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Carson House Care Centre

Inspection report

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

Summary of findings

Overall summary

This inspection was carried out over three days on the 18, 19, 20 July and 9 August 2017. Our visit on the 18 July and 9 August 2017 were unannounced.

We last inspected Carson House Care Centre in January 2017. At that inspection we assessed the service as inadequate in safe, effective, responsive and well-led and requires improvement in caring. At that inspection we identified multiple regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to dignity and respect, the need for consent, safe care and treatment, meeting nutritional and hydration needs, good governance, staffing, and fit and proper persons employed.

The overall rating for this service was Inadequate and the service was therefore placed in 'special measures'. We do this when services have been rated as 'Inadequate' in any key domain over two consecutive comprehensive inspections. The purpose of special measures is to ensure the provider makes significant improvement to become compliant with the Regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At the time of the last inspection a receivership company had been appointed to sell the home and an external care management organisation had been appointed to oversee the day to day management and care delivery at the home. The receivership company had been appointed from 26 September 2016 to 5 June 2017. This meant at this inspection the receivership company were no longer managing the service and that the original registered provider had been reinstated to manage the service again on 6 June 2017.

This inspection was to check if improvements had been made and to review the ratings

Carson House Care Centre is situated in the Stalybridge area of Tameside and provides accommodation for up to 45 people who require nursing and personal care. All rooms provide single accommodation and 43 rooms have en-suite facilities.

Bedrooms are located over two floors and can be accessed by stairs or a passenger lift. Communal bathrooms and toilet facilities were available throughout the home. The home is divided into four units, two on the ground floor and two on the upper floor; each unit consisted of a lounge, dining area and small kitchen facilities. One unit is dedicated to providing general nursing care, one unit (CBU) provides specialist mental health nursing for men who have behaviour that challenge and the other two units provide mental health nursing for men and women in separate units.

The laundry and main kitchen are located on the lower ground floor. There are two enclosed patio areas at the rear of the building that were also accessible to people who use the service.

At the time of our inspection there were 39 people living at Carson House.

At the time of this inspection the service did not have a registered manager in place. The previous registered manager left the organisation in December 2016. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection, we saw that some improvements had been made. However we identified multiple continued breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to person-centred care, consent, safe care and treatment, safeguarding service users from abuse and improper treatment, good governance of the service, staffing and ensuring fit and proper persons are employed. We are currently considering our options in relation to enforcement in response to some of the breaches of regulations identified. We have issued requirement notices for all breaches identified at this inspection. Please see the section at the back of the inspection report to explain the actions taken.

Some people living at Carson House Care Centre, their relatives, and staff spoke highly of the service. For example one person said "I've lived in a few homes and this is the best one, the staff know my needs. Sometimes there are agency staff but on here we have people who've been here a long time." However some comments from relatives were not so positive about the care their relative received and the decor of the home.

As found at the last inspection there were enough staff available to meet people's needs. However, we observed that some staff did not positively engage with people or provide individualised personal care.

As at the last inspection we found that safe and appropriate recruitment and selection practices had not been carried out by management to satisfy themselves that only suitable staff were employed to care for vulnerable people.

We had on- going concerns in relation to staff supervision because staff were not receiving supervision on a regular, ongoing basis and there was no evidence that staff had received an annual appraisal. This meant that staff were not being appropriately guided and supported to fulfil their job role effectively.

From examining the staff training matrix (record) we found there were continued gaps in the training staff had received. This meant some staff may not be appropriately trained and skilled to meet all the needs of the people living at the home.

We found that not all staff had received training relating to safeguarding adults and clear and accurate records were not being kept of any safeguarding investigations carried out, including the outcomes of those investigations.

During this inspection we found some improvements had taken place regarding the management and administration of medicines. For example a 'medication count sheet' had been implemented for boxed medication and we conducted a count of the contents of three boxed medications and the balances were all accurate. However we found that stocks of medication carried over from the previous month had not been recorded on the medication administration records (MAR's). This meant there was not an accurate record of medication in the home and therefore accurate audits of medication administration could not be undertaken.

We found that some risk assessments relating to keeping people safe had not been reviewed on a regular

basis and some care files contained out of date information. This meant people were at risk of potential harm.

Some of the routine safety checks of the premises had not been undertaken, for example checks of water temperature delivery, window restrictors and nurse call bells. This meant the provider could not be sure people using the service were kept as safe as possible at all times.

As at the last inspection we found some people's documentation to consent to care and treatment had been signed by family members who did not always have the legal right to provide this consent. The home had not checked with relatives to ascertain whether these legal safeguards were in place.

At this inspection, we saw that improvements had been made to the general cleanliness of the home and an external company had undertaken deep cleaning throughout the whole home. However, we found that clear and accurate records were not being kept of the cleaning that was being undertaken by domestic and care staff and no records had been kept of any cleaning that had been undertaken in the kitchen since the end of 2016.

We found that robust systems had not been implemented to monitor the quality and safety of the service people received.

At the time of the inspection the Clinical Commission Group (CCG) had suspended admissions to the home due to the concerns identified at our last inspection of the service. The CCG told us they were currently working with the service to try and improve standards of care.

We found improvements had been made in relation to people having their hydration and nutritional needs met. The chef and cook had a good understanding of people's dietary needs and people had a choice of meals.

As found at the last inspection we saw a continued use of plastic plates, dishes ad cups which was not person centred. We made a recommendation that people only used plastic crockery if they had been individually assessed as requiring them with the reason clearly identified in the care plan.

We found that when staff interacted with people they treated people with respect and dignity. However we recommended that staff should provide people with consistent and positive interaction.

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 safe.

Errors were identified regarding the proper and safe management and administration of medicines.

We found that the registered provider had not done all that was reasonably practicable to mitigate risk to people.

All appropriate checks had not been undertaken to ensure suitable staff were employed to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not effective

People did not always receive care and support from staff who had completed or updated their required training.

Not all staff had received regular, on-going supervision and there was no evidence staff members had received an annual appraisal.

Individual people's consent to care documentation had not always been signed by people who had the legal right to do so.

People's nutritional needs were being met through a choice of suitable foods being offered.

Is the service caring?

Requires Improvement

The service was not always caring.

Some comments from a relative stated that people were not well cared for at Carson House Care Centre.

People mostly received support by caring staff however positive interaction by staff was limited.

We recommended that staff should provide people with consistent and positive interaction.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not fully supported to follow their individual interests or supported in their aspirations and what they liked to do.

Some peoples care files contained out of date information.

Nurses' and care staff written communication between shift handovers were vague and lacked detail.

Is the service well-led?

Inadequate

The service was not well led.

At the time of this inspection the home did not have a manager who was registered with the Care Quality Commission.

The acting manager and the acting manager support were not familiar with the current regulations that govern CQC registered services.

We found very limited improvements had been made since our last inspection.

The systems in place to monitor the quality and safety of service provision were not effective which meant we found continued issues and concerns that we found at the last inspection.

Staff did not feel supported by the management team.

Carson House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 18, 19, 20 July and 9 August 2017, day one and day four of the inspection were unannounced. Day one of the inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Day two and day four of the inspection was carried out by one adult social care inspector and day three was carried out by two adult social care inspectors.

Before we visited the home, we checked information we held about the service including the last inspection report and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

We spoke with the Clinical Commissioning Group (CCG) in order to obtain their opinion of the service being delivered and we were told they also had the same concerns that we had identified during this inspection and at the previous inspection.

On this occasion, we had not asked the service to complete a Provider Information Return (PIR). This is a document that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We walked around the home and looked in all communal areas, bathrooms, the main kitchen area, store rooms, medication rooms and the laundry. We also looked in several people's bedrooms and outside the building; in the garden and patio area.

During the four days of inspection, we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff. This included five people's individual care records, a sample of medicine administration records and ten staff personnel files to check for information to demonstrate safe recruitment practices were taking place. We also looked at supervision and appraisal records, training records and records relating to the management of the home such as the quality assurance systems.

We spoke with 13 people living at Carson House and following the inspection we conducted telephone interviews with five relatives. We also spoke with the registered provider, the acting home manager, the acting manager support, the home administrator, the chef, one kitchen staff, two nurses, one domestic staff who was also working as a cook, nine care staff members, the activity coordinator and the maintenance person.

Requires Improvement

Is the service safe?

Our findings

During our last inspection, we found a number of errors in the way medicines were being managed which meant there was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Safe care and treatment

During this inspection we found some improvements had been made in the way medicines were being managed. We saw that a 'medication count record' had recently been implemented. This record was used to maintain a running balance of boxed medication and their contents. We undertook a count of three boxed medications and found that the balances were accurate.

At the last inspection we found the pill crushers contained a significant amount of tablet residue left from when previously used. During this inspection we found ten new pill crushers and two new tablet counters had been purchased and were all clean.

We reviewed documents that confirmed that both the home's nurses were registered with the Nursing and Midwifery Council (NMC). The NMC ensures that registered nurses keep their skills and knowledge up to date and uphold professional standards. We looked at the training record that indicated that all the nurses and one team leader had completed up to date medication administration training.

We saw excess stocks of medication were being stored. For example we saw one person had eight boxes of medication, used to treat diabetes, dating back to October 2016. We saw that none of the balances of this medication had been carried over and recorded on the medication administration record (MAR). This was discussed with the acting manager who confirmed they had already identified the shortfall. However there was no evidence of what action had been taken. This meant there was not an accurate recording of the amount of medication stored in the home and therefore the registered provider could not be satisfied that people had received their medication as prescribed by their General Practitioner.

In the treatment room we found sixteen full one litre sharps bins, four 5.8 litre sharps bins and one full five litre sharps bin. A sharps bin is a specially designed rigid box used to safely dispose contaminated sharps for example used needles, insulin pens and lancets. We saw that the lids on some of these bins were not secure which meant staff were at risk of needle stick injuries and contamination by used sharps. When full, the box should to be collected in a timely manner for disposal by a clinical waste company. Following the inspection we received confirmation from the acting manager that the sharps bins had been collected and we saw a copy of the clinical waste contract for future collections.

The above examples demonstrate a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During our last inspection, we found a number of shortfalls in relation to people receiving safe care and treatment. The shortfalls were in relation to the lack of risk assessments being in place, safety checks not being undertaken, the general lack of cleanliness around the home and people not being protected from the

risk of abuse. This meant there was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Safe care and treatment

During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

We looked at a sample of five people's individual care records and found that people had risk assessments in place. For example we saw a risk assessment for the use of bed rails and a falls risk assessment both undertaken in June 2017. However as found at the last inspection some risk assessments had not been regularly updated. We saw in one file it was documented that the person was at risk of developing ulcers due to their medical condition and their waterlow score was dated 16/11/14 with no evidence that it had been reviewed or updated. A Waterlow score gives an estimated risk for the potential development of a pressure sore. This was raised with the acting manager who assured us this person had not developed any ulcers and following the inspection we received confirmation that a full review of this persons care file had been undertaken.

We found that people had personal emergency evacuation plans (PEEPs) in place in the front of their individual care files. A PEEP provides additional information on accessibility and means of escape for people with limited mobility or limited ability to understand instructions and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire. However in one file we saw the PEEPs information was out of date and stated that the person was fully mobile and needed no equipment for evacuation when in fact they were receiving end of life care and were immobile. In addition the fire evacuation folder had a section for PEEPs, all of which were dated 2015. This out of date information placed people at risk in the event of an emergency evacuation situation arising.

We reviewed the systems in place to monitor and maintain safety in the home including the safety of the premises and equipment used in the home. We found not all appropriate safety checks had been maintained or carried out to ensure people were cared for in a safe environment. This meant people were put at potential risk.

We saw that weekly fire alarm testing and weekly fire drills had been carried out and monthly checks on the emergency lighting systems had been carried out.

During the inspection we saw several bedroom doors, all of which were fire safety doors, had been wedged open. We were told that out of the 46 bedrooms, all of which had fire safety doors, only eight doors had fire dorgards in place. A Dorgard is a safe and legal solution that allows doors to be safely held open as the dorgard automatically releases and closes the door in the event of the fire alarm activating. This meant that in the event of fire, doors wedged open could place people at risk of harm.

We were told that the means of escape were visually checked by the maintenance person but these checks were not formally recorded. As identified at the last inspection we saw the fire door on the Challenging Behaviour Unit (CBU) had a large overhead bolt. Although this door was not bolted we requested the bolt be removed to reduce the risk of it being locked in which case would put people at risk in the event of a fire.

During the inspection we asked to see the fire risk assessment. We were given the fire risk assessment that was undertaken in December 2016 as seen at the last inspection. However on the fourth day of the inspection we were emailed a fire risk assessment, by the registered provider that had been undertaken in July 2017. It was of concern that the deputy manager and the deputy manager support were unaware that a

further fire risk assessment had been undertaken. The 2017 assessment identified a number of concerns, which had been previously identified in the assessment undertaken in 2016. The registered provider did not give a time frame but told us appropriate action would be taken to address the outstanding concerns.

During the inspection we found some environmental safety checks not been undertaken. For example there was no evidence that the temperature of hot water at the point of delivery had been checked. There was no evidence to demonstrate that window restrictors or nurse call bells were tested. Following the fourth day of the inspection we received an email from the registered provider stating the maintenance person had undertaken these safety checks. We asked to be sent a copy of these checks but at the time of writing this report we had not received them.

It was of some concern that the acting manager and the acting manager support had some difficulty locating safety and maintenance certificates during the inspection. Once located we saw certificates to confirm that Legionella testing had been undertaken just prior to our inspection. We were told that a recent gas safety check had been undertaken and the home were awaiting the certificate. This certificate was not seen during the inspection. We saw that the servicing of the hoist and passenger lift were both out of date. The hoist was due to be serviced in May 2017 and the lift was last serviced in June 2016. This meant that people using the service and staff were at risk of using equipment that could be unsafe.

As found a the last inspection the electrical installation report dated April 2014 stated that essential safety improvements were required and had deemed the installation as 'unsatisfactory'. This was discussed at length with the acting manager support. We received email confirmation from the electrical company that they had completed seven of the twenty items listed in the report that required attention. We were told by the electrical company that the maintenance person employed by Carson House Care Centre had undertaken the rest of the required items. There was no evidence provided on inspection to support this but the electrical company confirmed they had checked the required work had been undertaken and they had rectified the rest of the required work and the Electrical Installation should be tested and inspected again no later than 2019.

We saw the walk way leading from the first floor women's unit to an enclosed patio area was uneven and was a potential trip hazard. We asked the acting manager and the acting manager support if there were any checks or risk assessments on the environment and safety of the building had been undertaken. We were told that none had been undertaken.

During the inspection we undertook tour of the building and saw many items of electrical equipment that had not had a portable appliance test (PAT) to ensure they were safe to be used. However we were informed that PAT had been arranged for 1 August 2017.

The above examples demonstrate a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During our last inspection, the acting manager could not provide assurances that robust and safe recruitment practices had been followed when recruiting new staff to ensure that only suitable people had been employed to care for vulnerable people. This meant there was a breach of Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Fit and proper person employed.

During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

During the inspection we looked at ten staff personnel files to check that safe recruitment practices had been undertaken. We reviewed these files to check they contained required information including a full work history, a recent photograph, proof of identity, health information, a minimum of two appropriate references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carried out checks and identifies if any information is on file that could mean a person may be unsuitable to work with vulnerable people.

We found that six files contained an enhanced DBS disclosure and all files contained photocopies of proof of identification documentation, for example, passport details, driving licence and utility bills. However, none of the proof of identification documentation had been signed or dated by the person who had taken the copies and seen the originals. Four files contained no evidence to demonstrate that an enhanced DBS had been obtained prior to employment starting. One file contained only one reference, one file contained no references and none of the files contained a photograph of the person.

The above examples demonstrate a continued breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed.

During our last inspection, we found that due to high use of agency staff there was risk people would not receive safe and effective care from staff who knew them. This meant there was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Staffing

During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

We looked at staffing levels to ascertain if safe and appropriate levels of care and nursing staff were on duty during the day and night. On day one of our inspection we looked at the staffing rota for the service which indicated that all nursing and care staff were working long days, which is from eight in the morning until eight in the evening. There were four nurses on duty, two from an agency and the acting manager who was a qualified nurse. There were three care staff covering the young men's unit, four care staff covering the 'behaviour that challenges' unit in the morning, and three in the afternoon/evening and two care staff covering the 'ladies unit'. Night staff cover was provided by two nurses and between five and six care staff. At the time of the inspection, there were 37 people requiring nursing care and two requiring residential care. We spoke with the staff on the young men's unit who told us they thought enough staff were on duty at any one time to meet the assessed needs of the men on the unit.

During the last inspection it was reported that there were enough staff to meet people's needs, but the use of agency staff meant that people were not always being cared for by people who knew them or were fully aware of their individual care needs.

During the course of the inspection we were informed that a new manager had been appointed and were currently working their notice. As at the last inspection we were told by the acting manager they were addressing the staffing issues through ongoing recruitment to the vacant posts. Following the inspection we were told that two care staff, a cook and a kitchen assistant and been recruited.

We had some concerns around the quality of care provided by some of the agency staff employed and this is discussed further in the responsive section of the report.

The above example demonstrates a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.

Evidence was available to demonstrate that each agency worker had an individual profile on record and that the service had checked out the background details to make sure people from the agency were suitable to work with vulnerable people.

We checked that the service had made sure that all the nurses working in the home had a current PIN number, which they did. To work nurse or a midwife in the UK, the nurse must register with the Nursing and Midwifery Council (NMC). The NMC is the regulator for all nurses and midwives in the UK. When you register with the NMC, they will give you a unique pin number.

We saw staff had access to personal protective equipment (PPE) to minimise the risk of cross infection and we observed staff appropriately using the PPE.

During our last inspection, we found Carson House Care Centre was not conducting their service in line with the Health and Social Care Act 2008 Code of Practice on the prevention and control of Infections Guidance This meant there was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Safe care and treatment.

During this inspection we found some improvements had been made in the prevention and control of infection but there were continued shortfalls which meant there was a continued breach of regulation.

We found since the last inspection many areas of the home had been steamed cleaned and the general cleanliness of the home had improved. However it was noted that many areas of the home were tired and worn in appearance. Carpets although steamed cleaned were still worn and stained in places and walls, door frames and skirting boards were chipped and worn.

We were told by the acting manager support that no refurbishment or redecoration had taken place since the last inspection although we were told there was a plan now in place which we asked to see. Although we asked to see the plan it was not made available to us during the inspection.

The maintenance person told us they worked three days a week at the home. They told us there was not a formal record of work that needed to be undertaken and they were verbally informed of what work was required although they did keep a record of the work they had undertaken. We discussed this with the acting manager support that it would be good practice to have a formal record of work requested to be completed and also evidence of when the work was completed and by whom.

The domestic staff had a cleaning record. However the records were vague and did not evidence exactly what had been cleaned and when. We saw the record consisted of a staff signature against a date and bedroom number. It was not clear how often the communal areas were to be cleaned and there were gaps in the cleaning records completed by night staff. In addition it was not clear from looking at the night staff cleaning records exactly what their clearing responsibilities were.

We saw the kitchen looked clean and well organised. We asked to see the cleaning schedules kept for the kitchen. We were told by the chef and the kitchen assistant that records were not currently being kept. We were told they had not been recorded since the end of 2016 because they did not have a book in which to record the cleaning carried out. This information was passed over to the acting manager and the acting manager support.

One relative we spoke with said "The place looks tired. They always make promises that it's going to be done up but it's never materialised."

During the course of our inspection we saw that Safety Data Sheets in relation to Substances Hazardous to Health had not been obtained from the suppliers of the cleaning materials used in the home, as per the requirements of Control of Substances Hazardous to health (COSHH) Regulations. COSHH legislation requires employers to control substances that are hazardous to health and to ensure their safe use and therefore the absence of these data sheets has the potential to put people at risk. However during the course of the inspection these were obtained.

As found at the last inspection we found communal bathrooms and toilets to be clean and had full hand washing facilities; however, we found bins needed for the disposal of continence products were not available. We saw the bins were standard domestic bins that did not have a foot operated pedal used to open the lid. This meant there was a risk of cross infection.

At our inspection in May 2016 and January 2017, we found that there was no dirty and clean flow in the laundry, which meant that clean laundry coming out of the dryer was carried past the dirty laundry waiting to be loaded into the washing machine. This was unchanged at this inspection and had been identified in the Protection and Control of Infection Unit audit undertaken on 6 July 2017 by Tameside and Glossop NHS Foundation Trust Health.

We did not see any evidence that Carson House Care Centre had a copy of the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections Guidance. Without the Code of Practice it meant the registered provider could not be sure the home was conducting their service in line with The Department of Health guidance. We asked to see the infection control policy but this was not made available during the inspection. The lack of an accessible policy meant staff were not provided with up to date information that reflected current legislation.

The above example demonstrates a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

We looked at the arrangements that were in place to safeguard people from potential abuse. We saw a safeguarding policy and procedure was in place although this was dated January 2013 and made reference to the previous provider Elder Homes and the outdated Health and Social Act 2008 (Regulated Activities) regulations 2010. This meant that staff did not have access to current up to date and robust policies and procedures.

We looked at the home's training matrix (record) that showed us 41% of staff members did not have up-to-date training in the safeguarding of vulnerable adults. Following the inspection the acting manager sent us planned dates throughout 2017 for staff to undertake the safeguarding adults training.

We asked to look at the records kept at the home of any allegations of abuse that had been made. These records could not be located and were not made available during the inspection. There was no evidence that any audits, analysis or reviews had been undertaken to look at trends or lessons learnt to reduce the risk of people not receiving safe care and treatment.

The above examples demonstrate a breach of Regulation of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Safeguarding service users from abuse and improper treatment

One comment from a person living at Carson House was "I don't like being here- there's nothing special about here. Staff are ok, but nothing special. I do feel safe though- no one would hurt me." Another comment was "I feel safe."

The relatives we spoke with told us they felt their relatives were safe. One comment was "Yes, I feel that [their relative] is safe. The Staff couldn't do any more with him than they do. They've been good through good times and through bad. [Their relative] likes the staff and they all seem to like him."

Another comment was "As far as I am concerned [their relative] is safe. The Staff are lovely, she is well-fed and the place is always clean and tidy. "

As at the last inspection we examined records of accidents and incidents and saw that any incidents were clearly recorded, completed and acted upon where required. The home used a tracker system that analysed the information in several ways on a monthly and annual basis. Accident and incident information was reported in several formats, such as, an analysis of what happened, what times and on an individual basis.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, we found that not all staff had received receiving formal supervision on a regular basis, or an annual appraisal and there were gaps in staff receiving induction training and there were also gaps in the staff training. This meant there was a breach of Regulation 18 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Staffing

During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

We reviewed ten staff personnel files, supervision files and appraisal records to check if evidence was available to demonstrate that a robust system of induction, supervision and staff development was in place. No evidence was found in the personnel files we looked to demonstrate that people received an induction to the service when first starting their employment at the home.

We did find evidence in a separate 'supervision file' that most staff had received one formal supervision session in March, April, May or June 2017.

At the time of our inspection, no evidence could be found to demonstrate that annual staff appraisals were or had been taking place. We also found no evidence to demonstrate that nursing staff were being supported or provided with consistent clinical supervision.

At our request the provider sent us a copy of the staff training matrix and this showed us what training staff had undergone and when refresher training was due. There was little evidence to demonstrate that any improvements had taken place since our last inspection of the service. Records indicated that some staff had undergone the required mandatory training, for example moving and handling, food hygiene and safeguarding. However, as at the last inspection, large gaps were still apparent in the refresher training required to ensure existing staff keep their skills and knowledge up-to-date, for example of 53 staff on the training matrix, 45 had not completed refresher training in fire safety, 43 had not received refresher training in the Mental Capacity Act and 30 had not received refresher training in safeguarding vulnerable adults. It was also of concern, that Carson House Care Centre is a service supporting people who have mental health nursing needs; however, less than half the staff who provided direct care had completed up-to-date training on mental health awareness. There was also no evidence to demonstrate that nursing staff had received training to support and maintain their professional status or any training specific to their roles.

The above examples are a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing

During our last inspection, we found that consent to care had not been provided in accordance with the requirements of the Mental Capacity Act 2005 and associated Codes of Practice. This meant there was a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Need for consent

During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

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 made in their best interests and as least restrictive as possible

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We looked at whether Carson House Care Centre was working within the requirements of the MCA and DoLS.

As at the last inspection we saw evidence of a tracker document that showed information on applications submitted and approvals received so that at a glance, staff knew who had a current DoLS in place and when a new application needed to be made. However we looked at three files where a DoLS was in place. We saw that two of the DoLS were in date, but the third file showed the DoLS was out of date, although the acting manager was able to provide evidence that this been recently applied for.

In one of the care files we looked at we saw evidence that a Mental Capacity assessment had been undertaken around the person's finances and there was documentation in place to demonstrate that a best interest meeting had taken place. A best Interest meeting should be held where an adult aged sixteen and over lacks mental capacity to make a decision for themselves and needs others to make those decisions on their behalf in their best interests.

We noted on one file there was evidence that the person did not have capacity, however there was a consent form in place, but there were no signatures and nothing to indicate if anyone had power of attorney (POA) or a lasting power of attorney (LPA) for health and welfare and / or finances. A POA or a LPA is a way of giving someone you trust the legal authority to make decisions on your behalf.

We asked the acting manager how many people had a POA or LPA. We were told they did not know how many people had a POA or LPA or where any photocopied evidence of the documents were kept. Staff and management at Carson House Care Home had not sought confirmation that people making decisions around people's consent to care had the legal right to do so. This meant that consent to care had not been provided in accordance with the requirements of the Mental Capacity Act 2005 and associated Codes of Practice.

The above examples are a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for consent

During our last inspection, we found that people's health and wellbeing was put at risk from insufficient hydration measures. This meant there was a breach of Regulation 14 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Meeting nutritional and hydration needs

During this inspection we found improvements had been made and the regulation had been met.

During this inspection we observed the dinnertime meal being served on the nursing unit on the ground

floor of the home and the young men's unit on the first floor of the home. We were told that the dinnertime meal was usually a light meal, with the main meal being served at teatime. On the young men's unit there were three dining tables and most of the men were sat at these tables waiting to be served. The tables were bare, with no table cloths, place settings, napkins, crockery or cutlery. There were plastic jugs of juice on two of the tables and some men had made themselves a cup of tea or coffee.

We found that as on the young men's unit that the dining tables on the nursing unit were bare, with no table cloths, place settings or napkins. As found at the last inspection on the nursing unit, meals continued to be served on plastic plates and bowls and the hot drinks were served in plastic mugs with the exception of one person who brought their own pot mug with them to the dining room. We spoke with staff, the acting manager and the registered provider about this. We were told that they were used because some people were at risk of throwing them and they were dementia friendly table wear which suited other people. However during discussions with staff it was evident that not everybody using them were at risk of throwing them or had a diagnosis of dementia. As found at the last inspection the generic use of these plastic implements showed us that people were not given a choice and were being treated as individuals in an appropriate and dignified way at meal times. We observed on the nursing unit staff assisting people who required help with eating and drinking in a dignified and unhurried manner.

We recommended that that people only used plastic crockery if they had been individually assessed as requiring them with the reason clearly identified in the care plan.

As part of the inspection we went into the kitchen and spoke with the chef and the kitchen assistant. We saw there were sufficient supplies of food and drink to meet the needs of the people living at Carson House care Centre. From speaking with the chef and the kitchen assistant it was evident they had a good knowledge of people's individual dietary requirements and personal preferences. In addition there was a board in the kitchen with the names of people who required special diets such as diabetic diet, soft and vegetarian diets.

We saw that the menu was on a two week rolling programme and choices were available. Staff told us there was always a choice at meal times or people could request reasonable alternatives to what was on the menu. The chef and kitchen assistant confirmed this. One member of staff said "The food has definitely improved."

We saw from the last inspection that diabetic pudding alternatives were now readily available to people. For example diabetic ice cream, sugar free mousse and fruit salad with cream.

One visiting relative said "[Their relative] tells me that there is enough to eat."

One relative we spoke with said "The food is ok." They went on to tell us their relative required constant prompting to eat and drink. They told us that on occasions when they visit the uneaten breakfast is still there when the staff bring lunch in. This meant the person could be at risk of not having adequate diet and fluids.

Requires Improvement

Is the service caring?

Our findings

During our last inspection, we found that the provider failed to ensure people's privacy, choice and hygiene needs were appropriately met and people were not treated with dignity and respect. This meant there was a breach of Regulation 10 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Dignity and respect

During this inspection we found improvements had been made and the breach of regulation had been met. However a recommendation was made with regard to positive staff interaction.

One relative we spoke with told us that they the staff were caring. One person said "The staff treat [their relative] with dignity and respect. They always knock on the bedroom door and they are very polite and ask permission before doing anything. I can't really say a bad word about the staff, they are patient and caring."

However another relative said "A lot of the time [their relative] doesn't look clean." They went on to tell us that when they question this with staff they say they were just about to attend to him but this has happened on numerous occasions.

During this inspection and from our observations we saw that people looked clean and were appropriately dressed. People, who were able, were seen to be freely moving around the home and people looked comfortable in their surroundings and in the company of staff.

We observed inconsistences in staff interaction with people. We observed two occasions where there was positive engagement. One member of staff was sat talking to a person and encouraging them to have their meal. This same member of staff entered the room and interacted with people sat there by asking them how they were. Discussion with two members of staff provided evidence that they know the person they were supporting well, including information about what hobbies that person had. They had a good understanding of the individual's support needs regarding behaviours, diet and what support they needed to minimise any risks of their behaviour escalating.

Some other observations of staff during the course of the inspection showed us there was a lack of positive communication and engagement with people. For example we saw that staff employed to undertake one to one care were not having meaningful interactions with the person. They were seen to be sat next to them but not talking to or engaging with the person.

In other instances we found that interaction was limited. For example staff interacted with the person when they were undertaking a task or assisting them in some way and staff responded if spoken to or were asked for assistance. However we saw staff did not routinely acknowledge or talk to people as they passed them or were not seen just sat chatting with people.

We did not see that all staff actively worked in partnership with people to have a voice or that people were actively encouraged or empowered to help them reach their potential. This was discussed with the acting

manager, the acting manager support and the registered provider.

We recommended that staff should provide people with consistent and positive interaction.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection, we found that poorly written and verbal communication between staff could lead to a risk that vital information around people's immediate care needs may be missed and people may not receive the care and support they require. This meant there was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Good governance.

During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

At the last inspection, we reviewed the nurse's records for handover notes for the previous three days and we found that the structure of the form had been improved. They included a set format of information to be recorded for each person. We found the forms did not contain comprehensive information and only one of the four sections had been completed on all forms, the date was missing on two forms and there was no completed form for one shift.

During this inspection we looked at the handover sheets and saw different qualities in the content and recording methods. Some hand written recording were written on blank pieces of A4 paper whilst others used a set pro-forma. We noticed that handover notes were written separately by nursing staff and by care staff. The details in the nursing and care staff handover notes were basic in their detail, for example 'settled night,' 'settled in mood' and 'settled throughout the day – no new issues.'

Poorly written communication between all staff can lead to a risk that vital information around peoples immediate care needs may be missed and people may not receive the care and support they require.

In addition to separate handover notes we were told that nurses and care staff have separate handover sessions. The information discussed at handover and written handover notes are relevant to all staff when providing care and support and it would be preferable for handover sessions to be integrated so all staff have the consistent and necessary information to provide safe and effective care.

During the last inspection when looking at people's care documentation we found several examples where care plans were out of date and contained inaccurate information about current needs.

We looked at five peoples care records and found that individual records were kept in two formats and the paperwork was headed with the previous provider details, Elder Homes.

There was also a large file which included a range of information and people's care plans to support the staff when delivering and meeting individual care needs. We were told that that this file was kept in the office and only nursing staff used and recorded in this file. We asked six members of care staff and only one staff member confirmed they had read these files. One member of staff said, "We only use the monitoring and check files, we never have time to read the files and they are kept in the office anyway." We were informed that the monitoring and check files were files used by care staff to record for example people's weight ,

observation charts and food and fluid charts.

This meant that information on people's lifestyle choices and preferences and updated information to ensure peoples care support is delivered in a safe way was not being used as intended. Failure of staff to read and use this information potentially places people at risk of not receiving care and support in a safe or responsive manner.

The second care file was the 'monitoring check lists' which care staff completed daily. These checks included food and fluid intake, hygiene charts, behaviour monitoring and hourly checks. The hourly check record noted where the person was and what they were doing. The recordings we saw did not contain information of value in respect of engagement or fulfilment. Recordings made on the hour stated for example, 'In bed asleep,' 'In lounge standing up,' 'Sat in lounge,' 'Unsettled in lounge.' There was an absence of any recordings which indicated that positive interaction was taking place.

The two tier system of having two care files meant that staff were not having full access to information to guide them in delivering individualised care and support. The system in place must ensure all staff involved in the delivery of care and support have access to all relevant documentation.

The quality of the care plans was inconsistent. We looked at the care file for one person and found there was a nutritional support plan dated 18 July 2017 which was detailed and comprehensive and there had been input from the speech and language therapist (SALT). In addition there were records of their daily dietary intake. However in anther care file we found information relating to the persons dietary requirements were out of date. We saw that following involvement from the SALT team the person had been assessed as being 'nil by mouth.' Although staff spoken with were aware of this the information had not been transferred to the relevant care plan. This meant the person was at risk of not having their nutritional and hydration needs safely and appropriately met.

One care file we looked at contained a lot of information about an individual's behaviour that challenged and the risks they presented to other people and staff. When we visited this person in their room we saw that there care plan was out of date as the 'challenging behaviour' was no longer an issue. This person was now receiving end of life care and was being cared for in bed. Inspection of his communication passport (this is a document that provides up to date information on care and support needs which would follow the person if he/she is admitted to hospital) was out of date and did not reflect this person's current care and support needs.

Staff spoken with were able to describe the individual care needs of people but the inconsistent quality of the care plans meant that accurate, complete and contemporaneous plans of care were not being kept.

The above examples demonstrate a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance

During our last inspection, we found that people were not always receiving person centred care. This meant there was a breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Person centred care

During this inspection we found some improvements had been made but some continued shortfalls meant there was a continued breach of regulation.

We were told that since the last inspection Carson House Care Centre had employed the services of an

activity coordinator. We saw a poster in the dining room on the nursing unit advertising activities up to November 2017. For example there was a trip to Blackpool zoo, a holiday in Southport, a 91st birthday party, a summer fair, a river cruise and a trip to Bellevue dogs. We spoke with the activity coordinator who had been in post since February 2017. They told us three people went on the holiday to Southport which had been a great success and they were working hard to implement more activities for people.

One relative we spoke with said "There doesn't seem to be enough activities." Another relative said "[their relative] could probably do with more activities." Another relative told us there were insufficient activities and that they didn't see staff talking to residents as much as they should.

Staff spoken with told us that some activities took place but they were inconsistent. One member of staff "Activities are not good, they could be better." On one afternoon during the inspection we did see care staff engaging people in playing 'skittles'. However as found at the last inspection we did not see evidence that people were fully supported to follow their individual interests or that people were supported in their aspirations and what they liked to do.

During the inspection we observed three people in the communal lounge area on one unit. The TV was on but no one was watching it. One member of staff was in the lounge and for a period of 30 minutes and we did not observe any positive interactions or engagement with anybody in the lounge. The member of staff was observing people but made no attempt to engage with them. We saw when this person's shift finished they were re-placed by an agency member of staff whose practice was the same.

One care plan we looked at provide detailed strategies and interventions on how to support the person who was described as having 'challenging behaviour.' During our visit we did not see any of these strategies being implemented by the staff on duty. We had noted that this person had several areas of interest including music. When we spoke to with staff to check their knowledge of this person's background this was limited and they were not aware of his interests.

On the nursing unit we observed very similar practice by a member of agency staff. We were told they were providing one to one care. We saw they were sat next to the person but had limited interaction. Occasionally we saw they banged on the small table in front of the person in an attempt to obtain their attention but we did not observe any meaningful stimulation or interaction.

The above examples demonstrate a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person centred care

As part of our inspection, we looked at how complaints were responded to and managed at the home. We saw that a complaint policy was on display in the main reception area of the home dated 2014. When we brought the date of the policy to the attention of acting manager it was replaced by an updated version. In addition we saw a comment box also in the main reception area if people wanted to raise any issues anonymously.

As found at the last inspection we saw evidence that complaints were responded to and acted upon. We reviewed the complaints file and found the last recorded complaint was in November 2016 and appropriate action had been taken.

However we did see on the 'complaint register' that a complaint had been made in January 2017. We then found the original complaint letter and there was no evidence that an investigation had been undertaken or that the complainant had been responded to. We discussed this with acting managers support who said

they thought the complainant had been responded to but were unsure as to where the supporting paperwork was.

One relative we spoke with said "They [the staff] don't always give us the impression that they are listening to our concerns. When an issue is raised it takes a long time for them to address it."

Inadequate

Is the service well-led?

Our findings

At the time of the inspection Carson House did not have a registered manager in post. A registered manager had not been in post since the previous registered manager left Carson House Care Centre in December 2016. We saw the Care Quality Commission certificate of registration for the previous manager was still on display in the main reception area of the home. We asked for this outdated certificate to be removed.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We were told during this inspection that the clinical nurse lead had been appointed as the acting manager and had taken up the post on 3 July 2017 and was supported by the acting manager support. During the course of the inspection we saw that interviews for the post of manager were being undertaken.

The acting manager was available throughout the inspection and the acting manager support was available on the first three days of our inspection.

At the last inspection Carson House Care Centre was being managed by a care management organisation that had been appointed in September 2016 by the home receiver's. The receivers were in place from 26 September 2016 to 5 June 2017.

During our last inspection, we found there was a lack of oversight and inadequate monitoring of the quality and safety of the service provided. We did not find any evidence to support governance systems were being effectively utilised to asses, monitor and improve the quality of the service on a regular basis. This meant there was a breach of Regulation 17 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. Good governance. During this inspection we found continued shortfalls which meant there was a continued breach of regulation.

We asked the acting manager if they had a copy of the up to date Health and Social Act (2008) (Regulated Activities) Regulations 2014. We were told they thought so but they were unable to locate them during the inspection. Without the up to date Regulations the acting manager and the acting manager support would not be able to demonstrate compliance of meeting the regulations.

We saw some audits of the service had taken place, for example during June and July 2017 medication administration audits had been undertaken. However there was no evidence of what action had been taken when the audit had identified shortfalls.

We saw that an audit of the hoist had been undertaken in May, June and July 2017. However we saw that the May's audit had not been signed by the person undertaking the audit. In addition the audit documentation had an audit scoring box that had not been completed and there were no details of the

scoring formula. This meant the audit had not been fully and appropriately completed.

We saw a mattress audit had been completed for March and May 2017. However we saw the results for March identified that one mattress was 'malodours' but there was no evidence of what action had been taken.

We saw an infection control and general cleanliness audit had been undertaken by the domestic supervisor in June and July 2017. We saw no evidence of the action taken to address shortfalls identified in the June audit. For example it identified several loose radiator covers all of which we saw were still loose. It identified that one of the lounge windows did not have an 'opening arm and lock catch. We saw this issue had not been addressed.

The acting manager told us they did have daily 'walk about sheets' to check the level of cleanliness but these were not being completed.

We found the registered provider had failed to establish and operate effective systems to assess, monitor and improve the quality of service; had not mitigated the risks relating to the health, safety and welfare of people who used the service and did not effectively asses and monitor all aspects of the quality of the service on an ongoing basis.

Staff told us they did not feel well supported by the management team and were worried about job security and wages. One member of staff told us "There is still too much agency staff being used, what we need is a strong, confident, permanent manager." We were told "There is a lack of leadership and direction" and "The staff are really good but are not well directed."

We saw the statement of purpose that was on the notice board for people to access contained out of date information. For example it named the registered manager, who left the service in December 2016 and their qualifications and also gave the details of the previous registered provider. This meant that people were not given up to date, accurate information about the service.

We found much of the paperwork had not been updated and continued to contain the details of the previous registered provider, Elder Homes.

During the course of the inspection we found that the home did not have internet access although we saw the registered provider attempting to rectify the problem on day four of the inspection.

We asked the acting manager if any feedback questionnaires had been sent out to people living at Carson House Care Centre and / or their relatives or friends to obtain their feedback of the quality of the service being delivered. We were told that they did not think any had been sent out. This meant there was a lost opportunity to help improve the service based on comments received from people living at Carson House care Centre and their relatives and friends.

At the time of the inspection the Clinical Commission Group (CCG) had suspended admissions to the home due to issues of concerns identified at the last inspection and were currently working with the home to try and improve standards of care.

The above examples demonstrate a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

We saw the last Care Quality Commission report that included the rating of the service was displayed in the main reception area of the home, where people visiting the service could see it. At the time of this inspection the provider did not have a website where the latest rating would also be displayed.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had failed to ensure that people received person-centred care that was individual to their support needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment was not always provided with consent of the relevant person. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We found that the registered provider had not protected people against the risk associated with the safe administration and management of medicines. We found the registered provider did not follow good practice guidelines for infection control. We found some safety checks and environmental risk assessments and were not in place. Regulation 12 (1) (2) (a) (b) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment We found the registered provider had not fully protected people from potential abuse and improper treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure accurate, complete and contemporaneous records in respect to each service user. Systems to monitor the safety and quality of the service required improvements to ensure compliance with the regulations. Regulation 17 (1) (2) (a) (b) (c) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed We found the registered provider did not have robust recruitment procedures in place to ensure people using the service were kept safe. Regulation 19 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary training to carry out their role. People were not protected against the risks of unsafe or inappropriate care as staff had not received all necessary direction and support to carry out their role

Newly employed staff to the service had not undertaken an induction programme that would prepare them for their job role.

Regulation 18 (2) (a)