Standwalk Ltd

92 Carlton Road

Inspection report

92 Carlton Road
Whalley Range
Manchester
Lancashire
M16 8BE

Tel: 01612493349
Website: www.standwalk.com

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

Summary of findings

Overall summary

About the service
92 Carlton Road is a residential care home. The service provides support with personal care and accommodation for up to six people. At the time of our inspection, there were six people living at the home. The service was providing support to people with a range of needs, including younger and older adults, people with a learning disability, autism and mental health needs.

The service did not consistently apply the principles and values of Registering the Right Support and other best practice guidance. These when applied consistently ensure that people who use the service can live as full a life as possible and achieve the best possible life outcomes for themselves that include control, choice and independence.

The outcomes for people living at 92 Carlton Road did not fully reflect the principles and values of Registering the Right Support for the following reasons. We found people had not always received safe care and treatment and allegations of improper treatment had been substantiated.

People's experience of using this service and what we found
Safeguarding systems had not always been appropriately followed by a small number of the staff team as we found people had been subject to improper treatment.

The staff were not supported with their roles and responsibilities. The current physical intervention training was not person centred enough to manage one person's behaviours that challenged others. The service failed to follow best practice to ensure a restrictive intervention reduction programme was in place. This would potentially reduce the use of physical intervention and restraint.

Environmental risks had not been fully assessed to ensure people were safe. People's risk assessments were not followed due to some inconsistent approaches from staff. The management team had not analysed all accidents and incidents to help prevent future occurrences.

During the night we found the appropriate level of senior management was lacking. People's medicines were managed, administered and stored safely.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. We have made a recommendation about capacity assessments and best interest decisions.

The existing support plans captured people's assessed needs, but we found they were not easy to navigate. The service also needed to assure themselves all staff had read and signed people's specific behavioural support plans, so they were aware of people's potential triggers.

Quality assurance systems were not always effective and action plans, already in place, had not reflected some of the findings on this inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 11 October 2018). Since this rating was awarded, ownership of the legal entity 'Carlton House Care Limited' has changed. Carlton House Care Limited is now owned and managed by the Standwalk Ltd. We have used the previous rating to inform our planning and decisions about the rating at this inspection.

Why we inspected
The inspection was prompted in part due to concerns received about a high number of safeguarding incidents. A decision was made for us to inspect earlier than planned to examine those risks.

Please see the action we have told the provider to take at the end of this report.

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.

Follow up
During and after our inspection processes, we requested information from the provider about what action they were taking to address our serious concerns. We also worked alongside the relevant local authorities in light of the concerns we identified. During our enforcement processes, we continued to monitor the service for any further concerning information to help inform our inspection activity.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe, and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the 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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not effective.

Details are in our effective findings below.

Inadequate

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate

92 Carlton Road

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors on the first day. On the second day there was one inspector.

Service and service type
92 Carlton Road is a 'care home.' People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used information we had received through our ongoing monitoring of the service and feedback we received from the local authority and the community infection control team. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people and two people's relatives about their experience of the care provided. We spoke with six members of staff including, the service development manager, registered manager, the deputy manager and three care workers. We used the Short Observational Framework for Inspection (SOFI). SOFI is

a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed records relating to the care people were receiving and the management of a care home. This included, the medicine systems, two care plans, training and supervision records, audits, records of servicing and maintenance and a sample of policies and procedures.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- People were at risk of avoidable harm. Specific risk assessments were in place. However, these were not followed by the staff team. For example, one person had a detailed risk assessment when having hot drinks. The assessment had not been followed, resulting in two separate incidents were the person had recently burned themselves.
- The registered manager informed us the kitchen must be locked at all times due to potential risks of self-harm and injury. However, on one occasion the kitchen had not been locked and a near miss incident had been recorded involving a person, even though this person should be receiving support from two staff members at all times.
- Safety checks connected to the premises had not always been completed. On several occasions we requested to view the home's passenger lift 'Lifting Operations and Lifting Equipment Regulations' 1998 (LOLER) certificate to check this was safe. During the inspection it came to light the passenger lift exanimation had not been carried out due to a serious administrative issue by the home's insurance company. Regulation 9 of LOLER states the passenger lift must receive a thorough examination at least every six months if the lift is used at any time to carry people. The passenger lift was inspected shortly after the inspection, with minor recommendations noted in the report that were soon to be undertaken.
- Fire drills were conducted, however records of drills involving the night staff had not been completed. This meant the provider could not be sure all staff understood what to do in the event of a fire to reduce risks to people. Shortly after the inspection the provider informed us two-night drills were completed with staff.
- The provider did not act to prevent the reoccurrence of accidents and incidents. They did not identify factors that may have contributed to incidents or consider wider learning, despite the same incidents continuing to occur. The registered manager told us they did not monitor accident and incident information to look for themes and trends.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Prior to our inspection we received concerns about the conduct of a number of staff members. Concerns had been investigated and some staff members had been dismissed due to their poor practice.
- The allegations made were predominately about the care and treatment of one person. Allegations were of the improper use of physical intervention when this person displayed behaviours that challenged.
- We were satisfied the provider correctly followed their safeguarding policy and procedures to prevent this potential abuse from continuing when allegations were raised. However, the service had failed to consider

whether there was an overuse of physical intervention for one person, as the service had no systems in place to determine if physical interventions were being carried out safely. During the inspection we found one person had an unexplained thumb injury as a result of physical intervention, there was no indication how this injury had occurred.

● Shortly after the inspection we were provided with a safeguarding report that analysed all safeguarding matters that had taken place at the service. The service found a reduction from 67 in 2018 and 27 reported safeguarding's in 2019. However, this reduction in safeguarding incidents did not consider whether the use of physical intervention continued to be appropriate for one person at the service.

● Staff told us the registered manager and provider were approachable, they had no hesitation in raising any concerns they had. Staff felt sure action would be taken straight away. They knew where they could go outside of the organisation to raise concerns if necessary.

Staffing and recruitment

● There were suitable numbers of staff to provide the care and support people needed. The provider followed safe recruitment procedures.

● There had been a high turnover of staff within the last three months for various reasons. The registered manager confirmed 15 staff had left, with seven of those staff being dismissed or resigning due to allegations of poor conduct at the home.

● The registered manager informed us the service was actively recruiting new staff to reduce agency cover and provide better continuity of care for people. The rotas we viewed provided assurances there had been a reduction in the use of agency staff within the last month. The registered manager felt there had been a positive change to the staffing culture at the home as a result of new staff members coming on board.

● We found there was a lack of leadership during the night support to ensure the service was safely managed. The night rota consisted of seven support workers and one of the support workers would assume responsibility for leading the shift.

● We found there had been allegations of poor staff practice during the night, where a senior member of staff was not present. Shortly after the inspection the provider undertook analysis of incidents that had taken place at the service. It was noted within the last six months they highlighted six incidents out of 16 had occurred during the night. However, this analysis did not detail any potential trends or themes to establish why there had been a reduction in safeguarding's.

The service did not demonstrate staff on duty were suitably qualified, competent, skilled and experienced to manage people's needs. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● Medicines were managed, administered and stored safely.

● There were policies and procedures in place to ensure people received their medicines as prescribed by health care professionals. Protocols were also in place for people's individual medicines including 'as required' medicines. Medicines administration records were completed appropriately by staff and checks were conducted to ensure continued safe administration.

● Staff received medicines training and had their competency to administer medicines safely assessed.

● Although we found medicines were safely administered, records for the use of prescribed thickeners did not always show if people had their fluids thickened safely. The registered manager addressed this matter during the inspection.

Preventing and controlling infection

● The home was clean throughout and was free of malodours.

● Records showed staff were provided with training relating to infection control. Staff told us they were provided with personal protective equipment (PPE) and hand sanitisers were available for staff and people to use throughout the home.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Records showed where one person displayed regular behaviours that challenge, staff were not sufficiently trained to manage and deescalate such behaviours, there was an over reliance on the use of physical intervention with a lack of consideration to best practice guidance.
- Incidents forms viewed indicated a number of challenging interventions where staff members had been injured as a result. In discussion with the registered manager they accepted Creative Intervention Training Responses for Untoward Situations (CITRUS) training was not working for this person in question, but we found no other strategies had been considered and the provider was waiting for a new placement to manage this person's needs.
- We found the service had made no attempts to assess the staff team's competency in completing the CITRUS interventions, to establish whether it was the actual training that was not working or the staff members approach when used.
- We saw staff interacting with people positively but observed a minor incident that quickly escalated due to the way a staff member handled the incident. This was a further indication that the staff on duty did not poses the confidence or skills at to safely manage behaviours that challenge others.

The service had not ensured staff were competent, skilled and experienced to make sure that they can meet people's care and treatment. This placed people at risk of harm. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told us that they felt better supported since the appointment of the new manager. Staff had regular supervision and team meetings. One member of staff said, "I think we get fantastic support. The most recent [registered manager and deputy manager] are the best of the three managers that we have had. They have made it homelier and this has impacted positively on staff and people who live here."
- Staff had completed a range of on-line training courses. Face to face training was also provided in the use of physical intervention through a course called CITRUS.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- Prior to people moving to the service their needs were assessed. These assessments were used to develop the person's care plan and make decisions about the staff support they required, and skills needed to support the person.
- The service ensured assessments included input from relevant specialists, such as the positive behaviour support specialist and the learning disability community team.

Supporting people to eat and drink enough to maintain a balanced diet

● People's meals were flexible and took into account any specific dietary needs and people's preferences.

● People who required support with eating and drinking had guidelines in place for staff to follow. One relative said, "I know [person's name] has a particular diet and the service always sorts the meals out for them."

Supporting people to live healthier lives, access healthcare services and support; staff working with other agencies to provide consistent, effective, timely care

● People received effective, timely and responsive medical treatment when their health needs changed. Records demonstrated that staff had contacted people's GPs, dentists, speech and language therapists, occupational therapists and dieticians when required.

● People had hospital passports in place. These are documents people can take with them when they go to hospital and provide useful information for healthcare staff. Passports included information such as how the person expresses that they are in pain, how they take their medicines and information about how the person engaged with healthcare previously.

Ensuring consent to care and treatment in line with law and guidance

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● DoLS applications had been appropriately submitted to the local authority and were monitored to make sure they were adhered to.

● Capacity assessments and best interest decisions were made. These were not always decision specific and there was limited evidence of involvement from the person and significant others. There was no evidence that people had been unduly restricted.

We recommend the registered manager consider current guidance on assessing capacity and making best interest decisions.

Adapting service, design, decoration to meet people's needs

● The service had been designed to meet people's needs. People's bedrooms were spacious with en-suite shower facilities.

● Some people had personalised their rooms with help from their families, however other living areas were not personalised such as lounges due to some people's anxiety, as this could cause overstimulation for them.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence
- During the inspection we observed caring interactions provided by staff. However, we were not satisfied people at the service had always been treated in a respectful way.
- Prior to our inspection a number of safeguarding allegations were made, and some were substantiated about the conduct of staff, with poor care being delivered. The provider recognised this was unacceptable and these staff members were no longer working at the home. However, it was clear some people had not been treated in a dignified way.
- People were encouraged to be as independent as their abilities allowed. We observed people assisting staff with their laundry and preparing their meals.

Ensuring people are well treated and supported; respecting equality and diversity
- We observed staff interacting with people in a friendly and respectful way. Staff responded to requests for support. Staff were aware of people's different needs and responded to them in an individual way.
- People's relatives were positive about the service. Comments from relatives included, "I believe the service is good for [person's name]" and "Generally I have no concerns. The staff all seem fine with [person's name]."
- Records showed staff had received e-learning equality and diversity training. During the inspection we found staff demonstrated good awareness of people's diverse cultural heritage and spiritual needs. However, we found this had not always been the case at the service, with recent safeguarding concerns being raised. This meant people had not always been protected from discriminatory behaviours and poor practices.

Supporting people to express their views and be involved in making decisions about their care
- People were not always able to express their views and needs verbally. Each person had a communication passport which detailed their communication needs. These included; body language, facial expressions, and physical actions.
- One person told us staff listened to them but raised concerns about one staff which the registered manager followed up during the inspection. One person said, "The staff do listen, but [support workers name] is not very nice to me."
- Information about local advocacy services was available at the service. These services can be used to support people to express their views if they do not have friends or family to support them, or if they want support from someone independent.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans reflected people's preferences and personal history which provided guidance for staff on how to support them as they wished. However, some people had three care files which was time consuming to fully navigate. We discussed the importance of ensuring the care plans were easier to navigate so that all staff including new staff members could easily get up to speed with people's needs.
- Many of the people living at the service had complex needs and may have behaviour described as challenging. Each person had a positive behaviour support plan in place. We found the management team did not have the appropriate oversight to establish if new staff member had read and signed the care plans, to confirm they understood people's needs.

Meeting people's communication needs:
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The registered manager was aware of the AIS and each person's specific communication needs were detailed in their care records.
- There were aids to support communication if this was required, for example picture cards were available and the registered manager told us they would develop pictorial care records if required.

End of life care and support

- The service was not supporting anyone who was nearing the end of their life. We discussed with the registered manager how they would support someone who needed palliative care. The manager confirmed the service would get outside professionals in, GP and district nurses to support.
- We did see evidence that the provider had tried to speak with people and their relatives about their end of life care and support needs and in some cases, this had been declined.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- Each person took part in activities that were important to them. People's support plans contained information on what activities people had and had not enjoyed along with a planner of when people had chosen to do certain activities. One person told us, "I like to go out. I am going to Southport today."
- Care plans and risk assessments included the use of specialist mobility equipment in the community, and the extra precautions staff may have to take.

Improving care quality in response to complaints or concerns

● There was a complaints policy in place and this was available in different formats depending on people's communication styles.

● Complaints had been appropriately managed in line with the provider's procedure. They were managed in a timely manner and an apology given where appropriate.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Inadequate. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- While the provider and registered manager had identified concerns and were working on an improvement plan to address shortfalls; the service had not been monitored sufficiently following our previous inspection to ensure regulatory requirements would be met and quality sustained. We found multiple breaches of regulations in relation to safe care and treatment, staffing, and good governance.
- The service recruited an experienced manager who registered with the CQC in November 2019. The providers service development manager also visited the service regularly to support the manager and completed their own quality audit.
- Systems to monitor and assess the safety and quality of the service were not always effective. Whilst audits had been completed to assess and monitor the service, these did not identify the shortfalls we found. For example, robust analysis of accidents and incidents was lacking and post incident de-briefs had not always been robustly explored.
- At the time of inspection, we could only review two months of accident and incidents, as the previous forms had been archived away. We requested these documents several times, but the service struggled to provide this information. This was a further indication the governance systems at the home were ineffective.
- The registered manager was aware the use of CITRUS physical intervention was not always effective with one particular person at the service. However, we found the service had failed to explore other strategies and good practice to keep this person and others safe.
- The provider did not always have good oversight at the service. During and after the inspection we made attempts to obtain the most recent LOLER certificate to check whether the passenger lift was safe. The provider was not aware the LOLER examination had been missed.

Governance systems were not robust at identifying the shortfalls we found. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Prior to our inspection we found there had been substantiated safeguarding's incidents at the home involving a small number of staff team. This was an indication the culture at the service did not protect people from receiving improper treatment.
- The management team were taking steps to change the existing culture at the service. The registered

manager told us the introduction of a new deputy manager and senior team leaders supported these changes as staff were being closely mentored to develop a better culture within the staff group.
● Although we found the service was going in the right direction, the registered manager was open that the service was not fully there yet in respect of an inclusive staff culture, but felt assured this service had improved in respect of the care and treatment people received.
● Staff told us that there had been recent improvements at the home. Some staff told us, "When I first came staff morale wasn't' good. It has improved drastically. Poor staff have gone, and we are recruiting people and have a new culture" and "It [service] has improved since the new manager. There is a better team approach."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The management team understood their duty of candour responsibilities. During the inspection the registered manager informed us of an incident where a staff member had been assaulted while on duty, they were open and told us incidents such as these were not acceptable.
● However, we found the service had missed an opportunity to keep people's relatives at the service fully informed in respect of the recent safeguarding issues at the home. In discussion with the management team they did not want to disclose certain information as it did not impact the majority of people at the service but accepted in hindsight the service missed an opportunity to keep people's relatives fully informed of the allegations. This was an area the management team were looking to address going forward.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● People were involved in meetings at the service. These were on a 1:1 basis with the person's key worker.
● People, their relatives and staff were provided with questionnaires to comment on how the service was doing. However, we found these questionnaires were not service specific and it was not clear what people or their relatives at 92 Carlton Road said. The registered manager confirmed this process would be reviewed.
● In addition, staff were also encouraged to regularly feedback about the service delivery and share ideas and suggestions on how the service could be improved. One staff member told us, "Yes we have team meetings, we can raise our points of view."

Continuous learning and improving care
● Opportunities for learning and improving care needed to be improved further. The provider and registered manager had not ensured incidents were fully explored. This meant opportunities to learn and improve were not always noticed.
● Although the registered manager had only been in post for a short time, they had already started to put together an action plan they planned to systematically work through. Whilst the management team were clear on the action that needed to be taken, we found some aspects noted on this inspection had not been captured in the action plan.