Care Worldwide (Carlton) Limited

Carlton Lodge

Inspection report

28 Carlton Street
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Tel: 01924227516

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection of Carlton Lodge took place on 8 May 2017 and was unannounced. The home was previously inspected in March 2015 and rated good overall with requiring improvement in the responsive domain due to a lack of available activities for people to engage with. There were no breaches of regulations at this previous inspection.

Carlton Lodge is a converted property in a suburban street which provides care and support for ten adults needing support with their mental health needs or who have a learning disability including people on the autism spectrum. There were nine people in the home on the day we inspected as one person was away from the service.

There was a registered manager in post and we spoke with them on the day of the inspection. They were also registered to manage two other properties owned by the same provider and shared their time between all three. 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.

Staff had a sound understanding of how to deal with more complex behaviour and knew what may be seen as abuse. They were confident in how to report such concerns and we saw evidence of appropriate referrals to the local authority.

Risks were not always managed in a person-centred manner and assessments were often generic. We found assessments had not been updated often enough and personal emergency evacuation plans were not reflective of current need.

Staffing levels meant people's needs were met in a timely manner and staff had time to spend with people. Medication was administered, stored and recorded appropriately.

The ongoing refurbishment of the home meant the communal lounge was not conducive to offering a homely environment but we saw this was work in progress. The dining room and some other communal areas had been redesigned sensitively and appropriately.

People's nutritional and hydration needs were supported where this was necessary, and staff encouraged people to make healthy choices. Health and social care support was accessed as required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, although this was seen in practice, records did not always evidence best interest decision-making.

Staff had received an induction, one to one supervision and training which ensured they were equipped to support people well.

We observed staff to be patient, kind and caring with people. They paid attention to the smallest of details and promoted people's dignity and privacy.

Care records were in the process of being updated and reviewed. Staff were being trained to complete these reviews. Most contained good descriptions of people's individual needs and how these were to be met.

Complaints were handled well with apologies given to people where standards had fallen short.

The registered manager had clearly made an impact and made some significant progress in altering the culture of the home. However, they acknowledged there was still more to be done and had developed an action plan as evidence of this. The quality assurance systems needed further development to ensure they provided an accurate reflection of the support being provided for people.

We found two breaches of regulations relating to the need for consent and safe care and treatment. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

Some risk assessments did not reflect individual need and required updating.

Staffing levels were appropriate to meet people's needs in a timely manner and medication was administered safely.

Staff knew what may constitute abuse and how to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

There was little written evidence of best interests decision-making where people lacked the capacity to make a specific decision.

Staff received supervision and training to ensure they were competent in their roles.

People's nutritional and health care needs were met appropriately.

Is the service caring?

Good

The service was caring.

Staff engaged well with people and people responded positively.

We saw staff were kind, caring and attentive to people's needs.

People's privacy and dignity was promoted in all interactions.

Is the service responsive?

Good

The service was responsive.

Although care records were difficult to navigate around they did reflect individual need.

People were able to go out or remain in the home during the day or evening according to their preference.

Complaints were handled thoroughly and in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well led.

The home had a happy and calm atmosphere and people appeared comfortable.

The registered manager had made progress on some necessary changes and acknowledged there were still more to do.

The quality assurance measures needed further development to more accurately reflect what was happening in the home.

Carlton Lodge

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.

This inspection took place on 8 May 2017 and was unannounced. The inspection team consisted of one adult social care inspector.

Before the inspection the provider completed a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We checked information held by the local authority safeguarding and commissioning teams in addition to other partner agencies and intelligence received by the Care Quality Commission.

We spoke with one person using the service and we observed other people who were unable to verbally communicate or were too shy to talk. In addition, we spoke with four members of staff including two support workers, the cook and the registered manager.

We looked at four care records including risk assessments, three staff files, training records, minutes of staff meetings, complaints, safeguarding records, accident logs, medicine administration records and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

Risk assessments were contained within care records but did not provide sufficient guidance for staff in how to manage specific situations. They had been reviewed at least quarterly but few had been amended to reflect current needs. Different situations were cited with the risk or hazard being recorded, a list of people who could be harmed and the risk controls in place to reduce the likelihood of this happening. Situations included going out into the community, behaviour which may challenge others, risk of self harm and falls. However, they provided little person specific guidance for staff.

Staff did have an understanding of what actions to take in the event of a fire. The provider did have personal emergency evacuation plans (PEEPs) which described the equipment a person may need, how mobile they were, their level of cognition, any sensory loss which may impact on their evacuation and any medication they may need. However, these had not been updated regularly. This is a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as risks for people were not assessed or mitigated often enough.

We looked at accident and incident records and found evidence of who was involved, the location, details of the incident and a review of whether the action taken was appropriate. This was reviewed by the regional manager in addition to the registered manager. If people had incurred an injury, body maps were completed to indicate the extent and location. Both safeguarding and accidents had monthly 'trend' sheets which considered key information and enabled the registered manager to identify any patterns or where further action may be needed.

One new staff member told us, "I think people are safe as there are enough staff around to support people." They also had a good awareness of what may constitute a safeguarding concern. They told us, "I am here to ensure people are not in a position where they can be harmed." Another staff member said, "People are safe. We are being particularly careful during this redecorating period." They knew how to report any abuse which they told us may include altercations between people living in the home or financial abuse.

The registered manager spoke with us about a recent safeguarding issue which had been dealt with swiftly and appropriately. They explained the action that had been taken and we saw records which supported this. Where decisions had been taken with people who had lacked capacity, even if temporarily, it was evident immediate safety had been the focus of both the person and any other people in the vicinity. We also saw any decisions were made in the person's best interests. We looked at other safeguarding records and found concerns had been reported correctly to the local authority and to the Care Quality Commission (CQC).

Where there had been incidents between people living in the home behavioural charts had been completed to identify if there had been possible triggers and the actions taken to defuse any situation. The staff had managed some complex and difficult behaviour well showing how they responded at the time of the incident and also actions following such events. We also saw evidence of increased staffing ratios where this had been deemed necessary.

Staff files contained the appropriate checks including Disclosure and Barring Checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. References were checked and verified and any gaps in employment reviewed.

Staffing levels appeared appropriate to meeting people's needs in a timely manner. There were four support staff (one of whom was a team leader) on duty at all times, including during the night, and there were an additional six flexible hours used daily to accommodate people's social needs, such as going out or doing activities in the home. One staff member said they had struggled to recruit staff and had been asked to cover extra shifts, although they stressed they were happy to do this. They also said the service never used agency staff.

We checked the administration of medication and found this was all completed correctly. The home had recently started using an electronic medication administration system which helped the staff member to provide the right tablet at the right time. Each required medication, including the dosage, was shown on the record with a photograph of the person to aid identification. The support worker administering the medication checked the contents of the box against the running total on the system to ensure stock levels tallied. We checked the stock levels against the records and found no discrepancies. Once the tablet had been popped out of the packet, the system was ticked to show it had been administered and then again once the person had taken it. If the person refused their medication there was the option to record this as well.

There was a facility to keep paper records in the event of a power cut so the home had thought through an emergency plan. The home had no controlled drugs at the time of inspection. All dates of opening were recorded to ensure no medicine was used past its expiry date. We saw where people had the capacity to decide, they requested their own PRN (as required) medication which was administered to help reduce their feelings of anxiety. The electronic records had full details of all PRN medication including why the person had been prescribed it and directions for staff as to when to offer it to people. We saw medication audits had been completed for both the old system and were due later in the week for the new system.

The staff member paid due attention to infection control by washing their hands and wearing gloves prior to administering any medication. We found the medication room and fridge temperatures were recorded and a fan was in the room as the temperature was at the high end of the permissible range. All staff administering medication had been subject to competency checks which assessed their knowledge, administration and assessment of people.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Four people in the home had a DoLS in place and none had conditions imposed.

We saw where people had capacity they had signed an agreement form to consent to their care records, attend reviews at least six monthly, gave their permission for the use of photographs, and agreed to prescribed medication being ordered. We also saw an agreement giving staff permission to enter a person's room in the event of an emergency. The provider had a 'no restraint' policy and staff training was ongoing in regards to de-escalation techniques. We saw incidents logged where people had been biting themselves or grabbing other people, but staff intervened and diverted them appropriately.

One staff member told us, "We use capacity assessments to determine if someone can make a decision. These decisions are always in their best interests." However, when we looked in people's care records we did not see evidence of these. In one person's record an agreement to accept care form was signed by a family member in 2009 with no apparent legal authority to do so, and then by the previous registered manager in the home in 2016. There was no evidence of a mental capacity assessment or best interests decision recorded. The registered manager was aware of this shortfall and had plans in place to rectify this. This is a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as consent had not been obtained for people lacking the ability to make a decision by the appropriate people.

The home was in the process of refurbishment which was taking some time as the contractors were working around the needs of people in the home. The lounge had no carpet, bare floorboards and had been recently repainted. There were two large sofas and an armchair which were in the process of being replaced during the refurbishment. The registered manager assured us the carpet fitters were due to visit on 11 May to measure and arrange delivery of the carpet. There were also no blinds or curtains in the lounge which meant it was not very homely. The registered manager explained most people congregated in the hallway, which we observed as there was a sofa there and offered more privacy.

The registered manager advised us they were also waiting for the delivery of ten new bedroom doors and for the downstairs bathroom to be refitted. Where the refurbishment had been completed, such as the dining room, this had helped to create a pleasant and more relaxed environment. People's rooms were

personalised with wallpaper chosen by themselves to suit their interests and we saw use of equipment such as sensory lighting to ensure people could relax.

People were supported to make choices about their meals through pictures of specific food or drink items or plated meals. There was a pictorial menu board in the dining area and daily choices were displayed there. People were encouraged to help lay the tables for meals and to tidy up afterwards. Deliveries of fresh and frozen food were regular and we saw one arrive during the inspection which consisted of fresh fruit, salad and vegetables which we later observed people eating. Staff told us people were supported to make healthy choices but respected their decisions when they preferred other foods. One staff member said a dietician had been supporting one person due to their weight loss and staff encouraged fortified foods and high calorie snacks.

We saw staff had received an induction which included looking at medication, meeting people's needs including information about their particular conditions, de-escalation techniques, positive behaviour support, safeguarding, nutrition, documentation, accidents and emergency procedures including fire and first aid. One staff member said their role had been explained to them, they had had time to read each person's care records, and shadowed other more experienced colleagues before working alone. They said, "Until I was 100% confident I was not allowed to do any tasks."

Staff had received regular supervision with the registered manager and this was through individual meetings. Staff had the opportunity to discuss their health, training needs, reflect on their practice, discuss people living in the service and agree goals and ambitions. We saw these were recorded and signed and dated by both employee and registered manager. Any outstanding actions were followed up at subsequent meetings which ensured staff's morale was maintained and they felt supported.

Discussion comments were open and honest which showed staff had a positive relationship with the registered manager. One of the questions included, 'Is there anything stopping you from improving? How can I support?' which again reinforced the promotion of staff's welfare, confidence and knowledge. In one record, praise was given to a staff member on their handling of an emergency situation. We saw people had been given the opportunity to develop by moving into new roles supported by working alongside the registered manager, and constructive feedback was then recorded to assist staff's further development.

We looked at staff training records and found staff had accessed courses in mental capacity and DoLS, safe food handling, hazard identification and risk assessment, equality and diversity, dignity in care, fire prevention, infection control and safeguarding. For more senior staff they had also completed medication training. Newer staff had completed the Care Certificate. This is a set of minimum standards that should be covered as part of induction training of new care workers. It was difficult to determine how up to date staff were as the training matrix was not current but a random sample of files showed most courses had been completed within the past 18 months. The registered manager was aware of the need to develop a training register to ensure all staff had completed required training.

Staff were aware of who may need support with pressure care and the equipment which was used to facilitate this. One staff member spoke with us about one person's particular routines to help promote their skin integrity. Another told us one person's pressure areas were checked regularly during transfers and the person was also able to say if they were sore. The support worker also said the district nursing service provided regular monitoring visits. We saw pressure care equipment in use such as mattresses and cushions.

There was a structured handover system in place which recorded key information such as any 'as required' (PRN) medication which had been administered, which staff members were allocated specific tasks and

responsibilities during a shift and also details of any impending appointments or activities for people to ensure staff cover met these needs.

Good

Is the service caring?

Our findings

Some people in the service were not able to communicate verbally and the registered manager had ordered some Picture Exchange Communication cards and other resources to help facilitate people's abilities to make choices. People were spoken with, asking how they were, even if they were not able to respond verbally, which showed staff considered people's wellbeing and comfort. Staff took their cues from body language and facial expressions which was supported by evidence in people's care records as to the best forms of communication.

We asked staff how they facilitated conversation with people who were unable to respond verbally. One staff member told us, "We referred one person to the Speech and Language Therapy team as they just stopped talking. We now know they can make simple choices through the use of gestures. We tried picture cards but they didn't like these and wouldn't use them. Another person here does though."

We observed staff talking to people about their interests. One person was discussing a recent football match and their outing to the local pub to join in the karaoke. A bit later we heard a staff member talking to one person about their interests in buses and diggers. They were offered a drink during this conversation and duly supported to have this.

One person came running into the lounge without any footwear which was potentially harmful due to the lack of carpet because of the redecoration but a staff member quickly observed this and prompted the person to go and get their shoes. On their return the staff member assisted them to put them on. We later observed this staff member dancing with the person as they liked to rock from side to side and were enjoying listening to the music playing on the radio.

During our conversation with a member of staff one person chose to sit between us and the staff member immediately knew they wanted a drink, and promptly got them one. This showed staff knew people well.

Staff had a keyworker system in place which meant each staff member had responsibility for a particular individual ensuring they had all the personal effects required such as clothing and toiletries, any health appointments were made and attended and any other needs were met as required such as haircuts. We saw in the staff minutes from April 2017 a further discussion around this role which included ensuring people's files and records were up to date, the organisation of three monthly reviews for people with family and significant others and planning health and medication reviews.

People's privacy and dignity was promoted through discreet interventions from staff where people required support with personal care. Staff always acknowledged people and ensured they were happy and settled.

One staff member told us, "We know what is important to people by talking to them and engaging with them. We get to know them and read through their records." They told us about one person who liked to pray and they sat with them while they did this. They also helped them to attend church on a regular basis.

Good

Is the service responsive?

Our findings

One person told us, "I get out a lot here. I am going to Asda." We later saw this person had bought a cookery book and was discussing different recipes with staff to see which ones they could make. We observed other people listening to the radio and a bit later in the day watching quiz shows on the TV. One person was sat on the sofa in the hallway doing some drawing and was immersed in this task.

The registered manager told us they were aware people did not have enough structured activity to do which had been noted during the previous inspection. On the day we inspected we saw staff using the 'flexible hours' allocation take people shopping and for walks to the local park while ensuring people who wanted to remain in the home could do so safely with staff support. One staff member said, "These extra hours also allow flexibility about going out at night such as to the pub where a few people like to go."

We looked at care records and found they contained a brief description of the person including their interests and photograph. Key contact information such as next of kin and GP was recorded and dated to show it was current. An overview of people's main support needs was at the front of the file which helped staff get an insight as to how best to support them. One person's preference for staff talking to them via stories was recorded and we observed this happened on more than one occasion during the day showing staff understood the best means of engaging with this person.

In a different person's record it referred to that individual's limited social awareness and how this may impact on their behaviour. Some of these records were evaluated but not all information appeared to incorporate recent incidents, and there was lot of information in the files which made them difficult to navigate. The registered manager advised us they were in the process of altering these records to make them easier to access. We saw one of the new style booklets which meant records would be more focused and reflective of individual needs, linking their support needs to the safe management of risk.

Care records included support plans for health and mobility, bathing, medication, 'keeping me safe', pressure care where relevant and family information amongst other areas. People's dietary preferences and bedtime routines were recorded as was information about people's communication abilities and behavioural patterns. Where capacity was more limited, pictorial records were used to show what people liked and things that were important to them.

Statements were person-centred such as, 'I am friendly and like to be around others although I am shy and can get nervous' and 'I may sometimes refuse to get out of the bath. I need encouragement to stand. Staff must not lift me. I will get out but you will need to be patient.' Other significant health information was also noted so staff could see quickly important facts about supporting someone safely.

Where people's needs had changed we saw new support plans had been created. Again, where people had capacity to help write these there was evidence of their agreement, such as, 'I have agreed to this as I have lost my temper a lot recently. I don't want to do this again.' The support plan focused on the individual saying; 'I want you to understand what makes me angry and how to help me before I lose my temper.' This

was followed by a list of trigger factors to help staff identify when intervention such as distraction or medication may be required. All staff had signed and dated this support plan to show they had read it. This document had been reviewed following further concerns and reflected the current situation for this person.

We saw in another care plan for bathing, 'I like to have a bath in the morning. I need assistance to check the shampoo is washed out, to prompt me to clean my teeth and put on clean clothes.' We asked about care file audits as they were referred to but one staff member said, "Support staff are just learning about doing care plan reviews as it used to be just managers who did them. However, going forward we will be included." This was also part of the registered manager's plan to amend the support plans.

Support workers completed daily notes to reflect tasks completed and activities undertaken for each person. Notes were also recorded of any professionals' visits and weight monitoring. In the daily notes we sampled we saw details of what food and drink had been taken, what the person had done during the day and what they had achieved for themselves. In one record we saw '[Name] has made their own cup of tea.' In another record it was logged, 'I asked [name] if they would like their finger and toe nails painted. They said yes and went and got their nail polish. [Name] chose the colour and spoke to me about what else they needed from their case.' Daily records showed evidence of people going on trips out.

The complaints procedure was accessible for all people and we saw evidence of one complaint which had been dealt with in depth, staff spoken with and an apology given due to miscommunication.

Requires Improvement

Is the service well-led?

Our findings

Although we were unable to obtain much direct service user feedback, we observed interactions to be positive and people were happy and settled.

One new staff member told us, "I feel really well supported. I think this home is going in the right direction. Our vision is for everyone to have the best quality of life possible." This staff member had also met the regional manager not long after they had started which had also made them feel welcome. Another staff member said, "I love working here and I've learnt a lot. I feel able to report any issues and am confident they will be acted on." They continued, "The manager is approachable and listens. Morale has increased recently. If we needed extra help we would get it." Staff meeting minutes from December 2016 also reflected this, 'Staff said they did not feel isolated anymore and were comfortable in challenging things and making suggestions.'

The registered manager arranged regular staff meetings and we saw where staff had not attended this was noted in their records and a meeting set up with the registered manager to ascertain the reason for non-attendance. This was to ensure all staff received current information and were part of the team. We saw in staff meeting minutes from April 2017 a guest speaker had attended to talk to staff about how best to support people in the service. In these same minutes was an example of how one person had been supported to raise concerns about receipt of their external healthcare at a different venue to their usual place. However, through support from the service, this had been reverted to their original location which had increased this person's confidence in managing their own care needs.

Minutes were detailed and showed discussions around training needs and completion, guidance about specific policies and procedures such as behaviour management, appropriate recording and handling of complaints, and expected standards of care intervention. The registered manager asked staff at one point to reflect, 'Would this be good enough for me?' when considering how a person was clothed and presented. The registered manager said, "Near enough is not good enough" which gave staff clear expectations and emphasised the focus on delivering support in a person-centred manner. Where polices were discussed staff's understanding was checked by asking for examples of different scenarios where it may apply to ensure all had the correct knowledge.

We asked staff what they thought the values of the home were. One told us, "I am looking forward to the development of the home. Some people here could move into independent living and I am hoping I can help be part of that. For those that stay I just want to keep them happy."

The registered manager told us of recent management changes. A new team leader had begun the week previous to the inspection and a deputy manager was due to start the week after. They were confident this would strengthen the management team to ensure much of the work they had identified needed action would now be able to take place. They had a comprehensive action plan in place which was based on the key lines of enquiry used by the CQC when we inspect.

We asked staff what they thought had been achieved and one staff member said, "One person has been taught how to wash up and this helps promote their independence." They told us they received regular feedback from the registered manager on their own performance which helped ensure they were providing quality support. They also felt able to ask for this is they needed reassurance.

The home had limited audits. We saw audits for catering, health and safety and a full home audit, all dated 28 February 2017. The catering audit had scored 100% as had the health and safety audit which considered the state of outside grounds, laundry, hot water temperatures and equipment checks. The monthly home audit had also been scored 100% but this was questionable as it said there were individual risk assessments in place and it referred to bed rails which were not in place. This meant the audits were not sufficient in their robustness to identify concerns.

However, we did see a recent comprehensive audit completed on 19 April 2017 by the registered provider. This had considered six key areas; resident safety, care planning, resident experience, workforce, environment and management. Issues raised in this audit reflected the concerns noted at this inspection including out of date risk assessments, lack of positive behaviour support guidance in care plans, limited family involvement in reviews and the lack of structured activities on offer. It also focused on all the positives such as the involvement of people in everyday decisions as far as possible, analysis of falls and appropriate follow up actions being taken and the ratings from the previous inspection being on display as required under the regulations. This meant effective auditing had begun to take place.

As a result of this audit, a comprehensive action plan had been created which set a deadline for completion of certain tasks which we saw this was realistic. Some actions had already been completed by the time of the inspection showing the registered manager was keen to address concerns promptly and plans had been made to address other issues in a suitable timescale.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 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 Where people lacked capacity to make specific decisions there was no recorded evidence of an assessment or best interest decision being made.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risk assessments were out of date and not personalised.