Care Worldwide (Carlton) Limited

Carlton Lodge

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection was carried out on 22 May 2018, 4 June 2018 and 18 June 2018 and was unannounced on all three days. We had previously inspected the home in May 2017 and rated it as requires improvement.

Carlton Lodge is a 'care home' for up to 10 adults needing support with their mental health needs or who have a learning disability including people on the autism spectrum.. At the time of the inspection there were nine people in the home. People in care homes receive accommodation and nursing or personal care as a single package. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

There was no registered manager in post, but there was a newly appointed manager who said they would be registering with the Care Quality Commission. 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.

We identified eight breaches in the regulations relating to person centred care, dignity and respect, need for consent, safe care and treatment, safeguarding service users from abuse and improper treatment, meeting nutritional and hydration needs, staffing and good governance.

The Registered Provider was not working within the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service did not live as ordinary life as any citizen.

We found staffing levels were not sufficient to meet people's needs and this impacted throughout people's care and support. We saw many occasions where people were unsupervised despite known risks to their safety and well-being. There were risks, such as fire safety and vehicle safety, which were not addressed. People said or indicated they did not feel safe or happy in the home. People were not adequately safeguarded and there was evidence of restraint being used without suitable measures in place to ensure people's rights and safety were promoted. There was no clear accountability for people's finances and no systems to prevent financial abuse. People's mental capacity was not thoroughly assessed. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible.

Accidents and incidents were not consistently recorded and there was insufficient oversight or monitoring to identify where lessons could be learned.

Staff, with the exception of a few, had a poor approach to interacting with people. People's dignity was compromised and staff did not support them respectfully. There was a complete lack of person centred care and little meaningful activity taking place. People were not involved in planning their care and they had little

choice or input into the quality of their life at Carlton Lodge. People's complaints were not taken seriously.

The home was not well run or managed and there was a lack of leadership and direction for staff. There were insufficient systems in place to ensure people received appropriate standards of care or to drive improvement.

The overall rating for this service is 'Inadequate' and the service has therefore been placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not safeguarded from abuse and there was inappropriate use of restraint.

People told us they did not feel safe.

There were insufficient skilled, trained and experienced staff to ensure people were supported in line with their current needs.

Is the service effective?

Inadequate

The service was not effective.

Care was not delivered in line with people's needs and choices.

Staff lacked the necessary skills, knowledge and experience to care for people appropriately.

Care and treatment was not always sought in line with current legislation and guidance.

Is the service caring?

Inadequate

The service was not caring.

Staff lacked empathy for people's needs and interactions were poor.

Staff interaction was not respectful of people's rights.

People's dignity and privacy was not respected.

Is the service responsive?

Inadequate

The service was not responsive to people's needs.

Care was not person-centred; there were no meaningful activities and people experienced a poor quality of life at Carlton Lodge.

People were not listened to or their complaints taken seriously.

Some care records had been improved in style and format, although there were errors in the content that may have affected how people's care was managed. Some people's care records lacked important information.

Is the service well-led?

Inadequate

The service was not well led.

There was poor management in the home; staff lacked support and direction and there was a negative culture.

There were no clear systems in place for addressing priorities in people's care and ensuring risks were identified, mitigated and monitored.

Audits were not robust and where these had begun to be improved by the new management team, these did not address key priorities or secure improvement.

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.

We inspected the service on 22 May 2018, 4 June 2018 and 18 June 2018. The inspection was unannounced on all three days. The inspection team comprised of two adult social care inspectors.

Prior to the inspection we reviewed all information about the service including information sent to us by the provider as well as liaison with stakeholders including the local authority. 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.This inspection was scheduled partly in response to concerns raised with us about poor quality of care and inappropriate use of restraint.

We spoke with all the people who used the service, although only five people were able to communicate verbally with us. We spoke with four staff, the manager, the area manager and the training manager. We looked at four records of people's care and records to illustrate how the service was run. We looked at premises and equipment and documentation relating to the safety of these.

Inadequate

Is the service safe?

Our findings

At our last inspection of May 2017, this key question was rated as requires improvement. This was because risk assessments were out of date and not personalised.
At this inspection we found serious concerns which meant the rating deteriorated to inadequate.

People told us they did not feel safe. One person said they felt unsafe because staff shouted all the time and did not supervise people properly. Two people told us they were afraid of other people's behaviour.

People were not safe at Carlton Lodge. Risks to their safety were not adequately assessed or mitigated to keep people safe. For example, we found people were at risk of serious risk of harm of choking and aspiration. Two people who used the service were identified to inspectors by the regional manager and the manager as being at high risk of choking and both people needed close supervision when eating and drinking. We found these people were not supervised and one of the people, who required a modified diet was given food which put them at risk, such as hot dogs. One person required thickener in their fluids to prevent them from aspirating on their drinks. This was not done and they were given unlimited drinks which had not been thickened to the correct constancy, again putting them at risk. We looked at the choking risk assessment for one person and found this contained generic information, not specific to keeping the person safe.

Despite inspectors bringing their observations to the attention of the manager and regional manager, there were repeated incidents observed by inspectors and supporting professionals from the local authority. These were observations in which these two people were given unsuitable food and drinks and left unsupervised whilst eating and drinking.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider was not doing all that was reasonably practicable to mitigate risks associated with people's care.

We asked to see documents to show the safe use of the company vehicles. The regional manager and manager told us the vehicle had been for an MOT recently but they were unable to locate the documentation. The member of staff who drove the car told us the car had had its MOT and was booked in for some repairs. We asked whether the car had passed the MOT and were told it had. On the second day of the inspection we requested the documents again. We found two MOT documents, one dated 17 May 2018 which showed the vehicle had failed with major faults including brakes and seatbelt faults and required immediate repair. The other one was dated 24 May 2018 and showed the vehicle had then passed following repairs done. We looked at the mileage logs which showed service users had been transported in the vehicle each day between 17 and 24 May 2018 and 220 miles had been done since the failed MOT. This meant people had been put at risk of harm from using a vehicle which was not roadworthy and it was allowed to be used without a valid MOT certificate.

We found people were not kept safe from the risk of fire. There was no record of who was in or out of the

building and when inspectors asked if anyone had gone out, or who was where, no staff could be certain of people's whereabouts. After the first day of the inspection the manager implemented a signing in/out book. However, we found on the two subsequent days of the inspection this was not used consistently and so people were not fully accounted for.

On the first day of the inspection we heard the fire alarm sound. We saw staff escort people to leave through the back door. Staff looked puzzled and shrugged their shoulders. We asked if it was a planned fire drill and was told it was not. All service users were accounted for in the garden and when the alarm stopped sounding; staff began to move back inside. We asked the deputy manager how they knew it was safe for people to return inside. The deputy manager said it would be a false alarm and it happened sometimes. We asked if any of the staff had checked the building to see if there was a fire and were told no staff had checked. The maintenance man told us it was a false alarm but was unable to say how they knew this as no checks had been made. The deputy manager and the maintenance man showed us the fire panel and told us the alarm had indicated it was in the zone near the laundry and the kitchen. Both areas were not checked until we asked for this to be done. Furthermore, people had been asked to leave through the zone where the fire panel showed the fire to be.

Following the first day of the inspection we raised concerns with the fire officer and they made a visit to the premises on 1 June 2018. The fire officer reported that they felt people were at risk because of poor safety precautions and made some recommendations, with a plan to return in two months.

We looked at a written risk assessment dated 31 January 2018 which had been done by an external company. This showed there were significant and immediate risks to people's safety in relation to fire, including doors that were not adequate and a risk people could be trapped in their rooms. There was no evidence of any action having been taken to address the risks and the manager was unable to confirm what had been done about it. We asked the registered provider to take immediate action to ensure people were safe from the risk of fire. The regional manager sent us some further information after the inspection which showed that a quote had been requested for some aspects of the work, but this was not scheduled for immediate completion. This did not address all the concerns raised by the fire officer and there was no further indication from the registered provider as to how they were managing the risks.

We found there were further risks introduced into the service without considering the impact on people's safety. For example, on the third day a decorating company arrived at 8am at the same time as the inspectors. They did not sign in to the service and no checks were made on their identity. The decorators told us they had not been told anything about the service, any areas they could not go, or any information about any expected conduct or risks within the home. They had not been told about what to do in the event of a fire or where they should keep their equipment. We saw unattended ladders, floor sheet and paint in pots. We asked the manager if they had considered any risks or completed a risk assessment and they told us they had not. This meant there had been no consideration for the needs and safety of people who used the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not ensure that the premises were safe to be used for their intended purpose.

There were insufficient staff deployed to meet people's needs safely. The manager told us some people required one to one or two to one staff support at times, and in order to access the community. We saw this was not met. This meant people were unable to go out as they needed to. Staff rotas we looked at did not indicate whether any of the people had been offered one to one support in line with their needs.

On the second morning of the inspection we saw two members of care staff on duty to support eight people. One of the staff told us they were new and on their third shift and told us there was only one other staff on duty with them. We looked at staff rotas and saw there were only two care staff scheduled to work between 8am and 10am. We saw the new member of staff was alone with four people whilst the other member of staff was administering medicines. The member of staff appeared to be harassed and said they were struggling to support people. They told us there were four people still to get up and said, "I'm trying to watch all these," gesturing to the four people, all of whom needed assistance for different reasons.

The registered provider sent us information following the inspection, which stated their intentions to improve staffing levels, but no evidence of action taken. Furthermore, the local authority reported concerns to CQC following their visits on 9 and 11 June 2018. These include a lack of staff visible in the service, no allocated one to one support, or supervision for people when eating and drinking.

We found people were frequently left unsupervised even though there were known risks associated with their care and previous incidents of behaviour which challenged the service. People whose behaviour at times threatened the safety of others, were left in close proximity to other vulnerable people without supervision and there were potential risks of altercations. Staff we spoke with said they knew people's behaviour could be a danger to others at times although they were not confident to manage this.

We found staff did not understand people's individual triggers for behaviour which could challenge others and we saw incidents of behaviour which challenged the service were not managed appropriately. For example, one person grabbed a mobile phone from another person and staff intervened only to wrestle the phone out of the person's hands and return it.

We looked at records of accidents and incidents and found there were repeated incidents involving one person assaulting other people and staff. There was little recorded evidence of action taken following such incidents to identify any potential triggers, understand the behaviour of the person or prevent harm to themselves and others. There were insufficient staff with understanding of people's needs to respond and prevent such repetition of similar accidents and incidents.

We concluded there was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There were insufficient numbers of suitably qualified, competent, skilled and experiences staff to meet people's current needs.

We looked at the systems and processes for managing medicines and how people were supported to take their medicines as prescribed. We noted there had been a significant number of medicine errors noted on the home's medicine error sheet. However, we did not identify any concerns during the inspection and we found stock levels we checked were accurate. We saw people were supported in a timely way with their medicines and recording was appropriate. Medicines were stored securely, however, the home had been without a medicines refrigerator and there was little effort being made to ensure one was obtained in a timely manner. We asked for one person's antibiotics to be stored appropriately in light of this and staff put them in the main fridge as a temporary measure.

We found some minor discrepancies regarding medicines management. For example, there were no dates of opening on some medicines, one person's medicine was in stock, but not booked in, and there were some missing signatures when medicine was recorded as being given. There were some protocols in place where medicine needed to be given 'as required' (PRN), but these were not consistent for all people prescribed PRN medicines.

Accidents and incidents were not properly recorded or acted upon and there was no opportunity made to learn from when things had gone wrong. We received information that there had been an incident in which two people had gone to hospital. This was as a result of drinking large quantities of alcohol whilst accompanied to the pub by a member of staff. We asked the manager about this incident and asked to see the record of this. There was no record and the manager said they had been too busy to write an incident report. There was no evidence this had been discussed with the people concerned or the risks to their health managed. There had been no lessons learned from this; we spoke with one member of staff who said they were planning to take the same people to the pub the same day, but no risk assessment had been done for this.

We found people were at risk of serious harm because safeguarding concerns were not recognised or acted upon. Staff had a poor understanding of how to ensure people were safe from the risk of abuse and there was little management oversight to ensure people were protected from harm. One person made an allegation of abuse during the first day of the inspection and we found no immediate action was taken to refer this to the safeguarding authority.

We saw information regarding an alleged physical assault, but found people were not safeguarded because insufficient action was taken to identify or respond to concerns and closely monitor where people may be at risk of abuse.

People were at risk of serious harm because inappropriate restraint was used. We looked at one incident record in which one person had been restrained by staff resulting in marks on the person's neck. There had been no management investigation and we asked for this to be carried out. However, there was a delay in this being done and no action had been taken to prevent one of the members of staff from working in the service. We were not satisfied that the matter had been properly investigated to ensure people were not at risk of abuse.

We saw in one person's care record restraint of the person had been used on a previous occasion and there was a record of 'low standing holding technique in use.' Staff were unable to explain what this meant. Staff lacked understanding of the policy in relation to restraint and the manager said they were reviewing this policy. We asked the registered provider to send us a copy of this after the inspection, although this was not received.

We found people were at significant risk of financial abuse because there were no systems in place to manage their monies. We asked the manager and the regional manager to show the systems used to ensure people's finances were managed securely. The manager told us they had 'no idea' about where people's monies came from and was unable to give any assurance whether safeguards were in place or controls to ensure financial abuse was prevented.

This was a breach of Regulation 13 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

Parts of the home, in particular, communal areas were not clean; carpets and chairs were stained and worn. The manager told us there was an intended plan to refurbish the home but we did not see this.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

Inadequate

Is the service effective?

Our findings

At our last inspection in May 2017 this key question was rated as requires improvement. This was because there were no records of best interest decisions made for people who lacked capacity. At this inspection we found there were still concerns around this and we found additional concerns in this key question, meaning the rating deteriorated to inadequate.

Some people were able to tell us their care and support needs were not met and they felt they had little or no choice in the care they received. One person said, "This place is not right for me, the staff don't know what they're doing, they just mess about. I've got more about me and can do so much for myself but what I want isn't here." They told us staff spent time talking together and did not supervise or support people effectively. They said, "You never see them, they're always upstairs and we just sit about down here. They're not watching people like they should."

There were some assessments in people's care records but we found care was not delivered according to their needs. We found staff lacked understanding of how to meet people's needs. Staff we spoke with did not know what was in people's care records; some staff were new and said they did not have the skills, knowledge and abilities to ensure people were cared for effectively. We looked at the care records for two people, who had been identified to us as having behaviour which challenged. We saw there was a positive behaviour support plan in place for one person, but not for the other person. The support plan we looked at had been compiled by associated professionals, not by the service. It included ways to divert the person's attention and understand their non-verbal communication cues, but our observations showed staff did not have regard for this. For example, the plan stated staff should refer to the person by their name first when initiating communication, and to avoid the use of the word 'no. However, staff used the word 'no' throughout their interactions with the person which caused the person further anxiety.

One member of staff told us it was their first day at the service and they did not know any of the people, yet we saw they were attempting to support people on their own at frequent times during the day. The member of staff said, "I don't really know what I'm doing, I'm just trying my best." We saw where one person was repeatedly slapping themselves on the head, staff did nothing to support or distract them.

The senior staff on duty on 18 May 2018 did not know why one person was prescribed antibiotics, which meant they did not know the person's health needs. The manager showed us there was a key worker list and staff were allocated oversight of individual people's care. However they said staff would not be aware of this as this system had not yet been implemented.

We saw training records showed staff had undertaken training in a range of different topics. We spoke with the training manager who said they were providing induction and training. They said this was mostly done through watching training materials, although there was face to face and practical training in some areas, such as moving and handling, first aid and training for managing behaviour which challenged. We found training which was completed was not effective in practice. For example, information showed staff had received dignity training, yet we saw there were no effective mechanisms to ensure this was effective in

practice and people's dignity was not promoted. The speech and language team gave training to staff on the risks of choking, yet staff did not follow the advice learned in the training to ensure the correct diet was given to a person. Staff who had attended training in management of actual or potential aggression (MAPA) were involved in incidents of inappropriate restraint, so techniques learned had not been used in practice.

Where agency staff were used, we found insufficient checks had been made to determine their identity or suitability. We looked at the file which contained agency staff profiles but there was date on these and no information about any training they had done. We saw an incident record which referred to a member of agency staff and asked the regional manager for the agency staff details. These were not available and there was no evidence the agency staff identity or training had been verified. The regional manager obtained the agency staff profile from the agency and gave this to us. However, this had not been obtained in advance of the agency staff working and gave no assurance of the agency staff competence training or skills.

We found from staff rotas a further member of agency staff had worked in the home. The manager and regional manager were unable to identify the member of agency staff, other than their first name and could not verify whether any identification or training details had been before allowing the agency staff to work in the home. The manager was unable to confirm the agency staff had any induction or information about people's needs.

Staff meetings and supervisions had not taken place for several months. One member of staff had a last recorded supervision in 2016. Supervision sessions were one to one meetings with their line manager to discuss work related issues. We saw one member of staff was required to have frequent supervisions following a serious incident, but there was only one supervision record and no evidence of any further sessions. The manager told us this was intended to be improved moving forward. The manager told us there were no staff meeting minutes to read because there had been no meetings. The manager told us this was going to be addressed but had not yet been done.

This was a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staff did not receive effective training and support to enable them to carry out their role.

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. We saw there were some mental capacity assessments but these were limited and only referred to personal care and finances for some people. There was some evidence of best interest discussions having taken place, but these lacked detail.

Consent to care and treatment was not always sought in line with guidance and legislation. People's rights were not promoted and staff lacked regard for people's choice, ignoring their attempts to express their views about their care and support.

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. We saw evidence of some DoLS applications and authorisations in place, although staff we spoke with did not know who had these authorisations.

This was a breach of Regulation 11 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

The premises were in a poor state of décor, although there was some evidence of attention to areas in need of improvement, such as the floor covering in the laundry room and redecoration of communal areas.

People's dietary needs were not regarded and people did not receive appropriate support for eating and drinking. Where people had particular dietary needs, these were not regarded. We saw the dining experience was very poor and people were not supported in a person-centred way. Meals were served at a serving hatch from which people, if they were able, collected their own meal and sat down. On the first day of the inspection we saw one person was seated to a table without their meal. We then saw a senior member of staff brought a meal to the table and then proceeded to eat it themselves, without any regard for the person who had no lunch and was watching them eat. Another member of staff came into the dining room after a few minutes and brought the person's meal to them, but it was apparent the member of staff was focused on meeting their own needs first. People were served at different times and there was no quality social aspect of this part of the day.

Some people wanted to have second helpings and they returned to the serving hatch where they banged on the doors, unacknowledged by either the cook in the kitchen or staff in the dining room. One person did not want their meal and was not offered any alternative. People were not supervised as they should have been for their safety; on one day there were three staff seated together at a table for lunch whilst people sat at tables without their required support. These staff had drinks with their meal, whilst people who used the service did not.

This was a breach of Regulation 14 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Meeting nutritional and hydration needs.
We spoke with the cook who said they did not work to any menus, they based the days meals upon what they had in the kitchen. There was no evidence people had been consulted about what they might like to eat or drink. The cook told us they knew what people's dietary needs were because staff told them, but there were no records to support this. There was limited evidence to show how people were supported to lead healthier lives or have access to ongoing healthcare support. One person's records showed they were gaining weight, yet there was no information about what was being done to support them to achieve a healthy weight.

Inadequate

Is the service caring?

Our findings

At the last inspection in May 2017 we rated this key question as good. This was because we had no concerns about the way staff interacted with people. At this inspection the key question had deteriorated to inadequate as we had serious concerns.

We saw only very few incidences where staff interaction was kind and caring, but on the whole we found staff's approach was neither caring or supportive of people's needs. For example, on the first day of the inspection we saw one person was visibly upset and tearful. We saw staff noticed this, but offered no support or reassurance.

On the second day of the inspection we saw one person with limited verbal skills was anxious throughout the day, continuously seeking reassurance from staff, but there was no reassurance given by staff. We saw one member of staff laughed and mocked when the person asked to go home and the person's facial expressions then showed further anxiety and distress. This staff approach was not respectful of the person and was not challenged by a member of the management team who was present.

Staff had little regard for how they spoke about people and often we observed this took place in people's presence. We saw one person was incontinent of faeces in a communal area observed by other people and by staff, who did little to ensure their dignity and referred to the person as 'being naughty.' On another occasion the person was incontinent of urine and again referred to by staff as 'naughty.' We observed a member of the management team was present but made no challenge to this staff member.

Where people tried to be involved in their care and support, their expressed wishes were not considered. For example, one person repeatedly said they wanted to go out but they were told they had to wait for staff to be available. Staff told people they could go out in the car or to their favourite shop, but this did not take place as promised.

There was a lack of regard for people's privacy and dignity. We saw on the first day of the inspection, one person was seated in the communal area wearing a short nightdress for much of the morning, with no encouragement from staff to be dressed. We saw another person was not adequately clothed and wore only a continence pad as they walked round the home. We saw two occasions when people used or were supported to use the bathroom but with the door remaining open, which compromised their dignity as other people wandered round the home and could access the area. Another person was incontinent of urine and staff walked past, attending only when the inspector intervened and alerted the regional manager to this.

Following the first day of the inspection, we received information from a member of local authority staff who had observed staff did not respond when they saw one person standing at the top of the stairs with a continence pad round their ankles and covered in faeces. The local authority staff had to take charge of the situation for the person's safety and dignity.

We observed staff spoke about people instead of respectfully involving them in the discussion. Whilst sitting eating with people at lunch time, staff constantly had their own conversations with little regard for the people at the table. The nature of the conversations were not inclusive of people, such as what hours staff were working and who they would be working with.

We saw staff sighed and 'rolled their eyes' at times when attending to people's needs. The regional manager told us they had also noticed this, yet there was no evidence to show what they had done about it.

We heard staff spoke with complete lack of understanding for people's needs and often within their earshot. One member of staff told inspectors "[Person] likes to buy stuff and then just breaks it, stuff doesn't last two minutes, breaks everything." On another occasion, a member of staff referred to damage to an internal wall and stated, "That's downs syndrome," pointing to the person who had caused the damage.

We observed staff supporting one person with a colouring activity. The person initially had some pens and the book but the member of staff took this off them and proceeded to ask the person for different coloured pens so they could colour in themselves instead. The person became agitated and started throwing the pens around the room and the member of staff just laughed. No attempt was made to calm the person or engage with any respect for their needs.

On the third day of the inspection we saw an entry in the communications book which showed one person had been into the community wearing no shoes, and reminding staff to ensure they had their shoes. This was also reported by the local authority staff supporting the service. We spoke with the person's social worker who confirmed they would always need their shoes on when in the community.

On the first day of the inspection one person told us they were feeling angry because they were unable to go out and there were not the staff available to support them with this and they liked to be independent. On the second day of the inspection we saw the person was very angry and marched into the dining room. They said they were unable to go out because staff were busy with other people.

This was a breach of Regulation 10 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

Inadequate

Is the service responsive?

Our findings

At the last inspection in May 2017 we rated this key question as good. At this inspection however, we had serious concerns about how care was not responsive to people's needs and the rating for the key question deteriorated to inadequate.

We found care was not at all person centred and people were not treated with respect. Staff were not responsive to people's needs and did not listen to what people were trying to say. Where people did not have the ability to communicate verbally, staff made little attempt to understand their actions.

We observed staff walked past people without speaking to them at times. On one occasion we saw one person who was agitated, swearing and making two fingered gestures to other people, which caused them to be upset. We saw a member of staff walk past without acknowledging any of the people, even though the person continued to swear at them.

We saw one person tried to take the hand of a member of staff and lead them to the kitchen to indicate they wanted food or drink. We saw staff pulled their arm away and resisted the person's effort to take them, so the person took the inspector by the hand and went to the kitchen where they stood at the barrier looking in the direction of the fruit bowl. We asked staff if the person might be hungry, to which staff replied the person was 'always eating' but did nothing to meet their request.

On the third day of the inspection we saw the local authority staff who were supporting the service had to intervene when a member of staff ignored a person who was showing signs of distress. The local authority staff asked care staff to offer reassurance and try to understand what the person was communicating. The member of staff said, "It doesn't mean anything, this is what they do all the time." This showed the member of staff lacked understanding of the needs of individual service users.

We found there was no stimulation for people and no meaningful activities. When people attempted to make their needs known they received inappropriate responses from staff. For example, on one of the days of the inspection, we heard one person say, "I'm bored," to which staff replied, "You're bored? Why?" There was no attempt to engage the person in conversation about what they might like to do. We saw another person expressed a wish to go to a particular shop. Staff agreed with the person they could go there on that day and then explained to us this was the person's favourite place to go. We heard staff later told the person they could not go to the shop, which caused the person some distress. This meant there was no routine for those service users who required this as an essential part of their life, such as those with autistic spectrum disorders and no awareness of the importance of this.

We saw staff asked one person, "What do you fancy doing this afternoon?" to which the person replied, "Watch my telly." Staff then said, "No, no you don't want to watch your telly, that's boring, you want to do something much more exciting, how about going to [name of shop] with me? I love [name of shop]." The member of staff walked away from the person and there was no further engagement with them to ensure they were involved in meaningful activity planning in line with their own interests.

On the first day of the inspection, one person told us, "I'm bored. I've got more about me than just to sit about in this place. I like to be out, round Normanton but I can't always go if there's no staff free to go with me." On the second day of the inspection we saw one person waited for more than an hour with their bag packed ready to go out, but there was no support for them. They said, "It's doing my head in, I can't stand it. I've got to get out and I have to wait, it's not fair." We heard staff say, "You'll just have to wait." The person became visibly upset and staff were aware of this but did nothing to support them.

We observed the handover on the morning of the third day of inspection and asked the deputy what activities were planned for the day. They told us, "Once everything's done, such as meds [meaning medicine administration], we will decide who is going out and then we'll take it from there." They told us there was no clear plan and people had not yet been consulted about what they would like to do.

We saw there were very few resources available for people to engage with. There were no activities taking place for any of the people. Staff told inspectors the CD player was broken and therefore there was no music available.

On the third day of the inspection we saw the manager was playing music for one person, played through a member of staff's personal mobile phone balanced on a window ledge. We asked the manager if the CD player was still broken and they said it was. They were unable to say why this had not been replaced. The television played in the main lounge constantly on all three days of the inspection, although we did not see anyone watching this or being asked what they wanted to watch, if anything. The sound from the music in the hallway was too loud for the sound from the television to be heard in the lounge.

On the last day of the inspection we spoke with the manager about whether they had obtained any further resources for people's meaningful occupation. The manager told us it was 'still a work in progress' and pointed to some boxes containing various items, such as picture cards, toy bricks and books. We saw some of these books were not in good condition. The manager told us there were some further resources in the portacabin in the garden. We saw a cupboard containing some board games. There was no evidence any of the resources being used by anyone and these were kept in the cupboard during all the days of the inspection.

This was a breach of Regulation 9 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

The manager told us since they came into post they had been working to improve the care plans. We looked at four care plans and saw there was some difference in style and format in the ones which had been updated. Information was easier to locate where work had been done to improve these. However, we found there were gaps in the recording of people's information; the last entry in one person's care plan was February 2018. In two care plans that had been improved we found there was an error, because critical information had been copied and pasted in each, to say the person had had a stroke in 2016. We asked the manager about this and were told this was a mistake.

Complaints were not responded to or recorded. We saw when people raised concerns and complaints they were overlooked or ignored. For example, one person complained they were unable to go out and another person made their needs very clear when they were unhappy with their care, yet there was no response or acknowledgement for these people.

Inadequate

Is the service well-led?

Our findings

At the last inspection we rated the key question as requires improvements. This was because we identified two breaches in the regulations. At this inspection we found the key question had deteriorated to inadequate. This was because there had been changes to the management and there was no adequate management or leadership in the home.

The manager had been in post for a very short time at the time of the inspection and they told us they intended to register with the Care Quality Commission.
On the first day of the inspection we saw an action plan which was not dated, which we were told had been drawn up prior to the inspection of the service to address areas in need of improvement. At the end of the first day of the inspection we told the regional manager and the manager we had serious concerns about staffing levels, safeguarding risks including people's finances, and fire safety.

On the second day of the inspection we found little action had been taken to address identified areas to action. We asked the manager and the regional manager what action they had taken since the first day of the inspection. They told us they had updated some people's care plans and introduced a signing in system. However, we found there had been little done to prioritise or address the concerns we raised on the first day.

The action plan had not been amended in line with the most recent concerns; staffing levels had not improved, safeguarding risks were continuing, there was no further evidence of how people's finances were managed and there had been no mitigation of the fire risks. On the third day of the inspection we received an updated action plan dated 17 June 2018 which was aligned to the concerns identified through the inspection. However, there were still continuing concerns not appropriately actioned, such as safeguarding risks and fire safety.

There was no oversight of the quality of people's care or staff practice. Staff were not clear about their roles or responsibilities and there were poor systems in place to ensure even the most basic standards of care for people. For example, members of the management team were present when staff delivered poor care, but this was not challenged.

We found there were ineffective governance systems in place. Managers had not assessed or mitigated risk, or taken sufficient action to ensure people's safety and wellbeing where there were known risks, such as fire safety, vehicle safety and individual risks to each person. Inspectors found there was a lack of management presence or demonstration of leadership in the home. The management team were not visible in the service other than predominantly in the office or at one of the provider's other locations and there was a very negative culture in the home.

We saw on the third day of the inspection the manager spent some short periods of time out of the office, although they were deployed offering one to one support to a person, but without having oversight of the service or offering any leadership to staff on duty.

We asked the manager how they monitored practice in the home and they said they did daily walk rounds, although we found these were not always done daily and they were not always documented. On the first day of the inspection the manager said they would make sure they recorded these, yet on the third day of the inspection we found there were only four recorded dates of daily walk rounds for the month of June 2018. Documentation to show how the service was being managed was poor. The manager spent their working week between all three of the provider's homes. The manager was unable to tell us how they had a clear oversight of practice in Carlton Lodge and there were no spot checks of staff practice.

We saw there were no documented audits for March and April 2018 and the manager and regional manager said they could find no evidence of any audits having been done during this period. We saw some audits for May 2018 but where issues were identified as in need of improvement there was no evidence of any action taken. Audits had not identified areas of most immediate concern, such as people's care needs, staffing and risks within the service. There was little regard for the values of choice, promotion of independence and inclusion as outlined in the guidance for Registering the Right Support.

We concluded there was a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.