New Century Care (St. Leonards) Limited

Clyde House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**

Summary of findings

Overall summary

Clyde House provides accommodation, personal and nursing care for up to 48 older people, some of whom have limited mobility, are physically very frail with health problems such as heart disease, diabetes and strokes. There were people at Clyde House also living with dementia and receiving end of life care. There were 35 people living at the home at the time of our inspection. Accommodation is arranged over three floors and each person had their own bedroom. Each floor has lift access, making all areas of the home accessible to people. The top floor known as Tay Wing provides care and support for up to 14 people who live with dementia and there were currently 11 people on Tay Wing.

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

We carried out an unannounced comprehensive inspection of this service on 7 and 9 October 2015. After that inspection we received new information of concerns in relation to people's safety and insufficient experienced staff. As a result we undertook a focused inspection 25 February 2016 to look into those concerns. This report only covers our findings in relation to this topic. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clyde House Home on our website at www.cqc.org.uk

Whilst there is a manager recorded as registered, we were informed that that the manager has now left the service. An interim manager has been in post since December 2015. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated regulations about how the service is run.

Risks to people's safety and welfare had not always been appropriately addressed. People were placed at risk of falls and injuries due to poor positioning in chairs and lack of appropriate risk assessments. People were also placed at risk of choking whilst they were assisted with meals as their meals were not of correct consistency and they were not placed in an upright position. .

Care plans did not all reflect people's assessed level of care needs and care delivery was not person specific or holistic. We found that people with specific health problems such as wound care did not have sufficient guidance in place for staff to deliver safe care. This had resulted in potential risks to their safety and well-being. Injuries to people had not been recorded and there were no care plans or risk assessments in place to prevent a re-occurrence of injury or to ensure peoples safety.

There were insufficient numbers of suitably skilled and experienced staff deployed in the service to meet people's needs. This meant that people waited unreasonable lengths of time for care and for assistance with their meals. Staffing deployment had impacted on people receiving the support required to ensure their

safety, health and nutritional needs were met.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

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

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

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

The management, administration and storage of medicines was safe.

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

Clyde House

Detailed findings

Background to this inspection

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

The inspection took place on the 25 February 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

Three inspectors undertook this inspection.

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

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

We spoke with 14 people living at the service, five relatives, six care staff, the chef, the activity co-ordinator, two housekeeping staff, two registered nurses, the area manager and the interim manager.

Inadequate

Is the service safe?

Our findings

Not everyone told us that they felt safe. We received differing information from people which included, "It depends who is around to help me, I see so many new faces that it is sometimes confusing and I become worried," and "No I don't always feel safe." We were also told, "I have no worries, ''I'm safe and okay," and "If I felt unsafe I would tell someone."

The provider had not managed risks to individuals' safety and welfare appropriately. Before this inspection we received concerns that specific people had been placed at risk from falls and choking (whilst eating) due to poor positioning. We looked at care plans to ensure people were safe and risk assessments to gather an overall picture of how staff kept people safe. We found that whilst there were moving and handling assessments in place not all contained information of safe positioning whilst sitting in standard armchairs. Chairs had not been appropriately assessed to meet people's individual needs. For example we had evidence of one person sitting in an armchair with a foot stool in a position that was clearly unsafe. We found that this person had now been placed in a recliner chair. There was no information within the care plan of why the recliner chair was now required or an assessment undertaken that identified this was an appropriate chair for them. This person had not been referred to the occupational therapist for their expert advice. We also found that there had been no discussion with the family or a best interest meeting held as this person was living with dementia and was unable to participate in discussions to keep themselves safe. The lack of appropriate risk assessment had placed this person at risk from injury. Staff were not able to tell us what a safe position was for this person.

Another person had a chair that had been specifically made for their use after being assessed by an occupational therapist. However the person did not use this chair during the inspection. We asked staff why the chair was not being used. We were told that they hadn't had time to move the person from the wheelchair to their special chair. The wheelchair did not give the person the support needed to meet their assessed needs. The family told us during the inspection that the chair was to be used to ensure the person was in the correct position to eat and to ensure that their body was in comfortable position.

Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, and pressure damage.However not all reflected changes to their health and welfare. For example, one person had a pressure ulcer (partial-thickness skin loss or damage) to their left ankle, a skin tear on their right shin, bruising to their right calf and ankle and a red broken spot on their left hand. We found that the only documentation completed was a body map. There was no record within daily notes and care plans that identified what action had been taken such as the dressing used. The staff had not followed the organisation policies in place in respect of wound care documentation. This stated there should be wound care plans and photographs of wounds for staff to monitor improvement or deterioration. These were not in place. None of the risk assessments for this person had been updated to reflect the changes to their skin integrity such as the waterlow score. The waterlow score is an assessment tool that gives an estimated risk for the development of a pressure sore in a given person. The interim manager had not been informed of these wounds and injuries. The lack of documentation and knowledge of wounds placed the person at risk from receiving inappropriate care.

There were people who had arrived to Clyde House recently from another of the providers homes. We were told that all people who had moved in had had a full needs assessment on transfer and this was confirmed. However care plans that had transferred with people were not rewritten and we found that some were inaccurate and placed people at risk by staff who did not know them. For example there were instructions for one person who lived with diabetes that if the blood sugar was above 20 mmols that meant they were hypoglycaemic and required a glass of milk and sugar. However hypoglycaemia is a low blood sugar not high blood sugar. The action of giving milk and sugar to a person with a blood sugar of 20 mmols is potentially a high risk to their health.

Risk associated with the use of pressure relieving equipment had not always been assessed and used appropriately. For example, four pressure relieving mattresses were found to be set on the wrong setting for individual people. One person's weight was 60kgs and their mattress was set at 40kgs. Pressure relieving mattresses should be set according to people's individual weight to ensure the mattress provides the correct therapeutic support. The risk of pressure mattresses being incorrect is that it could cause pressure damage. We also saw that two people whose risk assessment stated they were at high risk of pressure damage were sat in one position without a pressure cushion or a change of position.

We looked at people's food and fluid records. The care plans directed staff to monitor people's fluid intake when it had been identified the person was at risk from dehydration. Some records were incomplete and none were added up to provide the total amount of fluid taken over 24 hours. Therefore the records would not be an effective way of monitoring how much they had eaten or drunk. For one person who was unable to ask for drinks or drink independently, their records identified that they had not received sufficient amounts of drinks on three consecutive days The registered nurse told us that the person needed to be monitored as they were not drinking well but the manager informed us that there was no reason for the person to be on a fluid chart. This person was at risk from pressure damage and dehydration.

One person had been identified as being at risk of choking when eating. The speech and language therapy team had assessed the person and advised they receive a soft (fork) mashable diet and be sat upright and supervised throughout meals. We saw that the person was provided with a meal that included green beans that were served whole. The person was sat in a recliner chair and did not have staff present with them whilst they ate their meal. A senior care staff member intervened when we queried this and this person was then taken through to the dining room and sat in a wheelchair to eat their meal. The meal was changed to one that was the correct consistency. We saw a further example of a person being assisted in a semi reclined position in bed whilst the care directives stated that they should be sitting upright. Guidance from health professionals had not been followed which placed these people at risk of choking.

People at risk of developing pressure wounds had care plans in place that gave staff instruction about how frequently they should be repositioned. Staff told us they repositioned people every four hours, however we found that this was not happening. During our inspection people were sat for up to six hours without being offered a change of position or a visit to the bathroom. On Tay wing one person sat asleep in a chair in the lounge from 9:30 am until they were woken for lunch and remained sitting there until 3pm when they were taken to their room for personal care. We saw other charts that showed that some people had gone for longer than four hours without being repositioned. Staff told us that this happened on occasion when they were busy and could not get to people in time. One visitor told us that the previous day one person had been left in the lounge despite staff being told that the person was uncomfortable and wanted to go to bed for a rest for seven hours. This has been referred to social services under safeguarding.

Accidents and incidents had not always been documented when they occurred. Two people who had injuries and unwitnessed bruising. We could not find any supporting accident forms completed that

identified when they occurred. Looking through daily notes we could not find any supporting documentation as to when they had been noted or what action was taken. The only documentation which mentioned any injuries were body maps. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect people from harm. The provider also could not demonstrate there had been any learning from accidents and incidents.

People were not always protected by robust infection control measures. Staff were seen carrying soiled laundry against their uniform with no aprons and gloves on. Staff were also seen wearing the same gloves whilst going from one person to another when supporting people in their rooms. This meant there was a potential of cross infection between the staff member and other people being supported.

The risks to individuals' safety and welfare had not been assessed and managed effectively. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before the inspection we received concerns that there were not enough trained and experienced staff to ensure peoples' individual needs were met and to ensure their safety. We confirmed this on the day of inspection.

The allocation sheet for the day of inspection told us that there were three care staff on Tay wing, which we confirmed. However there was also supposed to be a RN. At 09:30am there was still no RN. The three care staff said that they hadn't seen a trained nurse yet. One staff member said, "Not sure who is the nurse today." Another staff member said, "There is no senior care staff but we are all doing our best." We asked if they had had a handover from night staff but said they had not. This meant any changes that may have occurred overnight such as injury, sleeplessness or feeling unwell were not known by staff. An RN arrived on Tay unit at 10 am. It was not clear from discussion with the RN of how staff were being deployed that morning and why there had been no RN on Tay wing. We observed that people in the communal area were not always appropriately supported or supervised during the morning. One person was sitting asleep with a beaker of tea from 09:30 am until lunch was served, our observations told us that no-one interacted with this person during that time and no assistance was given with drinks.

On the middle floor there was one care staff member supporting 13 people until an agency staff member arrived at 10 am. The interim manager said there was another staff member on that floor but that was not what staff told us or what we saw. The one care staff member on the middle floor was also answering the front door. The staff member was rushed and told us that all of the people they were looking after needed two staff for their care needs. We saw examples on this floor that identified that there were not enough staff. One person was calling out for staff, their bed had been partially stripped, this person told us, "Waiting for staff to help me, they are short staffed." At 09:55 am we visited one person whose tea and toast was cold and untouched and the person was lying with their head on their bedrail bumper and not in a position to eat their breakfast. People were being assisted with breakfast by the agency nurse between 10:30 am and 11:00am. This was not recorded as their individual preference.

The interim manager told us there was a shortage of two staff members on the garden floor as the agency staff had not arrived. The garden floor had 11 people and there was one care staff member on their own from 8 am until 10 am when an agency care staff member arrived. However we were told that two new registered nurses (RN's) recently employed as deputy manager and clinical lead were able to step in to the shortfall as they were supernummery. This was not the most appropriate solution as they had not completed their induction. Staff said, "We need more staff, we know there are interviews going on," "It's hard going at the moment but we try our best."

Staff struggled to provide care and to supervise people in communal areas. We observed people were left for up to 55 minutes in the lounge area without interaction. We also noted that people did not have access to a call bell, which isolated them further. Staff were not able to offer assistance to meet people's individual needs.

People and relatives told us that call bells were not responded to promptly. One person said, "There are just not enough staff around. You can wait ages for a call bell to be answered and I've had several accidents, which is really embarrassing". Another person said, "Sometimes they [staff] say 'We're busy; you'll just have to wait your turn'". A relative told us, "I'm not impressed. There are just not enough staff; people are left sitting for too long waiting for assistance." Another relative said, "I come most days and staffing is a problem – sometimes there is only one care staff on the garden floor, it's not enough to help people with their meals and give them the care they need." This was confirmed by staff we spoke with. One staff member said, "It was okay when there were only six residents but we have more now from the other home and it is worrying me. Today I have an agency care staff who is great but it's her first time, I have been on my own on this floor and it worries me."

Staff said that they were constantly rushed and did not always have time to give people the individual attention they needed. They said that this was largely due to trying to finish care delivery which took them away from other people and tasks. Supporting people to get up for the day was still being undertaken at midday and this was not always people's individual preference. One person said, "We have been told about the problems with staff so we know it's not for ever." One staff member said, "Its busy today and so we are struggling a bit." Another person told us, "Things are a bit out of sorts here, faces disappear and new faces come and go, I have had to wait for assistance but there is a lot going on what with the new staff and the decorating." Another said, "Not sure what is happening lately, been chaotic, late with washes and staff not coming back very quickly but they are lovely."

We made staff on Tay wing aware that a person in bed had undressed (the door was open), was uncovered and had been incontinent. Staff said they could not leave the lounge to help change them and would have to wait until another staff member became free. This person was still waiting two hours later. Another person asked staff if they could go out in the garden as the decorators were upsetting her, staff said it wasn't possible as they could not leave Tay wing with two staff. This person was seen to approach the locked doors of Tay wing every time staff and visitors came in or left. We were told that it may be possible for the person to visit the garden later in the day.

We observed the midday and evening meal service and saw there was insufficient staff to give the support people required. We saw that meals were left in front of people and staff did not return promptly to assist people to eat. It was often a different member of staff that returned, this meant people did not receive a consistent or personalised approach to care delivery. At lunchtime, a staff member who was assisting a person to eat was repeatedly interrupted by others needing attention and at one point left the person they were assisting to attend to another person's needs.

Care delivery records told us that people were not receiving personal care, baths or showers as their preferences stated. For some people there was a week where they had received a wash but no offer of a shower or bath. Oral hygiene assistance was often left blank despite a care plan stating the person wished regular assistance with brushing teeth following their midday meal. Records for promoting continence needs were not completed more than once in 24 hours. This did not assure us that people's indiv needs were being met.

There were insufficient numbers of staff deployed in the service to keep people safe and meet their needs.

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

We did find however there were systems in place to manage medicines safely. Medicine administration record (MAR) charts clearly stated the medicines people had been prescribed and when they should be taken. MAR charts included people's photographs, and any allergies they had. The MAR charts were up to date, completed fully and signed by staff. We observed staff when they gave out medicines. We saw medicines were given to people individually, the trolley was closed and locked each time medicines were removed, and staff signed the MAR only when people had taken the medicine. Medicines were kept in locked trolleys, which were secured in a locked room. Staff followed the home's medicine policy with regard to medicines given 'as required' (PRN), such as paracetamol.

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