helping this person was seated to the side and not in front, and insufficient time was given between mouthfuls. The person was also left unsupervised for a period of time and made attempts to eat and drink independently which placed them at risk. We raised our concerns with a registered nurse who intervened and advised the care assistant accordingly. We also asked the care assistant if they had prior knowledge of the SaLT guidance and they confirmed to us they did not.

We reviewed the management approach to accidents and incidents and found two separate forms were in use for recording of such events. One method involved recording events in an accident book, and the other method involved detailing events on an internal incident report form. Whilst we accepted that accidents and incidents were being recorded, the different methods being used meant different pieces of information were captured. We found staff were not consistent in which form they completed and it was not always clear who had completed either of the forms. Furthermore, from the information provided on both forms, it could not be determined what control measures had been implemented to reduce the likelihood of such events occurring again in the future. We discussed this with the provider during feedback and sought assurance that a more robust and effective system for the recording and monitoring of accidents and incidents would be implemented without delay.

In respect of the concerns identified above, this demonstrated a failure to do everything that is reasonably practicable to mitigate an already identified risk.

This is a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to safe care and treatment.

At our last inspection of Clyde Court in November 2016, we identified a number of issues relating to the prevention and control of infection and environmental concerns regarding the building and premises. During this inspection, we found improvements had been made. For example, staff had been provided with infection control refresher training and two bedrooms had been modernised and refurbished with new flooring laid. We also visited the basement laundry area where we were told new shelving units had been installed to ensure items were stored off the floor and the area had been repainted. We also saw an amount of structural building work had been completed to rectify areas of concerns identified at our last inspection. Décor on the upper floors was dated in presentation but the provider was seeking to address this through an on-going programme of improvements.

We found the historical issues relating to commodes in peoples' bedrooms not being emptied in a timely manner remained an on-going concern. This had been consistently raised at both relative and residents meeting. In the absence of the registered manager to discuss this we spoke with the provider and were told it was a minority of staff who were responsible and going forwards, the management team would take a more robust approach to ensure this did not happen again in future. In July 2016 the Community Infection Control Team completed an inspection and audit of Clyde Court and the home scored 74% (amber rating) which meant further improvement was required. The registered manager and provider should continue to ensure all areas for improvement identified on the infection control action plan are addressed in a timely manner.

We looked at how people's medicines were managed and we found systems in place which sought to ensure the safe storage, administration, ordering and disposal of medicines. This included medicines classed as a controlled drug. We looked at how medicines were monitored and checked by members of the management team and as the home was dual registered, the nursing staff checked medicines for those

people with nursing needs and senior carers checked medicines for those people with residential needs.

We reviewed a sample of medicine administration records (MAR) and found each contained a photograph of the person, as well as information about any allergies and details about how the person liked to take their medicines was recorded. Systems were also in place to record fridge temperatures, medication returns and any medication errors. We saw people's names were added to medicines stored in boxes and bottles, along with the date that the medicine was opened. Protocols for 'when required' (PRN) medicines were in place which enabled staff to determine when they should administer these type of medicines.

Safe recruitment and selection practices were followed which sought to ensure potential new employees were safe to work with vulnerable groups. We reviewed a sample of staff files, which included newly recruited staff, and found application forms had been completed and gaps in employment had been accounted for. Pre-employment checks had been completed regarding employment references, proof of identity and checks with the Disclosure and Barring Service (DBS). We also checked how the service ensured registered nurses who worked at Clyde Court maintained their registration. We saw the service kept a record of their Nursing and Midwifery Council (NMC) pin numbers and when their revalidation was due. Records showed all the registered nurses who worked at Clyde Court were registered and had a valid pin.

We reviewed staffing levels at Clyde Court by looking at a sample of staff rosters covering the previous three months before our inspection and through talking to people. Comments from people who used the service included, "The staff are often very busy but I don't wait too long if I need help."; "Everywhere can always have more staff but I think there is enough staff here to help me." Comments from visiting relatives' included: "I've never had a concern about staffing levels. If [relative] needs help, the staff are on hand."; "I always ask [relative] if the staff are around to help and I'm always told 'yes' I've no concerns of my own." Comments from staff included: "It's a busy home and mornings can be difficult sometimes but on the whole there is enough of us."; "I wouldn't say we were short staffed but you can never have enough staff."; "People can get up and go to bed when they please so we work around the residents. This is challenging for staff, especially first thing in the morning but it's about resident's choice."

The staffing establishment at Clyde Court consisted of the registered manager, a deputy manager, clinical nurse lead, care assistants, a cook, domestic staff and a maintenance person. A minimum of one registered nurse would be on duty at all times. The current registered manager and deputy were not registered nurses but they were supported by the clinical nurse lead. However, through our discussions with the registered provider, members of the management team and other registered nurses, we learnt staff had raised concerns about clinical oversight across the home and the capacity of the clinical nurse lead to deliver enhanced levels of nursing care whilst maintaining line management responsibilities. In response to these concerns, we were told plans were in place to recruit an experienced registered nurse to the role of deputy home manager and they would be supported by the clinical nurse lead. Overall, we were satisfied sufficient numbers of staff were employed to meet people's needs.

We looked to see how the service sought to protect people from abuse and found there were appropriate safeguarding and whistleblowing policies and procedures in place. Staff we spoke with demonstrated an understanding of the types of abuse and the procedure to follow if they suspected that a person was at risk of or was being abused. Staff understood whistleblowing procedures and told us they would not hesitate to raise an alert if required.

We checked to ensure people had a personal emergency evacuation plan (PEEP) in place. A PEEP provides details about the support people would need in the event of an emergency evacuation. We saw a PEEPS grab file was maintained and located in the nursing office and the registered manager also held relevant

records in their office. On upper floors, we saw an emergency rescue chair was located and available for use.

Health and safety and building maintenance records were examined and found to be in order with all relevant safety certificates in place. The home had a business continuity plan with relevant members of staff aware of actions to take in the event of a business failure caused through an unplanned event.

Requires Improvement

# Is the service effective?

## Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found mental capacity assessments had not been consistently completed to determine whether people had capacity to make specific decisions. For example, we looked in the care records of four people and we saw historical information which indicated these people had fluctuating capacity. However, a mental capacity assessment had been completed at the home which did not meet the requirements of the MCA and described each person as lacking capacity to make decisions in all areas of their lives. We found there was insufficient evidence within their care records to demonstrate why this had been determined to be the case. We also looked at an application that had been made by Clyde Court to the local authority to deprive a person of their liberty. It was evident from the documentation submitted by Clyde Court that assumptions had been made about this person on the basis of their age and diagnosis, rather than an assessment undertaken that had concluded the person lacked mental capacity to consent to their care and treatment or understand the safety implication of not receiving the care provided.. We found the DoLS application was not supported by any additional information such as risk assessments, capacity assessments or best interest meeting decisions and we noted the local authority had rejected the request to deprive this person of their liberty indicating that the person had capacity to make the decision to receive care and treatment or not if that was their decision. This demonstrated a failure to adhere to the principles of the Mental Capacity Act 2005.

This was a breach Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to the need for consent.

We looked at induction, training and professional development staff received to ensure they were fully supported and qualified to undertake their roles. We saw newly recruited staff completed an induction period which included shadowing opportunities and completion of mandatory training such as moving and handling, health and safety, safeguarding, infection control and the Care Certificate. The Care Certificate is a set of standards that social care and health workers adhere to in their daily working life. It is the new minimum standard that should be covered as part of induction training for new care workers. Existing care staff were provided with opportunities for vocational learning by completing level two and level three qualifications in care. Staff with managerial responsibilities had completed, or were working towards, level five qualifications.

We checked to ensure staff were receiving regular supervision sessions and that annual appraisals were completed. Staff supervision provides a framework for managers and staff to share key information,

promote good practice and challenge poor practice. By checking records and through talking to staff, we saw supervision was being completed on a regular basis. Key topics discussed during supervision included safeguarding, training and development and workloads.

On day one of our inspection, we completed observations during lunchtime service. We did this by completing a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. It was clear from the chatter that mealtimes were a relaxed and social occasion. People told us, and we observed people could choose what to eat from a choice of freshly prepared food. Comments from people who used the service included, "The food is wonderful.", "I can choose what I want and if I don't like what's on offer, I can have something else." One relative told us, "[Person] doesn't have a big appetite but the staff are very accommodating and [Person] has actually gained weight."

We spoke with the cook and the kitchen assistant about the dietary needs of the people living at Clyde Court and found they were aware of which people had specific needs, such as diabetes. They were knowledgeable about how to prepare foods for those with additional dietary needs and how to fortify food and fluids for those individuals who needed to gain weight. The cook also knew the food preferences of each person and we saw this was documented by the home.

In the sample of care records we viewed, documentation relating to eating and drinking was completed and up-to-date. People were weighed on a regular basis and nutrition assessments had been completed and reviewed. Where appropriate, referrals had been made to the community dieticians timely and follow-up actions completed.

People's care records showed that their routine day-to-day health needs were being met. People had access to a GP and we saw that district nurses visited the service on a regular basis to deliver care to those people funded for residential care. Through our discussions with members of the district nursing team, we learnt that communication can sometimes be a challenge and that staff from Clyde Court do not always share relevant information in a timely manner. We spoke with the clinical nurse lead about this who agreed to ensure that current channels of communication would be reviewed to ensure a consistent coordinated approach.

People who used the service at Clyde Court benefited from the support provided by the local NHS Nursing Home Team. This team made regular visits to the home to carry out clinical and medicine reviews. The Nursing Home Team could also issue prescriptions for certain ailments when this was deemed necessary to treat a person presenting with any new symptoms. This meant that people received regular health checks and medicine reviews that promoted their wellbeing and helped improve their quality of life.

Requires Improvement

# Is the service caring?

## Our findings

People told us staff were caring. One person commented, "The staff do their very best under difficult circumstances, but everyone is caring. Another person told us, "I have no worries here and the staff look after me well." A third person told us, "The carers as a whole are fantastic." A fourth person said, "Sometimes staff at night can be a bit grumpy when I press my buzzer but mostly everyone is very kind and caring."

We spoke with a number of visiting relatives, one person told us, "The staff are very committed and caring. I've no concerns." Another said, "There have been one or two issues since [relative] moved in but things are getting better and I'd agree that staff are caring." A third relative told us, "The staff work really hard and are always very busy but they remain caring."

We reviewed how people participated in planning and reviewing their care and support, including involvement of loved ones or lawful representatives. We found there was an inconsistent approach to this and relevant people were not always involved. Records were not sufficiently detailed to demonstrate how and when people may have been involved, or indeed, if they had chosen to not be involved.

People who used the service at Clyde Court were diverse and multi-cultural. The service also benefited from an equally diverse workforce which was reflective of the local community. Through talking to staff and members of the management team, we were satisfied the ethos and culture at the home was non-discriminatory and the rights of people with a protected characteristic was respected. Protected characteristics are a set of nine characteristics that are protected by law to prevent discrimination. For example, discrimination on the basis of age, disability, race, religion or belief and sexuality.

However, to fully embed the principles of equality, diversity and human rights in all aspects of life at Clyde Court, we recommend the service consults CQC's public website and seeks further guidance from the online toolkit entitled; Equally outstanding: Equality and human rights - good practice resource.

Throughout our inspection visits we observed a number of positive interactions between staff and people living at Clyde Court. Staff treated people with kindness and explanations were provided before a task was completed with people.

One person who used the service told us how staff had gone the extra mile to ensure they had a reliable WIFI connection to their bedroom. Historically there had been issues with the reliability of the WIFI signal but the provider had continually sought solutions to this which included engineer visits, the cost of which had been fully met by the provider. Finding a solution to the WIFI problem was extremely important to this person as they regularly enjoyed online content via the internet such as watching old films and documentaries.

We looked at Clyde Courts approach to end of life care (EoLC) and found the service was engaged in the 'Six Steps' End of Life Care Programme. This is the North West End of Life Programme for Care Homes and is co-ordinated by local NHS services. This means that for people who are nearing the end of their life, they could choose to remain at the home to be cared for in familiar surroundings by people they knew and trusted.

At our last inspection of Clyde Court we identified that people's privacy and dignity was not always respected. This was because visiting health care professionals had carried out clinical procedures with people in communal areas. During this inspection, we observed a Podiatrist visiting a person who was seated in the lounge area. Verbal consent was sought from the person before treatment commenced and privacy screens were used to protect the persons' dignity.

Requires Improvement

# Is the service responsive?

## Our findings

When we asked people how responsive they considered Clyde Court to be in meeting their needs, we received a mixed response. One person who used the service told us, "When I arrived here I was very poorly but now I'm so much better. This is testament to the staff here and NHS staff." Another told us, "On a day to day basis I don't think there is enough going on. Its gets very boring." A third person said, "I spend a lot of time in my room which gets me down sometimes. It would nice to have a change of scenery now and then." Comments from visiting relatives included, "My [person] doesn't enjoy the communal activities, I wish things would be more suited to [persons] needs. Another commented, "I think the team are responsive. If I have any issues I can speak to the manager or even the owner and things get done."

We looked at how people who used the service were engaged in social and leisure activities. We saw that a number of people were able to maintain community links by attending a local day centre and some people were regularly taken out by their family members. Communal activities within the home were provided and these ranged from armchair exercises, bingo, films nights and an entertainer who frequently visited the home. An activities coordinator was employed on a part-time basis and activity records were maintained which included the type of activity completed, number of people involved and the time and date. However, activities provided on a one-to-one basis were limited, particularly for people being cared for in their own rooms.

At our November 2016 inspection, we reported that some improvements had been made in respect of information contained within people's care records. Improvements at that time included the development of a one page profile that provided a summary of people's care needs and included a photograph of the person and details about how they wanted to be supported. However, at this inspection, we identified the one page profiles had not been completed for everyone and insufficient progress had been made to strengthen the 'person-centred' aspect of people's care records. For example, records remained too focused on medical/nursing issues and not enough information was captured about the individual concerning their life history, personal preferences, likes and dislikes, and people who are important to them. Additionally, daily notes completed by staff focused on task based care and did not reflect how people who used the service were being supported more widely. For example, people's goals were not identified and there was no information contained to demonstrate the support provided to achieve these on a daily basis.

We reviewed how people participated in planning and reviewing their care and support, including involvement of loved ones or lawful representatives. We found there was an inconsistent approach to this and relevant people were not always involved. Records were not sufficiently detailed to demonstrate how and when people may have been involved, or indeed, if they had chosen to not be involved.

We spoke at length with a registered nurse who had delegated responsibility to complete this work and they acknowledged this area of care and support planning was still 'work in progress' and that insufficient time had been allocated to complete this work effectively. In particular, the time required to involve people and their loved ones in order to capture such information. In the absence of the registered manager, we also raised this issue with the provider at feedback.

The recurrence of similar issues identified at our last inspection, demonstrated a failure to learn lessons from past experiences which meant care and support was not delivered in a person-centred way or in line with people's assessed needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to person-centred care.

Both the registered manager and provider were visible around the home and operated an 'open door policy.' Information was readily available and displayed prominently detailing how complaints can be made. People told us they felt confident in raising concerns and that issues would be taken seriously. The service maintained a complaints log which detailed outcomes. We also saw many examples of compliments to the service through thank you cards and letters of appreciation.

Requires Improvement

# Is the service well-led?

## Our findings

This is the third consecutive rating of 'requires improvement'. This meant the provider had failed to improve the overall rating of the home from 'requires Improvement'. The expectation would be that following the previous 'requires improvement' rating, the provider would have ensured the quality of care received had improved and attained a rating of either 'Good' or 'Outstanding' at this inspection. This had not been the case so we are reviewing our enforcement options. We plan to meet the registered manager and provider to seek further assurance as to how they are going to address the quality of care and ensure that it improves. Additionally, we will return to the home again in due course to review progress.

Following our last inspection of Clyde Court in November 2016, we rated the home 'inadequate' for the key question of 'well-led.' This was because audits were either not fit for purpose or had not been completed regularly and areas identified during audits as needing action, had not always been acted upon. We also found surveys were not monitored and action plans were not developed from them. As a consequence, we served a warning notice for Regulation 17. A warning notice compels a registered person to take action to rectify a breach of regulations.

We looked again at systems for governance and quality assurance. We saw a new system had been established and there was a variety of audit tools in place which looked at areas such as infection control, nutrition, building maintenance, mealtimes and observational audits. There was a medicines audit tool but the template document in use was out of date and referred to the CQC's old methodology and way of inspecting pre-2014. We also saw the registered provider was completing their own audits but the way in which information was recorded was not consistent and many of the provider 'audits' had simply been handwritten on loose pieces of blank paper and were not structured.

We recognised that some improvements had been made in respect of the number of audits being completed but further work was required to ensure remedial actions were clearly documented. We raised this with the provider during feedback and we were assured immediate action would be taken to ensure recording of outcomes and actions was consistent.

We looked at how information was shared with people who used the service and their relatives and found that resident and relatives' meetings were taking place but historically these were poorly attended. We also saw that questionnaires had been sent out and responses had been collated. However, it was not always clear what action had been taken in respect of issues raised via the questionnaires. In the entrance hall a 'You said, We did' notice board was displayed but the information displayed was not up-to-date.

We saw that during March 2017 the local authority contracts and quality monitoring team from Manchester City Council had visited Clyde Court and a number of key areas for improvement had been identified and an action plan developed. However, our findings from this inspection were in keeping with many of the issues previously identified by the local authority. This was further evidence that insufficient progress had been made.

The breaches identified during this inspection demonstrated that governance systems and quality assurance remain an area of concern. Furthermore, the matter relating to the person who used the service with a pressure sore and the information not being disclosed when asked during the inspection, brings us to question the transparency and openness of the management.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with regard to good governance.

The provider had previously been in receipt of Investors in People (IIP) accreditation but at the time of our inspection visit this had expired. The IIP accreditation programme looks at the leadership, support and management of employees and identifies good practice or areas for improvement.

Staff meetings were held on a regular basis and these were a combination of general staff meetings and meetings for registered nurses. Minutes of meetings demonstrated that a variety of issues and topics were discussed. Staff we whom we spoke confirmed they found the meetings useful and that they felt able to contribute to the wider running of the home through suggestions.

We looked at how the service works in partnership with others and how the quality of care provided meets the most up-to-day clinical and quality standards. We saw support was being offered by the local authority in respect of the home working towards completing the Dignity in Care Award and that staff had already started working towards the Gold Standard Framework for End of Life Care.

It is a legal requirement that providers display the rating they received at their last inspection, within the home and on their website if they have one. The rating of 'requires improvement' from our last inspection in November 2016 was not displayed in the home. The provider does not have a website. This meant people who currently used the service and their relatives, or anyone considering using the service, did not have access to the inspection report to determine the quality of care being provided at the home. We are reviewing this matter outside the inspection framework.