Care Quality Commission

Mrs Elizabeth Heather Martin

Clyde Court Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Good
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

Overall summary

This inspection took place on 4 March and 12 March 2015. The first visit was unannounced, which meant that the registered manager and staff did not know in advance that we were coming.

The service had been inspected in June 2013 when we found it complied with the regulations we looked at. We then inspected again in September 2013 in response to concerns raised, and we found that the service was not complying with the regulation relating to food and nutrition. At a subsequent inspection in November 2013 we found that the service was now complying with that regulation.

Clyde Court Nursing Home ('Clyde Court') provides nursing and residential care for up to 41 people.. The building has three floors. The second floor is accessible by a passenger lift. Downstairs there is a large room with seating areas and a dining area in the centre.

There is a registered manager in post, who became registered in June 2014.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered

Summary of findings

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.

We found the environment was safe and that people felt they were looked after safely.

Some staff told us there was a need for more staff at busy times, but judging from staff rotas, and our own observations, there were adequate numbers of staff on duty. Proper recruitment processes were carried out, including checks with the Disclosure and Barring Service (DBS). Staff had an understanding of safeguarding and knew how to report an issue if they became concerned.

Hand washing equipment was widely available to reduce the spread of infection. Medicines were obtained, stored and administered safely. We found that the cabinet for storing controlled drugs needed to be replaced with a larger model.

We found that not enough staff had received training on the Mental Capacity Act 2005, and the Deprivation of Liberty Safeguards (DoLS). In one case we found that bed rails were in use, which represented a deprivation of liberty, but the correct procedures had not been followed. We found this was a breach of the Regulation relating to consent, and the procedure to follow if someone lacks capacity and is unable to consent to their care and treatment.

Training was provided and uptake was recorded. Staff received supervision although the regularity of this was variable.

The food was well liked and the cook catered for people with special diets.

Residents told us, and relatives agreed, they were well supported and the staff had a caring approach. We saw that staff treated people with respect and were thoughtful about their need for privacy.

We saw that notice boards in some bedrooms included information which would be better recorded more discreetly in care plans. We saw evidence that Clyde Court provided good care for people at the end of their lives.

We found that care files contained information about individuals which would assist staff to deliver person-centred care. Some sections of the files were incomplete and had not been updated. We considered that the provision of care which matched people's needs required improvement. We found this was a breach of the Regulation relating to person-centred care.

There was an activities organiser three days a week who arranged a range of games and exercises. There was a system for dealing with complaints.

People spoke highly of the registered manager. There was a set of policies and procedures but they were produced by a commercial company and not specific to Clyde Court. We found there was no effective system of audits. This was a breach of the Regulation relating to monitoring the quality of the service.

The service had not implemented two requirements made at a meeting with Manchester City Council in December 2014. This was a further breach of the Regulation relating to monitoring the quality of the service.

The service had acted effectively with a staff disciplinary matter during 2014.

In relation to the breaches mentioned above, you can see what action we told the provider to take at the end of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe, and family members stated they had no concerns about their relatives' safety.

There were adequate numbers of staff on duty although some staff told us they could benefit from additional staff at busy times. Proper recruitment checks were carried out. Staff had an understanding of safeguarding.

Measures were in place to reduce the spread of infection. Medicines were obtained, stored and administered safely.

Is the service effective?

Requires Improvement

The service was not effective in all respects.

There was not enough training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. One person was being deprived of their liberty by the use of bedrails, and the service had not followed the correct procedure.

There was a good level of training provided and staff were supported through supervision.

The food was wholesome and nutritious. People had access to healthcare.

Is the service caring?

Requires Improvement

The service was not caring in all respects.

People told us the staff were caring and looked after them well. We observed staff behaving respectfully and considerately. They respected people's privacy.

We saw some notices on bedroom walls which were not discreet. People were not always treated in a way that matched their needs.

Some relatives had stated that the care for people at the end of their lives was compassionate.

Is the service responsive?

Requires Improvement

The service was not responsive in all respects.

The care files recorded information about individual people's history and needs. However, some parts of the files were incomplete and there was no system to show the staff had read the files.

The activities organiser arranged activities three days a week.

No formal complaints had been received recently, but the provider had responded to verbal complaints.

Summary of findings

Is the service well-led?

The service was not well led in all areas.

People living in Clyde Court and their relatives spoke highly of the registered manager and her leadership.

The service lacked an effective system of audits and those audits which did take place were sporadic. The service had also failed to implement two measures which it had agreed at a meeting with Manchester City Council in December 2014.

The service had dealt effectively with a disciplinary matter in 2014.

Requires Improvement

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.

This inspection took place over two days on 4 March and 12 March 2015. The first visit was unannounced. The second visit was made in order to meet the clinical lead who had been on leave on 4 March, and to review some additional files.

There were three members of the inspection team: two inspectors from the adult social care directorate 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. This expert had special expertise in the area of care for the elderly and those living with dementia.

Prior to the inspection we reviewed the information we held about the service. This included notifications submitted by the service, and minutes of meetings. We obtained the minutes of a safeguarding meeting held in December 2014. We contacted the contracts officer of Manchester City Council who informed us about their recent visit to the home.

During the inspection we spoke with nine people living in Clyde Court. We also used the Short Observational Framework for Inspection (SOFI) during our visit. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We talked with eight relatives who were visiting on the first day of our inspection. We interviewed six members of staff and talked with the registered manager, the clinical lead, the provider and a member of the provider's family who was actively involved in the management of the service.

We looked at five care files, staff rotas, three staff personnel files and other documents relating to the safety and maintenance of the building.

Good

Is the service safe?

Our findings

We spoke with nine people living in Clyde Court and asked them whether they felt safe living there. Nobody indicated that they felt unsafe, and nobody mentioned any example where the staff had behaved badly towards them or made them feel unsafe.

One person said: "Yes I feel safe here definitely. There is always someone in the lounge." This response showed that the person felt safer because there was always a member of staff present in the lounge to support them.

Another person said: "I feel safe and well looked after-- it's very good. The staff are very kind and helpful. They make sure I'm safe." We met the relative of a resident who had been involved in an incident some months earlier, who stated that they felt the incident had been handled very well by the home and that they had no qualms about their relative's safety now.

We asked to see staff rotas for the current week, the two weeks prior to the inspection and the two weeks following. These rotas confirmed what we were told about staffing levels. There were two nurses (one of whom was usually the clinical lead) and four care staff on duty during the day, from 8am to 8.30pm, and one nurse and two care staff at night. On the first day of our inspection one of the nurses had called in sick, which meant there was only one nurse on duty who was quite stressed. We asked the registered manager what they were doing to relieve the situation, and she said she had been contacting other staff to see if they could come in at short notice.

We asked staff whether they thought there were enough staff on duty. Two staff members told us there were times when they could do with more staff. They said this was because a high number of residents needed two staff to assist with their personal care, and this left the other members of staff stretched. They told us this happened occasionally. One member of staff said this was often the case in the morning at the busy time when they were supporting residents to get up and dressed. The CQC does not have any minimum recommended staffing levels, as the needs and dependency of people using a service vary so greatly. Nevertheless there should always be enough staff to ensure people are safe. We saw that staffing levels were discussed at staff meetings and the number of staff on duty until 8.30pm had been increased to help cope with a busy time in the evenings.

We looked at three personnel files of recently recruited staff and saw that the necessary checks were made to ensure that staff were suitable to work with vulnerable adults. Each personnel file had a checklist of documents that needed to be seen at the time of appointment, including proof of identity, evidence of a DBS check (Disclosure and Barring Service checks for any convictions or cautions) and references. The application forms were checked by an administrator. There was a record of the questions asked at interview which included questions about job candidates' experience, qualifications and suitability for the job. These processes were designed to ensure that only suitable staff were appointed.

Staff told us they had received recent training in safeguarding. The training matrix (or record) confirmed that the majority of staff had received training in September 2014. For seven staff the training dated back to early 2013, and there were four staff for whom the training was not recorded. We saw minutes of staff meetings showing that the procedure for reporting a safeguarding issue had been reinforced.

We interviewed six members of staff and asked about their understanding of safeguarding and protecting the vulnerable adults living in Clyde Court. One member of staff told us that they knew the residents well, and if anyone suffered abuse or was not treated fairly they felt confident they would identify it. They added that they took what people said seriously and would report any suspicion of abuse to the registered manager. They felt confident that the registered manager would investigate concerns thoroughly and deal with the issues.

We spoke with another staff member who was able to identify the various types of abuse that might occur in this setting. They said, if they noticed a change of mood in a resident who might not be able to communicate verbally, they would report it in the first instance to the nurse in charge and then to the registered manager if necessary. They also demonstrated an understanding of whistleblowing, although they could not tell us where they would find the whistleblowing policy if they needed to refer to it.

Good

Is the service safe?

We had a tour of the building and saw that it was well designed and equipped with the safety of residents in mind. We saw that in two bedrooms the cable for the alarm call was not connected, which meant that if the person in that room needed assistance they would not be able to summon it easily. We mentioned this to the registered manager who assured us the cable was connected at night when it was most likely to be needed.

On one of the upstairs landings there was a window with a crack and a small hole. This posed a danger if someone leant on it. The contract officer of Manchester City Council had told us that they had drawn attention to this twice and had now put a deadline on the provider to fix the window. The glazier arrived during our visit and the window was fixed.

We saw there were containers of liquid soap and sanitising hand gels on the walls, and bathrooms had posters to remind staff and visitors about safe hand washing methods. Personal protective equipment (namely disposable gloves and aprons) was available for staff in wall mounted dispensers. This indicated that the provider was aware of the need to prevent infection from spreading and protect people's health. We also saw that staff were wearing hairnets when they served lunch, which was a sensible precaution. One member of staff was designated as the infection prevention lead, which meant they were responsible for maintaining infection control. A member of staff told us an audit of mattresses had just started to ensure they presented no health risks.

We checked and saw that equipment such as hoists and a seat weighing scale had been serviced recently and carried stickers to prove it. This would help to ensure their safe operation.

One area of the building was an extension. We saw that all of the doors in this area had an automatic door closure system. This was intended to prevent the spread of fire. The remainder of the building was an older design. We saw fire evacuation equipment, namely aids for carrying people. We were concerned that a sofa in one bedroom did not display labels to show that it was fire resistant. We mentioned this to the registered manager and provider.

Each person had a personal evacuation plan readily accessible to the emergency services. We observed the sheet of information which was intended to be given to the fire service. It had basic details of each person but could have given more information about each person's mobility.

We looked at whether medicines were obtained, stored and administered safely. We spent time with the clinical lead, who was new in post, and one of the nurses who was responsible for administering medicines. The nurse explained that all the nurses had just been given their own office, which made it easier to keep records. She said that new medicines usually arrived a few days before they were needed, which meant there was time to check the right stock had arrived. This checking process was always done by two people, to reduce the possibility of error. The new Medicine Administration Record (MAR) was checked against the old one, and any information about new prescriptions, to ensure the correct medicines had arrived. We were told there had been some errors by the pharmacist, but the service was in the process of changing pharmacist. This demonstrated an active approach towards solving problems.

In the 'treatment room' where medicine was stored we saw that each person's medicines were kept in a named box. There were photographs on each MAR which would help to ensure that medication was given to the right person, especially if an agency nurse was working who did not know the residents. There were also names on the blister packs but no photographs. We saw evidence that the temperature of the fridge in the treatment room was checked regularly.

We saw that controlled drugs were stored in a lockable cabinet fixed to the wall, inside a secure locked cupboard, in a locked room. Controlled drugs are by their nature required by law to be kept in secure conditions. We noticed that the cabinet was too small because some bottles of controlled drugs were being stored outside the cabinet, because of lack of space. The clinical lead told us she was aware of this issue and had requested a bigger controlled drugs cabinet from the provider.

Requires Improvement

Is the service effective?

Our findings

The CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) which form part of the Mental Capacity Act 2005 (MCA). DoLS are intended to protect the rights of people who lack the capacity to make their own choices about their care.

We saw from the training matrix that less than 50% of the staff were recorded as having received training on the MCA. Slightly more had received training in DoLS in July and August 2014. Only three out of the eight nurses had received training on the MCA, although it was described as 'compulsory' on the training matrix. If staff including nurses were not aware of the provisions of the MCA then there was a risk that people's rights under the MCA and DoLS might not be protected.

We saw Clyde Court had policies on both MCA and DoLS. These were taken from a set of commercially produced policies which the provider subscribed to. There was no record showing that staff had read and understood these policies. We saw one mental capacity assessment from January 2015 which was incomplete and incorrectly filled out. We saw that on one care file a form had been completed stating that a person was not being deprived of their liberty. But the form was undated and did not set out the basis on which this assessment had been reached.

We also saw that one resident had bed rails. These are raised sides to the bed which prevent people falling out of bed. Because they also prevent people getting out of bed when they want to, they are seen as a deprivation of liberty, which means that if the person cannot consent to using them, the procedure in the MCA and DoLS needs to be followed. We saw that the provider had recorded on this person's file 'has limited capacity'. However there was no mental capacity assessment to support this finding. There had been no best interests assessment as to whether the restriction was in the person's best interest. There was also no application for a DoLS authorisation.

This meant that the service had not followed the correct procedure relating to someone who is incapable of consenting to a restriction of their liberty. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 11(1) and 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the training matrix which showed a good uptake of training in core competencies such as moving and handling, infection control, safeguarding, and health and safety. Other courses had been taken by fewer staff according to their role. For example three of the nurses had undertaken training in medication. Only three staff had taken the training in person-centred care. However we were told that all staff had been signed up to undertake this training in the near future.

We saw a schedule of planned training sessions for dates in 2015, which included person-centred care, and also MCA and DoLS The schedule said that the courses were mandatory and should be attended by all staff.

Staff we talked with gave mixed feedback about the training. Two of the staff told us the training was good, and that the registered manager ensured they were up to date. Another member of staff stated that they had asked to receive training in medication, but this had been refused. This was because medication was administered only by qualified nurses.

Staff had regular supervision although the interval at which supervisions took place varied, according to different members of staff. Supervisions offer staff the opportunity to discuss their work or training needs with their manager. One person said it was every three months; another person said they had had only one supervision with the new registered manager since her arrival in June 2014. The last supervision for one of the nurses had been in May 2014. The registered manager explained to us that during 2014 it had been difficult to arrange supervisions as there had been no deputy manager in place. From now on they would be every two months for all staff. The clinical lead would conduct supervisions with nurses. The registered manager was also planning annual appraisals with staff. One member of staff commented favourably on their experience of supervision: "The manager is very approachable. She listens and acts."

We observed the lunchtime arrangements. There was a whiteboard up in the dining area, for displaying the menu. We watched a member of staff writing up the menu shortly before lunch was served. The tables had tablecloths, and were laid with cutlery and glasses of soft drinks. The lunch looked appetising and we saw people enjoyed it. Some

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Is the service effective?

choices were offered for example people were asked if they wanted orange or blackcurrant juice. However, we noticed that the plates arrived already with gravy on, but we did not hear anyone being asked if they wanted gravy.

Background music was played during the lunch, which was an unrushed and sociable occasion. We saw that people were assisted to eat if they needed support.

One person told us they liked the food: "Lunch was good, and there was plenty of it." Other comments were: "I have no complaints about the food but more green vegetables would be nice", and: "The food is extremely good but I have noted a lack of fresh fruit and green vegetables on offer."

We talked with one of the cooks and asked how they catered for special diets. They showed us there were lists on the wall of the kitchen reminding them of which residents needed a special diet due to diabetes or for cultural reasons (eg a Halal diet). We saw that one person was receiving a specially cooked meal. Halal meat was kept in separate containers in the fridge. The cook told us they had contributed to menu planning and did the food ordering. They told us there were no restrictions about obtaining food on the grounds of price. We saw the kitchen was spacious and well equipped. Due to a concern raised prior to the inspection we specifically asked about the quality of the meat that was served. We saw that the meat that was served during the lunch we observed was suitable and well presented.

Care plans showed that attention was paid to maintaining people's health. Weight was recorded monthly. Information from district nurses was added to care plans.

People had regular appointments with dentists, opticians and podiatrists. One person told us they never bothered seeing a dentist, which was their choice. One member of staff told us that there was sometimes a lack of communication which hindered looking after people's health.

Requires Improvement

Is the service caring?

Our findings

We asked people living in Clyde Court about the care they received. One person told us: "I've been delighted with the care. It has not been lacking in anything. I am very impressed with the place, it's a very homely place…care permeates from the top…there is a very nice atmosphere." They added: "I would recommend it to my friends."

We met a family member who was visiting on the day of our inspection. They said: "I think [my relative] is looked after very well. I can't fault the carers. The carers here at the minute are very good. [My relative] has a good relationship with them." Another visitor told us: "I have just visited my [relative]. I am very happy with the care they give them. They are all very pleasant. I have no concerns."

We saw a card sent by someone who had lived in the home a short time on respite. It said: "Thank you all for looking after me and – most important – making me feel so welcome."

There was one negative comment in a questionnaire completed by family members: "Staff do not often engage with residents other than when they are passing by." This contrasted with our observations on the two days of our inspection.

One member of staff told us they enjoyed working at Clyde Court: "People keep coming back on respite. We have a laugh with them."

We saw some examples where staff treated people respectfully. During lunch a GP arrived to see one person. This meant they had to leave the table between courses. We saw staff asked them politely whether they minded doing so. When staff were assisting one person to eat they did so sensitively, proceeding at a pace which matched their needs.

During our observation in the lounge we saw there were staff present who interacted with residents. There were two male and two female staff on duty, which provided a good mix as there were quite a number of male residents. We saw staff treated people with respect and were considerate of their needs, for example ensuring people were comfortable. We did observe, however, that one person in a wheelchair was sat underneath a large projector too close to be able to watch it. This person was not spoken to by staff during the forty minutes that we were observing. We asked a member of staff who said this person did not like to be disturbed.

Staff told us they were trained always to knock on people's doors. They said they always tried to involve people in their care by asking what they wanted: "I always ask if they are comfortable. I ask them what they would like to wear, or if they would like a shave. I always make sure the curtains are closed before I give them any personal care." This showed the member of staff was careful to respect people's dignity and preferences. One of the stated objectives of Clyde Court was to "respect individual requirement for privacy at all times and treat all information relating to individuals in a confidential manner."

On the other hand, we saw that there were notice boards on bedroom walls, which were used to remind staff about the care needs of each resident. Some of the notices referred to incontinence pads. One said "Please use the pads in my bedroom". There was a pile of unused incontinence pads on the bedroom floor. Another notice simply said "Must wear a pad." We considered these notices were demeaning and undermined the person's dignity. We mentioned these notices to the registered manager who said they were intended as reminders for staff. However, the notices might be seen by the resident or by their family. The staff could be reminded of these needs more discreetly in the care plans.

We were also concerned that one person appeared to be in distress in their bedroom. We spoke to the registered manager who said that they had been taken to their room after lunch for bed rest, and added, "They often do a lot of shouting which is disturbing for other residents." Later in the day we saw they were sat up in bed and the television was switched on - and they had stopped shouting. We were not sure that this person's needs had been identified and met earlier in the day.

The service had embarked on training some of the nursing staff in the Six Steps programme. The Six Steps is an end of life programme, in the North West, designed to enable care homes to improve end of life care. The registered manager showed us an email from a family member who wrote: "I am glad that mum spent her last few days at your nursing home. I felt that you really cared for her and made her last few days comfortable." We also saw a card from a family member written earlier in the year which said: "I'm writing

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Is the service caring?

to say an enormous thank you for all the wondrous care that you gave my father…His last years were made as happy and comfortable as they could ever have been, and it was marvellous to know that he was warm and safe and in such good hands."

Requires Improvement

Is the service responsive?

Our findings

We looked at five care files. We examined whether the care being provided was person-centred. Person-centred care means care which is individualised and specific to the person concerned. That means care which recognises their particular strengths and needs, and offers them compassion, dignity, respect and choice. One aspect of person-centred care is to build up a detailed history of people's past lives, in order to enable staff to build up more meaningful relationships with them.

We saw that the care files contained personal information about people's history. For example on one file there was information about the person's lifelong support of a particular football club, which would enable the staff, including new staff, to engage with them in conversation. The file also recorded the person's preferred name, with details of their family and a summary of their medical history. On the file were guidelines for completing the care plan, which we saw in one case had been signed by the person's relative, which showed the care plan had been discussed with them.

The care plan included a single sheet with brief details on the person's needs: breathing, personal hygiene, safety, visitors, communication, skin care, mobility, sleeping, continence care, mood, social and spiritual care. These areas represented important areas of a person's care, and we considered that the plans we saw required more detail about how specifically to meet each person's needs. This would ensure that new staff or agency staff who did not know the person would be able to provide individual care.

We saw some parts of the files were incomplete. For example there was an audit tool template on one file which was not filled out. There was a communication sheet recording some information about the person which was neither signed nor dated. This would make it difficult to assess any changes in the person's condition or needs. We saw that some risk assessments were undated, which meant that it was difficult to know how long the risk had been present and whether it had increased or reduced. Separate sections of the care plan were not labelled or given headings, which made it awkward to find a particular section. There was no index on some of the care plans we looked at.

On another person's file we saw that risk assessments were completed for various risks, including moving and handling and falls, alongside a record of falls and other accidents. The risk assessments were reviewed monthly, which showed that this person's keyworker actively considered each month whether the risks to that individual had changed. This was an example of good person-centred care.

One person had a turn chart in their room which was intended to record the times that they were turned in bed, as a way of preventing pressure sores developing. The last times of turns recorded were on 15 February 2015, which meant that it had not been recorded for over two weeks whether they had been turned or not. There was no explanation in their care file as to why the recording had been stopped. The system for monitoring their needs and the risks to their health was not functioning properly.

We asked the clinical lead how they could be confident that staff had read care plans. They replied that the registered manager was introducing an audit of care plan updates. This meant that such an audit had not previously been completed.

We concluded that the provision of effective person-centred care was inconsistent and in need of improvement. This was a breach of Regulation 9 of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2010 which corresponds to Regulation 9(1) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to Regulation 9(3)(a).

Clyde Court employed an activities organiser who came in three days a week. We saw a varied plan of activities for those days. When we arrived we saw there was a game of Connect 4 taking place in the lounge, which the activities organiser was playing with three residents. It was difficult for the activities organiser while engaged in this game to make activities available for the remaining residents.

One person told us: "You have to make your own activities, there's not much entertainment. We do have physical activity once a week." We asked other people about what activities were available and they seemed unsure.

We saw an activity rota which listed activities on Mondays, Wednesdays and Fridays on a two week cycle. These were the days that the activities organiser came in. On each of

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Is the service responsive?

these days there was one activity in the morning and one in the afternoon. Not all of the activities would be suitable or available for everyone. For example a game of Scrabble would appeal to a limited number of people. However, between them the activities offered a reasonable range of pursuits for those willing and able to take part. Care staff were expected to provide activities on other days and at weekends, although they were busy looking after residents and inevitably we were told there were fewer activities on those days. During our visit we observed that staff did have time to engage in activities with people in the lounge. Before lunch we saw that some residents were helping to set the tables in the dining area, putting out cutlery and napkins. We saw this as a valuable activity which would increase people's sense of self -worth.

There was a programme of visiting entertainers planned twice a month for all of 2015. Staff told us and one resident confirmed that they really enjoyed these sessions.

A residents' meeting was planned for the week after our visit. This was the first one held since the registered manager had arrived the previous summer.

We saw responses to questionnaires completed by relatives. One relative suggested "more activities, more interaction." Another relative had written: "We would like the staff to encourage the residents to get involved in more outdoor activities and to socially interact with them more."

There was a complaints procedure in the office. There had been no written complaints in the past year. The service also kept a record of verbal complaints, of which there had been two. We saw that the registered manager had investigated each complaint and dealt with it. In one case a response to the complaint had been promised but had not yet been delivered.

One relative told us they were happy with how an incident about a year earlier had been dealt with.

Requires Improvement

Is the service well-led?

Our findings

We asked people living in Clyde Court what they thought of the management of the home. Their responses were all positive. One person said: "Good management - very approachable. I've never had any problems." Another person said of the management: "I feel very happy with it." A third person said: "The place is well-run. They work hard, the staff, and the place is spotlessly clean."

Residents described the registered manager as friendly, approachable and as setting a good example to the staff. One person said "She's good and takes note of what people say."

Staff we spoke with testified to there being a good atmosphere within the home. One member of staff said: "We are like a family here. We all work together." They commented that there had been a few changes of manager over the years and they were pleased the current registered manager was established in the post.

As well as the registered manager and the provider, we met one of the provider's family on both days of our visit and it was clear they played an active role in the management of the home. Both they and the manager stated they worked well together and shared the responsibility. They told us they were planning to rearrange the legal structure of the provider so that the family member would become formally and legally responsible.

When we arrived on the first day of the unannounced inspection, the registered manager was not present and we met the senior staff member, who was not very welcoming. They said they were too busy to deal with us, and walked off. As this was the senior person in charge this did not create a good first impression of Clyde Court. A well led organisation ought to have people able to deputise effectively for the registered manager when they are absent. However, the registered manager arrived shortly afterwards followed by the provider's family member. We were told that the senior staff member who had met us had been working under stress because another nurse had called in sick that morning. The registered manager made arrangements to replace that nurse during the morning.

We asked to see policies and procedures. We saw that all policies were adapted from templates supplied by a commercial company, with the name of the service added in. This included the Statement of Purpose, a document required of every service registered with the CQC, which sets out its values and aims. This meant that the policies were likely to be legally accurate and comprehensive, but also difficult to understand. It also meant they were not specific to Clyde Court. We asked staff whether they knew about the policies of the home. They told us that the policies were kept in the office, but there was no evidence that they had read and understood them.

We also asked about audits. We asked to see medication audits, audits of falls, accidents, pressure sores and safeguarding. The audits would include a record of relevant events, an analysis of them and suggestions for improvements. In this way the provider could identify whether and where quality and safety were in need of improvement. None of these audits were provided to us, indicating that there was not a system of regular audits of these areas. We did see an infection control audit, completed in February 2015. There were no previous audits in that area.

We saw records relating to the maintenance of the building and safety of equipment, for example the lift, hoists and slings, which showed that these aspects were well managed. There was however no written schedule of maintenance. The approach taken was to deal with issues as they arose.

We saw that care plan audits were done but they were a tick box exercise rather than a detailed examination of whether the care plans needed updating. The care plan audit tool indicated that the audit should be done monthly, but on one file we saw the last audit had been done on 7 October 2014, four months earlier.

The absence of effective regular audits was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to Regulation 17(2)(a) and (b).

Prior to the meeting we had obtained the minutes of a safeguarding meeting held by Manchester City Council on 16 December 2014. The meeting discussed a number of concerns which had been raised about the welfare of people living in Clyde Court. The registered manager and the provider's family member were present at the meeting and agreed to make two undertakings. The first was that they would carry out regular spot checks during the night

Requires Improvement

Is the service well-led?

to ensure that night staff were carrying out their duties correctly. At our inspection we discovered that only one such spot check had been carried out since the date of the meeting, on 26 February 2015. We discussed this with the registered manager who indicated she was reluctant to make these spot checks in the middle of the night.

The second undertaking made at the meeting in December 2014 was that staff handovers between shifts would be recorded. This would ensure there was a written record of information handed over, including about medication. It would also ensure that agency staff signed to indicate they had received handover information. The information specified at the meeting included information about residents at high risk of choking, so it was vital that agency staff were made aware of it. At our inspection in March 2015 we learnt that these handover sheets had not yet been introduced.

These failures to implement significant improvements agreed at a meeting with Manchester City Council constituted a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to Regulation 17(2)(e).

We had been informed about an incident in April 2014 when a member of staff had behaved inappropriately towards a person living in the home. The member of staff was immediately suspended and subsequently dismissed. At this inspection we enquired whether the former member of staff had been referred to the Disclosure and Barring Service (DBS) which would then make a decision as to whether they should be barred from working with vulnerable adults. We were assured that this referral had taken place, and then we saw a copy of the DBS referral form which included full details of the incident.

The prompt action taken by the provider showed that they had made a firm response to behaviour by staff which compromised the safety of residents. This was evidence that robust action was taken where necessary to ensure that staff behaved in a safe manner. The referral to the DBS also indicated a responsible approach towards ensuring that unsuitable staff would not work in the sector again.

The provider was meeting the registration requirements in terms of reporting deaths, serious injuries and other notifiable events to the CQC.

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	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment were being provided without the consent of service users and not in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider was not ensuring that service users received appropriate person-centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The quality and safety of the service, and risks relating to the health safety and welfare of service users, were not being regularly monitored.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not acted on feedback from Manchester City Council given for the purpose of improving the service.