New Century Care (St. Leonards) Limited

Clyde House

Inspection report

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06 May 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We inspected Clyde House on the 03, 04 and 06 May 2016. This was an unannounced inspection

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 28 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 nine 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 five homes in the South East.

Clyde House does not have a registered 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. An area manager and project manager were covering the management role and were present during the inspection.

At a comprehensive inspection in October 2015 the overall rating was Inadequate and the service was placed into special measures by the Care Quality Commission (CQC). Seven breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 were identified. We found significant risks to people due to the management of nutrition. Staff did not have relevant risk assessments in place to ensure their safety. People in the service did not receive care and support that was individualised to their needs and people were not always treated with dignity and respect. People had not been protected against unsafe treatment by the quality assurance systems in place. There were also concerns relating to the management and leadership of the practice, specifically in the well led domain. Following the inspection, we received an action plan which set out what actions were to be taken to achieve compliance. Due to concerns we received in February 2016 we undertook a focussed inspection to look at peoples' safety. We found that that the concerns were substantiated and that people's health and safety was not assured by the deployment and experience of staff. Continued breaches of Health and Social Care Act 2008 (Regulated Activities) 2014 were found.

During our inspection on 03, 04 and 06 May 2016, we looked to see if improvements had been made. We could see that some action had been taken to improve people's safety, but the management of risk to individual people remained. Improvement was still needed to ensure people received support in a person centred way and were treated with dignity and respect. People were still not receiving support that was individualised to their needs. There were still concerns in respect of the quality assurance systems in place

to drive improvement.

Accidents and incident reporting had taken place and recorded but lacked documented investigation and measures to ensure learning and preventative measures. Staff had training on keeping people safe and understood the process of reporting concerns. Staff had been checked to ensure they were suitable before starting work in the service.

Whilst occupancy has reduced in the home the provider has maintained the same staffing levels and reviewed dependency needs on a monthly basis. Permanent staff have been secured and started at the service which has reduced the reliance on agency staff usage. We were concerned that there was variable leadership and delivery of care on the two inspection days. On one day there was no clear deployment of staff and no clear leadership. Training had been booked to discuss person centred care. Staff said they felt supported and all staff were now having supervision.

Staff had an understanding of the Mental Capacity Act 2005 and had received refresher training. However, there were still some issues around consent and ensuring that people were offered choice whilst adhering to the risk strategies put in place by health professionals.

The meal delivery was seen to have improved on day one of the inspection process but day two was very different both in delivery and in quality.

People were supported to access health professionals or appointments. The home manager has identified that some services with other visiting healthcare professionals are not always supporting timely support and care and is working with the agencies to improve provision and input.

Training had been booked to discuss person centred care. Staff said they felt supported and all staff were now having supervision.
Staff had training on keeping people safe and understood the process of reporting concerns. Staff had been checked to ensure they were suitable before starting work in the service.
Staff had attended meetings to enable them to raise concerns and discuss issues collectively.

The service had systems and processes to assess and monitor that the service was of a good quality. However, we found these had not identified issues around person centred support. The service was working with Commissioners to ensure that clear outcomes for individuals in the service were identified and worked towards.

The overall rating for this provider is 'Inadequate'. This means that it remains in 'Special measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.
• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

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

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

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 and was not meeting the legal requirements that were previously in breach.

Risk assessments were devised and reviewed monthly. However, day to day management of people's individual risk assessments to maintain their health, safety and well-being were not followed and therefore placed people at risk.

There were not always enough suitably qualified and experienced staff to meet people's needs.

The management, administration and storage of medicines was safe.

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

Is the service effective?

Requires Improvement

Clyde House was not consistently effective and was not meeting all the legal requirements that were previously in breach.

Whilst improvements were seen in the meal time experience and in ensuring peoples nutritional and hydration needs were met, they were not fully embedded in to everyday care delivery.

We saw staff did not always follow good practice guidelines while assisting people to eat. Senior staff had no oversight of what people ate and drank as not all records were accurate.

Staff received on-going professional development through recent supervisions, and essential training that was specific to the needs of people had been progressed. However the training was not always put into day to day practice.

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

Is the service caring?

Requires Improvement

Clyde House was not consistently caring and was not fully meeting the legal requirements that were previously in breach.

Care delivery was not consistent on a day to day basis. We saw that at times staff focused on getting the job done and did not take account of people's individual preferences or respect their dignity.

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

Staff were not always seen to interact positively with people throughout our inspection. We saw staff undertake tasks with no verbal interaction with the person involved.

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

Is the service responsive?

Requires Improvement

Clyde House was not consistently responsive and was not fully meeting the legal requirements that were previously in breach.

Whilst care plans had been rewritten, some were not reflective of peoples individual health and social needs.

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

People told us that they were able to make everyday choices, but we did not see this happening during our visit. There were not enough meaningful activities for people to participate in as groups or individually to meet their social and welfare needs; so some people living at the home felt isolated.

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

Is the service well-led?

Inadequate

Clyde House was not well led and was not meeting the legal requirements that were previously in breach.

People were put at risk because systems for monitoring quality were not effective.

The leadership of the home was not consistent and this impacted negatively on the care people received.

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

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 03, 04 and 06 May 2016. This visit was unannounced, which meant the provider and staff did not know we were coming.

Four inspectors undertook this inspection.

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

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, five 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) over lunch 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 15 people living at the service, two visiting relatives, eight care staff, the chef, the activity co-ordinator, two registered nurses, the area manager and the project manager.

Inadequate

Is the service safe?

Our findings

At our inspections in October 2015 and February 2016 we found that people's health safety and welfare were not always safeguarded. The provider had not taken appropriate steps to ensure that there were measures in place to keep people safe. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We had also found there were not sufficient, experienced staff deployed to keep people safe or assist them to receive appropriate care and support. The service had not assessed the skills of staff deployed in the service on a temporary basis. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

An action plan was submitted by the provider that detailed how they would meet the legal requirements by April 2016. Whilst we found that some Improvements had been made, the provider was still not meeting all of the requirements of Regulation 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us they felt safe living at Clyde House. One person told us, "I feel protected here, and know I only have to ask staff to help me and they will." Another person said, "Too many changes to staff, never know who is coming to assist me." One relative told us, "I still have concerns." We found there were still shortfalls which compromised people's safety and placed people at risk from unsafe care.

Peoples' risk assessments had been reviewed in April 2016. They had not been updated in February and March 2016 as per their organisational policy of monthly review. We were told this was due to a review being undertaken by a member of the senior management. We found that changes to peoples' health had been documented however some lacked sufficient information and guidance to keep people safe. Care plans contained risk assessments specific to health needs such as mobility, continence care, falls, nutrition, pressure damage and a person's overall dependency. They looked at the identified risk and included a plan of action to promote safe care. We also saw that specialist advice had been sought following concerns raised at inspections; however we found the guidance was not always being followed. For example one person had been seen by a physiotherapist due to severe limb contractures. The plan included moving the person into different positions every hour and the use of foam blocks to support them. There was no written evidence that these instructions had been tried or used. Staff when asked told us that they had not followed the physiotherapist guidance as the person didn't like it. This person was on a soft diet however the meal served on the second day was not soft and consisted of food that was difficult to swallow. The position the person was in to eat did not reflect the guidance in the care plan. On two separate occasions we saw this person eating unsupervised despite the care plan stating that they must be supervised whilst eating.

In February 2016 we had identified one person at risk from skin damage due to poor positioning and lack of a suitable chair. At this inspection they were still in a position that placed them at risk from pressure damage. The person's limbs were not appropriately supported and bare skin was resting on the hard plastic of the chair. Their upper arm was resting unprotected on the pressure cushions lead. This had caused an indentation in their skin. This person was unable to move themselves or call for assistance. We saw that this person received assistance with their meal in a position that was not suitable or safe. We asked that this was

addressed immediately. Action was taken immediately by senior staff to ensure that the person was supported appropriately. On the second day we saw that the person was appropriately supported and in a position that was comfortable and safe.

Since our last inspection risk associated with the use of pressure relieving equipment and the use of bedrails had been re-assessed. Systems had been put into place to ensure staff checked the settings on a daily basis. However we found four mattresses on incorrect settings. For example one person's weight was 44kgs and the mattress was set on 70. For another person on bed rest the mattress was set on 120 when it should have been set on 30. We informed the registered nurse (RN) who changed the setting. The RN then explained mattress setting to a new care staff member. 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 were told by the project manager that it may be because the dials are knocked during the day by care staff or cleaners. The area manager informed us that new mattresses have been ordered that have an integral setting mechanism which will reduce risk.

Accidents and incidents had been documented when they occurred however there was still a lack of follow up or actions taken as a result of accidents and incidents. The audit of accidents and injuries had not been started as stated in the action plan. For people whose falls had been unwitnessed by staff, there was no record of an investigation and a plan to prevent further falls. This meant that the provider had not put preventative measures in place to prevent a re-occurrence and protect people from harm. The provider therefore could not demonstrate there had been any learning from accidents and incidents.

We were told those people with wounds had a new wound plan 'bundle'. We saw that for most people these were accurate, contained measurements of wounds, sketches and provided guidance for staff. However there were discrepancies found. One person had multiple wounds and there was a series of measurements but no sketches. None were labelled, numbered or dated to identify which wound was which, if one was improving and another deteriorating. We also found that some wounds/injuries were not fully documented, one person had an injury following a recent fall which had not been recorded. The audits for wounds had been started but not all wounds were recorded and therefore did not give the management team a correct oversight of wounds.

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

The risks associated with the use of bedrails had been assessed and complied with safety guidelines as recommended by The Health and Safety Executive.

There are 28 people currently living in the home over three floors. We had received weekly rotas since February 2016 which told us that the staffing levels had been consistent in numbers. Eight care staff in the morning, with two RN's, seven care staff in the afternoon with two RN's and at night there were 4 care staff and one RN. There was a heavy reliance on agency staff and there have been times when the staff on duty were mostly agency staff. For example on the second day of the inspection on Tay Wing three of the four staff were agency staff. We saw that this had impacted on the care delivery due to a lack of knowledge about the people they were supporting and the equipment they were using. We saw care staff trying to move a person in their specialist chair and staff were not sure of how to do it safely and twice the chair was jerked downwards, unsettling the person. We asked one agency staff member if a specific person needed assistance with eating their meal and admitted they weren't sure as they hadn't had a handover and they

hadn't been on that floor before.

The deployment of staff in the afternoon on the second day of inspection was confusing for people and for staff, as they were two staff short and the activity person was asked to go on to care duties. The allocation sheet for the day was missing and staff were unsure of where staff were working. We asked if there Staff were trying to cover three floors and on Tay Wing in the afternoon a new agency staff member was left on their own. She told us "I hope I am not on my own, but I don't know where the other staff are." This meant that she was looking after nine people without support. One person required 15 minute observations in the lounge with four other people who required discrete supervision and there were four other people either in their room or walking in the corridors. We informed a member of the management team and a care staff was sent up from the garden floor, which then left the garden floor with just one new care staff member. The new staff member said "Really busy, a bit daunting because I'm still new, just settling in."

During the inspection we found staff on the middle floor staff were unable to supervise the people in communal areas as they were assisting people in their rooms. We saw that two people were isolated in the middle lounge for up to an hour and a half. One person was not able to communicate their needs or call for assistance. We spoke to staff and they told us, "It's just difficult because the agency are all nice but they don't know the residents as well as us and everything takes longer, sometimes they get lost. Hopefully when the new staff start it will be better." Staff were not always able to offer assistance to meet people's individual needs.

We observed the midday and evening meal service and saw there were not always sufficient staff deployed to give the support people required. We saw that meals were left in front of people and some people ate food that was cool due to not having timely assistance. We also saw that people were assisted for a short time, then the staff left them to help another person, then returned to assist the first person.

The deployment and lack of experienced staff did impact on the care delivery seen on the second day of our inspection. We spoke with the management team who acknowledged that care delivery was variable on a day to day basis due to 500 hours of agency usage. However the recruitment drive was on-going, we were told they had conducted over 350 interviews and new staff had been employed. We were told they are experiencing difficulty in recruiting registered nurses to fill the vacancies but do have some interviews lined up. New care staff were currently on induction and would be working on the floor over the next few weeks. We shared our concerns that new staff were being supported (working alongside) by agency staff that were unfamiliar with the home and organisational policies whilst on induction. This was acknowledged but unavoidable due to the present circumstances.

The provider had not ensured that the deployment of staff had promoted the health and safety of people. This was a continued breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that people's food and fluid records were inaccurate and not effective in monitoring the risk of dehydration and weight loss. This inspection found that improvement had been made. The care plans directed staff to monitor people's fluid intake when it had been identified the person was at risk from drinking. Records were mostly complete and added up to provide the total amount of fluid taken. We saw that handover information identified those people who needed encouragement or referral to the GP. This ensured the risk of dehydration was mitigated.

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.

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

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. We saw from safeguarding records that staff had been raising concerns about possible abuse which the management had taken forward for investigation by the local authority.

Requires Improvement

Is the service effective?

Our findings

At the last inspection in October 2015, the provider was in breach of Regulations 11, 14 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care delivery was not always effective and consistent, and staff had not received appropriate training, professional development and staff supervision. We also could not be assured that people's nutritional needs were met.

The Provider submitted an action plan detailing how they would meet their legal requirements by 30 April 2016. Improvements had been made and the provider was now meeting the requirements of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Whilst improvements had been made in respect of meeting people's nutritional needs and staff training and development, there were still areas that required further time to be embedded and structured.

At the last inspection we found that not all staff had completed training to make sure they had the skills and knowledge to provide the support individuals needed. This inspection found that staff training had progressed. Whilst training was available it was still not effective in providing consistent good care delivery. We observed good and poor practice in moving and handling people, assisting people with their food and in delivering person centred care. There was also a lack of understanding shown by staff in supporting people who lived with dementia. This was observed by the lack of interaction when supporting them and not managing some behaviours effectively. We also found that there were new members of staff still on their initial induction working alone and unsupervised during our inspection.

Most staff had received a supervision completed by the project manager. They had the opportunity to raise concerns and share ideas. They also discussed their personal development needs. Two themes came up on most of the supervisions. Staff feedback raised concerns about the high use of agency staff and the inaccurate completion of care records. The project manager confirmed that this feedback was taken to senior managers and discussed at team meetings of how agency staff could be supported to work as part of the team. It was acknowledged that this was an on-going problem which was being resolved by a robust recruitment plan.

There was no evidence of any clinical training completed by nurses. The project manager said that some nurses had completed training either many years ago or in other roles. She was confident that nurses were competent in the use of catheters but all other clinical tasks were being led by district nurses. The district nurses met during the inspection were concerned that they were being asked to look at injuries such as bruising as they were registered nurses at Clyde House. The project manager was planning to book training for nurses in venepuncture (taking blood), syringe driver (a device for giving continuous medication) and catheters by the end of June but this had not been done yet. No observation checks of the competency of nurses had been completed yet.

The provider had not ensured that staff had received appropriate training and supervision to meet the needs of the people they cared for. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at training records. The training matrix (plan) showed that 62% of staff had completed the training they required for their roles. The project manager said this was an increase on 45% when she started. The target is 85% by the end of May 2016. This showed us that the provider was striving to drive improvement and ensure staff received training to meet the needs of people at Clyde House. Five new staff were working on their induction workbook. Two new staff members felt that the induction and the support from the staff team was good.

At our inspection in October 2015 we found the meal service at Clyde House was not a shared experience or an enjoyable event for people. It had become a task rather than something to be looked forward to. This inspection found that whilst there were improvements on the first day of the inspection, the second day showed us that it was not consistent. For example on the first day people were asked if they would like to eat in the dining area but this was not offered on the second day. On Tay Wing people either ate in their room or from a small table in front of their lounge chair. The dining table was only used by one person, but it was not successful due to interruptions by a health professional visit.

We saw varying levels of support given to people during our inspection. We saw good practices but we also saw poor practices. For example we saw one new member of permanent staff sit and support people with good eye contact and a kind approach. However we also saw staff supporting people whilst perched on a side table or an arm of chair without any interaction or eye contact. The difference of amount of food eaten was notable. We saw people on Tay Wing were left with meals in front of them that they were not able to eat without support. One person struggled on their own and ate very little. The RN was informed and told us, "Someone would go and assist." Unfortunately the food was cold and the person refused to eat.

At our last inspection we noted that there was no record kept for those people who had not eaten well. This inspection found that it was still not embedded in to everyday practice. One staff member said, "It depended on who was cooking." It was confirmed that this had been identified by the management team and action would be taken. Another staff member said, "We don't always write it down." Records stated what action staff had taken where there was identified weight loss. For example one person was losing weight. Action was recorded in the care plan that they had been referred to the GP and dietician and fortified food was being offered. However due to the lack of consistent recording of food eaten we were not assured that these action were being followed. We expressed concern to senior staff that trends of appetite changes were not being picked up early to prevent weight loss as daily records did not reflect amounts eaten.

The completion of fluid intake charts had improved and we saw that the majority of charts were added up to give a total over 24 hours. This gave staff information of whether fluids needed to be encouraged or referred to the GP. However we found that this information was not always communicated effectively to the next staff on duty. This placed people at risk of not having enough to eat and drink and is an area that still requires improvement. This was a continued breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found that staff were not always working within the principles of the Mental Capacity Act 2005 (MCA). We found some improvements to care documents had been made. The MCA says that assessment of capacity must be decision specific. It must also be recorded how the decision of capacity was reached. We found that the reference to people's mental capacity was recorded but did not include the steps of how it was reached. We were told that mental capacity assessments were undertaken by the GP but new mental capacity assessments for staff to undertake were to be introduced in the near future. Staff were able to tell us, "We recognise that peoples understanding and capacity can change quickly." Due to the high usage of agency staff not all staff were able to tell us about how certain decisions were made such as, where people spent their time, consenting to personal care and support or about whether people could use a call

bell. For one person who was under the care of a health professional for positioning advice due to their physical disabilities, there was a lack of recording of why the advice was not being followed. Some staff said the person chose not to be positioned whereas another member of staff said the person did not have the mental capacity to make the decision.

Staff had attended training in Deprivation of Liberty Safeguards (DoLS), which is part of the MCA framework. The purpose of DoLS is to ensure people, in this case, living in a care home are only deprived of their liberty in a safe and appropriate way. This is only done when it is in the best interest of the person, and has been agreed by relatives, health and social care professionals and there is no other way of safely supporting them. Staff were aware that the locked front door, which prevents people entering and leaving the home was a form of restraint and applications had been made to the local authority under DoLS about this. We also found that the people who lived on Tay Wing, where key pads prevented people leaving had been included in the DoLS referrals. We discussed with staff the use of recliner chairs and how the decision was made to use a recliner when the person could not participate in decisions and was known to be mobile at times. Staff told us that it had been discussed and was to prevent injury from falls as the person was unsteady. It had not been considered a deprivation of the person's liberty as it was in their best interest. However this was not clear from the documentation in their care plan and risk assessments. This was to be taken forward by staff for further discussion with the management about how that was to be recorded. Whilst improvements had been made in respect of ensuring that peoples consent was sought we found this was an area that required further embedding in everyday practices and improvement in documentation.

People received effective on-going healthcare support from external health professionals. People commented they regularly saw the GP, chiropodist and optician and visiting relatives felt staff were effective in responding to people's changing needs. Staff had referred people to the TVN and speech and language therapist as required.

We received varied feedback from people relatives and health professionals. People told us that they were happy living at Clyde House and felt their needs were being met. Some people felt unsettled due to the high turnover of staff but said "I'm getting to know the agency staff now, I like to know the staff who support me." A visitor told us that staffing levels were still a problem and that sometimes there was only one staff member for ten people. Another visitor said, "It's just the staffing that needs to improve, everything else is okay." A health professional told us, "I have concerns that there are not enough nurses to take our advice forward but I'm told that they are advertising."

Requires Improvement

Is the service caring?

Our findings

We saw variables of care delivery during our inspection. We met with some new care staff who were kind and compassionate in their role and were enjoying their introduction to care. They told us, "We are told to treat people with kindness and respect at all times." However we also saw staff were task orientated and did not always treat everyone with respect, kindness or maintain people's dignity. We undertook a SOFI which identified some staff were not interacting with people in a way that was respectful. There were people who were supported with food and drinks with no conversation or eye contact. We also saw one person who was being supported on a one to one basis with no verbal interaction or attempt to engage the person in an activity or interest, until prompted by the area manager.

People were not always treated with respect and dignity. During our inspection one person was moved with an electrical hoist in a communal lounge. The person's clothing was lifted whilst the straps were between their legs. Staff made no attempt to shield the person from other people or cover the person's lower body whilst undertaking this manoeuvre. This persons' dignity was not protected or promoted. Instead of moving the wheelchair to the person, staff pushed the person to the wheelchair, this meant the person was left swaying unsupported in the hoist. On Tay Wing, a strong odour of urine was noted. This was identified to staff who then proceeded to sniff each person's lap with no conversation or reason given for the action. This was not respectful.

We observed staff moving a person in their specialist chair. Staff did not know how the specialist armchair worked. When trying to move the chair they released the recline button and twice the person fell backwards sharply. Both staff members were standing behind the chair and there was no explanation or dialogue with the person in the chair. Both staff said they had no idea on how the chair worked. They struggled to get the chair out of the doorway into the corridor due to the size and layout of the corridor and chair. It was a difficult manoeuvre to watch as the staff were clearly struggling and the movement was jerky.

We spoke with agency staff who were unsure of people's names and did not know information recorded in their files about their pasts and their interests. This made it difficult for them to initiate conversation and the SOFI identified that there was a lack of positive interaction. During the observation there were times when care tasks were undertaken with no verbal communication. For example, one staff member assisted a person in their room to eat their lunch and there was no dialogue at all, not even explaining what the food was. We asked the staff member why the silence, and were told, "Well they can't talk and won't understand." Another person in their room was attempting to eat their meal without support but struggled due to their dementia and therefore ate very little. We reported this to the nurse in charge who told us she would ensure someone would offer them support. We did not observe this happening.

Whilst staff told us people should be encouraged and supported to make independent choices we didn't observe that peoples' wishes were always granted. People were at times confined to an area due to the deployment of staff. For example one person wished to go into the garden but was told that it wasn't possible and they had to wait until staff were available. They didn't get their walk. We were told this was unusual and they usually got walks when they wanted.

Peoples' privacy was not always protected. A health professional was visiting during lunchtime to review the care of a person. They sat at the dining table on Tay Wing with the registered nurse whilst they were discussing the persons' personal needs who was sitting on the other side of the room. The person eating their lunch, got up and approached us and said "Why sit there and talk about them, it's not right." We saw that on a white board in the ground floor office, people's weights and catheter change dates were clearly visible to visitors and people.

People's preferences for personal care were recorded for each person but not always followed due to inexperienced staff. For example one person appeared dishevelled with stained clothing. Staff told us that the person was not easy to assist and so had not had their wash. We asked what guidance had been given to them to enable them to give support, they told us no advice had been given. However on the second day an experienced staff member had managed to support the person with singing songs with them as this made them happy and relaxed. We also saw that some people did not always receive their shower or bath as they wished. We were told that due to high agency staff usage the work took much longer as they were not familiar with people and their ways.

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

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

At the last inspection the environment on Tay Wing which is specifically for those people who live with dementia was not dementia friendly or homely. At this inspection corridors were brighter and had textiles and objects such as vintage hats and scarves to encourage people to touch or recognise objects from the past. Doors had been painted and there was sign posting to promote independence. For example signage for people to recognise the lounge and bathrooms. The lounge however was still dark and not set out to be comfortable and relaxing for people, but there were plans to develop the lounge area. Sensory equipment for people to prompt memories or encourage mental stimulation were gradually being introduced but were not being offered by staff until prompted by the area manager. Whilst improvements had been made they were not embedded in to practice. The management team were aware there was further work to be undertaken and discussed their future plans for the service.

Visitors were welcomed throughout our visit. Relatives told us they could visit at any time and they were always made to feel welcome. Staff told us, "Families are encouraged to pop in at any time."

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in October 2015, the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care delivery was not always responsive to people's individual needs. We also found that care plans did not always show the most up-to-date information on people's needs, preferences and risks to their care.

The Provider submitted an action plan detailing how they would meet their legal requirements by 30 April 2016. Whilst improvements had been made the provider was not fully meeting the requirements of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found there were still areas of the regulation that required further time to be embedded and structured.

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

At our last inspection we had found communication and social well-being was an area of concern as a large amount of people were isolated in their bedrooms and in the lounge areas with little interaction from staff. This inspection found that support offered by staff was dependent on the staff team and deployment of staff. Because of this, we found the two days of inspection very different. During the first day we saw that there was some positives and improvements, for example meal time experience was enjoyed by people. However the second day proved that improvements were not embedded into everyday care delivery. We noted at times there were still no staff in communal areas and people were left eating with the television on in the background. There was no rationale given by staff or any evidence this was people's choice. There were also people whose only opportunity of respite from lying in their bed was meal times when they were sat up and assisted with their meal. Staff performed the tasks but did not use this one to one time to chat or offer reassurance. The SOFI identified that there was little empathy shown by staff to people and very little positive conversation especially on Tay Wing and the Garden Floor. For example: Staff were helping people to eat at a comfortable pace, but there was no conversation during the meal. One person was reaching out trying to hold the spoon themselves but the staff kept saying, 'no I will feed you.' This person was in an armchair with no table. It was not a relaxing meal atmosphere. The television was on loudly and no one was watching it. Later a care staff put music on but did not turn of the television until a relative asked her to. The noise was confusing for people and caused increasing confusion and agitation for one person who said, "It's driving me mad, the noise is horrible." This person then asked to leave the wing, which was denied as there were not enough staff at that time.

Activities were not reflective of people's individual interests and hobbies. The activity coordinator knew what people liked but the activity programme was generic and did not meet specific needs. For example, a person liked gardening but had no social needs care plan to help them maintain this hobby. We asked when this person was last enabled to do some gardening and the activity coordinator said once last year. Another person liked walking, but was on the top floor and relied on staff to take them into the gardens. A further person used to be a postman and their plan said they liked to walk but they were also on Tay Wing with no

outdoor access. Staff said only one person on Tay ever went outside. This person was heard asking for fresh air multiple times over the three days, but only once were staff able to take them.

The activity coordinator said she took seven people every two weeks to a local tea room. This was the more mobile people and only one person from Tay Wing was included in this. We saw that there was a musical entertainer each month and music for health, but this was not seen as available for people on Tay Wing. We were told that this was because they may cause a disruption. There were also craft activities, bingo and knitting, but we were told that this was really for the people who were able to participate. There were no specific activities implemented or offered for the people who lived with dementia. One person was in their room sitting with their table in front of them and was using their hands to try to move and pick up objects such as artificial flower vase. On two occasions we found this person bending down to pick up specks of carpet and this placed them at risk of toppling forward. We asked staff if there was any specific therapy offered to this person such as a sensory fiddle muff. A sensory fiddle muff brings comfort to people as they can safely fiddle with buttons and zips. This had not been considered at this time. Sensory objects such as hats, necklaces and scarves were hanging in the main corridor, but this person was not mobile and therefore could not access them. We did see for one person that the staff ensured that they had a carry cot and doll that was very important for the person. This was moved with the person throughout the day. Every morning the activity coordinator told us they went around to people in their rooms for a chat. However this was not recorded in the care plans we looked at. This also meant people in communal areas were left with just the television on and no access to daily papers or magazines or activity. We heard a relative say to staff that they thought it was a shame there were no activities on Tay Wing. We looked at six care plans and none had a plan for social needs. We saw that for some people an in-depth social history was in place, but this was not yet being used proactively to inform the care plan.

Staff asked people on Tay Wing what meals they wanted for the next day, there were no pictures and staff said they did not have any to use. Two staff were asked how accommodating the kitchen staff were if people changed their minds. They both said one cook was very helpful but the other was "moody and difficult"

Care was not always personalised to the individual and did not include important changes to their health. For example, reduced mobility and communication and behavioural problems. One person was distressed at times and we heard them shouting 'help me, help me' during personal care. Agency staff member asked us to get another carer to help. Afterward the agency worker said the person is often aggressive during personal care. There was no care plan in place for this. We asked the agency worker what guidance they had been given for managing this situation but they said they had not been given a plan. A permanent member of staff also confirmed there was no plan for managing the distress or aggression during personal care. We were told this was to stop them being left on. There was no detail in the persons care plan to offer meaningful activities as diversional management or how to manage the person's behavioural traits.

Some people's care plans lacked details of how to manage and provide specific care for their individual needs. For example a person had a history of chronic obstructive airways disease which affects breathing. However there was no care plan in place to guide staff if this person became breathless or distressed. This person had multiple chronic illnesses which affected their well being but there was minimal information to guide staff on how to manage them. Such as gout, seizures and confusion.

The evidence above demonstrates that there had been some improvement in the delivery of care in Clyde House but it was still task based rather than responsive to individual needs. This meant that people had not received person centred care that reflected their individual needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A complaints procedure was in place and displayed in the reception area of the home. We were told that people had a copy of the complaint procedure, however, this was not provided to people on Tay Wing in an accessible format. People told us "I would go to the office to complain." Most people told us they felt confident in raising any concerns or making a complaint. There had been a number of complaints received in the past few months and documentation confirmed complaints were taken seriously, investigated and feedback was given to the complainant.

Inadequate

Is the service well-led?

Our findings

At the last inspection in October 2015, the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were put at risk because systems for monitoring quality were not always effective and records were not accurate. We found the home had a vision and values statement but we did not see the values acted on during the inspection

The Provider submitted an action plan detailing how they would meet their legal requirements by 30 April 2016. Whilst some improvements had been made the provider was not meeting the requirements of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was no registered manager in post. The registered managers' post has been vacant since July 2015. An interim manager had been seconded by the organisation to Clyde House and will be submitting an application with CQC to be the registered manager of Clyde House.

The provider had put into place a new senior new management team in January 2015 and were undertaking organisational audits which had identified some of the shortfalls we found but work to improve had not progressed enough to address all the areas identified in this and our previous inspections of breaches of Regulation. The management structure, staff retention and recruitment at Clyde House had not been consistent and this had impacted on the action plan delivery. We found that the breaches of Regulation of the Health and Social Care Act 2014 identified in October 2015 and in February 2016 had not been met and the supplied action plan not fulfilled. This was the third inspection where we identified breaches in the quality assurance systems at the home and had identified people's records were not always accurate. This meant that people were at risk from inappropriate care delivery.

Quality assurance systems were in place, however they had not identified the shortfalls we found and had not addressed the problems with providing consistent safe care delivery. We found gaps in audits from when the last interim manager had left and in this inspection. We were told following our inspection in February 2016 that an audit would be undertaken due to the unreported and unrecorded bruising and skin damage found. This had not been undertaken. We found that there were still incidents/ accidents that were not being recorded. One injury had occurred early on the first day of the inspection and no accident record or body map recorded until we asked for information at 5pm. We were told that the RN had not had the opportunity to document the injury or the dressing applied. This was not in line with their organisational policy, which stated to be done immediately.

There was a lack of oversight of care staff by senior staff whilst providing care and support to the people living at Clyde House. For example, staff that were unsure of how to use certain equipment such as recliner chairs and wheel chairs which was potentially unsafe. We also saw a staff member struggling to assist a person to a sitting position without knowing that it was a two person manoeuvre.

There was a clear lack of leadership and accountability. On the second day there were two care staff short in the afternoon according to the staffing rota. We asked staff on Tay Wing and on the Garden floor if there was

a staffing issue and were told no, everyone is here. The allocation sheet was missing and staff were unsure of where they should be working and who they were working with. The reasons for not telling us the staffing shortage was not clear. The activity person was asked to move on to care duties but they didn't feel it was fair on the people as they needed the social interaction. The RN left Tay Wing for their hour lunch break with just one agency staff. The staffing risk assessment for Tay Wing states two members of staff were required at all times due to the needs of the people who lived there. Staff were trying to cover all areas of the building and this impacted on the care delivery. On one occasion a new staff member was left alone on the garden floor and was unsure of how to manage to answer call bells and assist people. The staff member told us, "I hope nothing happens, because I'm on the first day of my induction." On another we found an agency staff member working alone as the permanent staff were all in training. This indicated a lack of leadership that had not assessed, monitored and mitigated the risks relating to the health, safety and welfare of people and others who may be at risk on a day to day basis.

Clear lines of communication between staff, people and management were not clear. One person who remained on bed rest informed us of an ant infestation in their room which the senior staff were unaware of. This problem was dealt with immediately once we informed the area manager. When we queried a person's soft meal, staff told us that they knew that the diet for a person was incorrect but were afraid to return it to the chef.

We identified at this inspection that people were at times unstimulated and isolated and that staff did not actively engage with them due to time constraints and lack of understanding of person centred care. We also found that people's nutritional needs were not being managed effectively to enjoy the meal time experience on a day to day basis or monitored effectively. The care plan audits had not identified that people's specific health needs were not accurately reflected in their care plans, for example the management of behaviours that challenge and specific health problems. Safe moving and handling of people was found to be inconsistent and not all accidents and injuries had been documented and investigated for cause and trends.

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

The culture and values of the home were not yet embedded into every day care practice. We saw very different care delivery over two days which stemmed from lack of leadership on the second day. There was a lack of accountability or responsibility for deployment of staff and as a result staff were unsure of who they were working with, where they were working and who to report to. On one occasion the activity coordinator was asked to stop the activity plans and start on care duties. This was not received well. A new member of staff was sent from the ground floor to Tay wing as only one staff member was left to support the people. This new member of staff admitted that she didn't know people and was out of her depth.

Staff told us "We are getting new staff which will really help, the agency staff are good but they don't the home as well and everything takes longer." Another staff member said, "we are being supported and having training sessions and supervision." Staff we spoke with did not yet have an understanding of the vision of the home and from observing staff interactions with people; it was clear the vision of the home was not yet fully embedded into practice as care was task based rather than person centred. We saw poor practices undertaken and not challenged by senior staff. This told us that the culture of the home had still to change to ensure person centred care. Staff however spoke positively of the improvements to the service, "I really think things are getting better, the environment is improved and brighter to work in."

People, staff and visitors said the atmosphere in the home was pleasant and staff seemed to be happier and

less frantic. However due to staff deployment we saw that poor practice was accepted by staff. We also saw shortcuts in care delivery such as moving and handling and support with meals and drinks shortcut were noted due to time constraints and staff deployment. People therefore did not always receive the care they wanted and required.

The area manager told us one of the organisational core values was to have an open and transparent service. The provider was supporting staff, visitors and the people who lived at Clyde House to share their thoughts, concerns and ideas with them in order to enhance their service.
Supervision sessions with the project manager had resulted in staff sharing concerns about practices observed whilst working and this had led to the organisation referring safeguarding alerts to the local authority for support and investigation.

Friends and relatives meetings were planned and surveys were to be conducted to encourage people to be involved and raise ideas that could be implemented into practice. People and their visitors told us that they would like to be involved and welcomed the opportunity to share their views. One visitor said, "I think they are honest and want to improve the home."

Staff meetings had been held regularly over the past six months, and we were assured that regular meetings would be held whilst changes to the management structure continued. The area manager said, "There has been a lot of changes, and they are constant, everyday there is a new challenge."

We spoke with agency staff about how information was shared. They told us they were given minimal information about people and felt it could be better. They were not informed of the status of blood sugar irregularities, bruises or injuries or which people had not been drinking and eating enough. The management had identified this as an area that still needs developing and were dealing with this through meetings with staff, investigations and supervision.

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

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