Carrwood House

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

Summary of findings

Overall summary

We carried out this inspection on 30 and 31 March 2017. The first day of our inspection was unannounced. This meant no-one at the service knew that we were planning to visit.

Carrwood House is registered to provide accommodation and personal care for up to 16 people with learning disabilities and mental health needs. The home is situated in the Grimesthorpe area of Sheffield and is close to local amenities. The home has a communal lounge and dining room, access to a garden and a small car park. There were eight people living at the service on the days of the inspection.

It is a condition of registration with the Care Quality Commission that there is a registered manager in place. 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. There had not been a registered manager at the service since 2011. We met with the manager during the first day of our inspection who told us they were in the process of applying for registration with the Care Quality Commission.

At the last inspection on 27 and 29 April 2016 the service was rated inadequate and placed in special measures. This inspection was undertaken to check the registered provider now met all of the legal requirements. At this inspection we found that there were not enough improvements to take the service out of special measures. The Care Quality Commission is now considering the appropriate regulatory response to resolve the problems we found.

Staff did not fully understand what it meant to protect people from abuse. There were no effective systems in place to monitor allegations of abuse and any action subsequently taken. This would have enabled to service to identify any trends and lessons learnt.

There were not enough staff to meet the needs of people living at Carrwood House, particularly at night when only one member of staff was employed.

We found there were not appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

Safe staff recruitment procedures were adhered to.

People were offered a limited amount of options to meet their nutritional and hydration needs. Food and drink was not always stored correctly which meant it may not have been safe to consume. People told us they liked the food provided at Carrwood House.

Care records did not fully reflect whether a person had capacity to make decisions about their care and

treatment. Staff did not fully understand the Mental Capacity Act and its implications on their practice.

Staff did not receive regular supervision, annual appraisals, or appropriate training to support them to carry out their jobs effectively.

There were few activities available to people living at Carrwood House. No activities were advertised to be taking place.

People's care records contained gaps in information and were not regularly reviewed. This meant the information as how to best support people to meet their needs was incomplete and may have changed. There was no evidence that people's views and aspirations were taken into account when care records were reviewed.

The views of people living at the service and their relatives were not regularly obtained, and were not recorded

There were no policies and procedures available to view. These should be available to people living at Carrwood House to give them information about the service. For staff they can provide good practice guidance and information about the service's expectations of them.

We found the service did not have processes in place to enable them to respond to people and/or their relative's concerns or complaints.

There was no evidence of regular quality audits being undertaken to ensure safe practice and identify any improvements required.

During this inspection we found the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15, Premises and equipment, Regulation 18, Staffing; Regulation 9, Person-centred care; Regulation 11, Need for consent; Regulation 17, Good governance; Regulation 12, Safe care and treatment; Regulation 16, Receiving and acting on complaints; and Regulation 13, Safeguarding service users from abuse and improper treatment.

We found omissions in the reporting of incidents to CQC as required by regulations which was a breach of Regulation 15 and 18 of the Care Quality Commission (Registration) Regulations 2009 .

Full information about CQC's regulatory response to any 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.

There were not enough staff to meet the needs of everyone living at Carrwood House, particularly during the night.

The service did not have appropriate arrangements in place to manage medicines to ensure people were protected from the risks associated with medicines.

The service did not fully understand it's responsibilities to protect people from abuse.

Improvements were required to ensure the premises and equipment were safely maintained.

Is the service effective?

Inadequate

The service was not effective.

People were offered a limited amount of options to meet their nutritional and
hydration needs.

Care records did not reflect whether a person had capacity to make
decisions about their care and treatment.

Staff did not receive regular supervision, annual appraisals, or appropriate training to support them to carry out their jobs effectively.

Is the service caring?

Requires Improvement

The service was not always caring.

We saw care staff spent a lot of the day sitting in the dining room rather than proactively supporting or encouraging people.

People and relatives we spoke with made positive comments about the care staff.

Is the service responsive?

Inadequate

The service was not responsive.

There were limited activities available to people living at Carrwood House, and few opportunities to leave the premises to visit local amenities if a person required support with this.

Care records were incomplete and not regularly reviewed. This meant the information recorded did not always fully or accurately reflect the person's current level of need.

There was no complaints policy in place, and no record of any concerns that were raised or actions taken to resolve them.

Is the service well-led?

Inadequate

The service was not well-led.

The views of people living at Carrwood House and staff working there were not regularly obtained and were not recorded.

There was no evidence of regular quality audits being undertaken.

The service did not have any policies and procedures in place to reflect current legislation and good practice guidance.

The service remains in special measures and continues to be rated inadequate.

Carrwood House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 over two days on 30 and 31 March 2017. The first day was unannounced. On both days the inspection was carried out by one adult social care inspector.

Prior to the inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. A notification should be sent to the Care Quality Commission every time a significant incident has taken place. For example, where a person who uses the service experiences a serious injury.

Before the inspection we contacted staff at Healthwatch who reported they had no concerns recorded. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also contacted members of Sheffield City Council Social Services and Sheffield Clinical Commissioning Group. They told us they were continuing to jointly monitor the service and were offering support to the registered provider to improve as they had concerns regarding the level of risk to people living at Carrwood House.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). 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. They did not return a PIR and we took this into account when we made our judgements in this report.

During the inspection we spoke with six people who lived at the service and two of their relatives. We met with the manager, the registered provider and the registered provider's legal representative. We spoke with three members of staff. We spent time looking at written records, which included three care records, four staff files and other records relating to the management of the service. We checked the medication administration records for five people living at Carrwood House. We checked three people's financial

records. We spent time observing the daily life in the service including the care and support being delivered by all staff.

Inadequate

Is the service safe?

Our findings

We checked the progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

When we arrived at Carrwood House there was one care worker in the building and no other staff present. We were told the other care worker had gone shopping for washing powder. This care worker returned with several bags of shopping half an hour later. Staff we spoke with told us there were usually two care workers covering the day shift from 8am to 8pm and one care worker covering the night shift from 8pm to 8am.

Staff we spoke with told us the current staffing levels were not enough to meet everyone's needs. We were told about an incident when the police had to be called during the night in response to a window being smashed. One care worker told us it was difficult to safely manage the home when there was only one care worker on the night shift. Another care worker told us, "It can be difficult with two [staff] on during the day if we need to take a person to an appointment or to go shopping." We were told some people living at Carrwood House required the assistance of two care workers to support them with them their personal care needs. This meant there were no care staff available to support any other people during this time.

During the day there was a cleaner employed between 9am and 2pm on weekdays, and we were told another cleaner had recently been employed to cover the weekends. Care workers told us they undertook cleaning duties in their absence.

The manager was employed to work at the home Monday to Wednesday. They told us they had been in post for approximately four months at the time of this inspection. The deputy manager had worked Thursday and Friday, but we were told they had recently left the service. Staff we spoke with told us there was no longer a third member of staff employed to cook lunch and an evening meal, this was done by one of the two care workers on shift. The administrator had also left the service and their tasks were undertaken by the manager and the registered provider.

The manager confirmed this was an accurate reflection of current staffing levels. They told us an additional care worker was brought in on occasion. For example, when a person needed to be supported to attend an appointment away from the home. During the first day of our inspection an additional care worker did arrive to assist with cooking lunch. Care staff told us this was unusual and one staff member said, "Probably only happened because you [CQC] are here."

We asked the manager if they used a staffing dependency tool to work out how many staff were needed in relation to the current level of needs of the people living at Carrwood House. The manager told us they did not use any tool and the staffing levels were predominantly financially driven.

We found the registered provider had not ensured there were sufficient numbers of competent, skilled, and experienced staff deployed to meet the needs of the people living at Carrwood House. This was a continued

to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We looked at whether medicines were stored securely and dispensed safely. The medicines were kept in a locked trolley in the office on the ground floor. We felt the room was very warm and there was no fan to cool the air. The temperature of the room had been recorded during March 2017. On 22 and 23 March the temperature was recorded as over the safe limit of 25 degrees Celsius. There was no temperature recorded for 24 and 25 March and on the 26 March the temperature was again recorded as being over 25 degrees Celsius. There was no evidence care staff had taken any action or reported this to the manager. We saw opened bottles of liquid medicines were not always labelled to say when they had been opened. This meant they have could have exceeded the 'use before' date. This meant we could not be sure medicines stored in the office were fit for use.

There was no medicines management protocol available for us to look at on both days of our inspection. However, on people's individual medicines records we saw there was a written protocol when a person was prescribed PRN medicines. PRN medicines are prescribed to be taken as and when needed, for example, for pain relief. The protocol stated PRN medicines should always be offered to people as prescribed, and if not required, the reason as to why should be marked on the person's Medication Administration Record (MAR) chart. Four of the five MAR charts we looked at listed one or more PRN medicines prescribed for the person. Three of these four were not completed in line with the service's own PRN protocol. It was not always recorded whether the person had been offered their PRN medicines. Where it was recorded the person had declined their medicine, the reason why was not always stated.

Care workers should sign the person's MAR chart to confirm they have given the person their medicine or record a reason why not. There were missing signatures on two of the MAR charts we looked at. One MAR chart had been signed twice on the same day for a medicine prescribed to be taken once a day. This meant we could not be sure people were given the right medicines at the right time.

Care workers told us they received medicines training via the local pharmacy, who also supplied the medicines prescribed for people living at Carrwood House. A care worker told us this training was last delivered approximately six months ago. After the training, care workers were then expected to be shadowed correctly dispensing medicines by a more experienced member of staff five times before being signed off as competent to do this unsupervised. We looked at the file of a member of staff who had responsibility for medicines and we saw a certificate to confirm they had received this training. However, the form to record the observations of their competency in this area had not been completed.

We found the registered provider had not ensured medicines were managed, stored or administered in a safe way. This continued to be a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment.

We checked the progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

One care worker we spoke with told us they had not received any training in safeguarding vulnerable adults

from abuse and their training records confirmed this. Staff we spoke with were not able to tell us what possible abuse may look like and what to do if they suspected abuse may have taken place.

Since our last inspection CQC had raised two safeguarding concerns with the local authority. These were regarding concerns raised by whistle-blowers about low staffing levels, lack of heating, the gas cooker not working, and alleged mismanagement of people's finances. At the time of this inspection one of these concerns has been investigated through to conclusion where institutional abuse and neglect were substantiated at the case conference.

During this inspection the manager told us of four safeguarding concerns they had raised with the local authority. One of these was regarding how two members of staff dealt with a person displaying challenging behaviour. Institutional abuse was substantiated at the case conference. We were told disciplinary action was taken against the staff involved. Neither of the files relating to these members of staff contained details of a complete investigation taking place. One member of staff had resigned following the incident. We asked if they had been referred to the relevant organisation as abuse had been substantiated. The manager told us they 'thought so.' There was no evidence on this person's file this had happened.

The remaining three concerns the manager had raised with the local authority identified people living at Carrwood House as the alleged perpetrators of abuse against staff and other people living at Carrwood House. These were not progressed to investigation by the local authority. Managing challenging behaviours can be part of the reasons why some people are assessed as needing a high level of care and support. Safeguarding concerns are raised about vulnerable adults rather than care staff. Care staff are not vulnerable. This shows the manager may not have fully understood how best to support vulnerable adults at risk of abuse.

There was no safeguarding policy and associated procedure available for us to look at on either days of our inspection. We asked if the manager held a record of all safeguarding concerns raised. This would enable any trends to be identified and any lessons learnt. We were shown a file which contained two of the four safeguarding alert forms sent to the local authority. There was no record of the outcome of any of the alerts.

The manager told us 'Carrwood House' was named as the financial appointee for three people living at Carrwood House. We were told there should be a detailed financial record kept for each person. We checked the financial records for these three people and saw they were significantly out of date. We asked the registered provider's legal representative about this and we were told the records were with the service's accountant for 'sign off.' They showed us a 'personal financial transaction form' they were planning to implement at the start of the new financial year. The current system may have meant people were vulnerable to financial abuse.

We found the registered provider had not ensured the systems and processes in place were operated effectively to ensure people were protected from abuse and improper treatment in accordance with Regulation 13. This continued to be a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safeguarding service users from abuse and improper treatment.

We checked the progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment.

During the inspection we checked whether all bathrooms and toilets now had running hot and cold water. We found this was the case. There was a staff cleaning rota on each bathroom door which had not been

signed each day to confirm each bathroom had been checked and cleaned. We asked the care staff about this and they told us this was because the cleaner was on holiday. However, they told us they did cover cleaning duties in this member of staff's absence. We saw care staff had mopped the dining room floor during the first day of the inspection and the cleaner had returned from leave on the second day.

During our inspection we asked the manager to show us the most recent documents relating to the servicing and checks of the environment, premises and equipment. We saw certificates for satisfactory inspections of gas safety, electrical items, and legionella. Records relating to fire safety did not contain any evidence of fire drills taking place. It is important that regular fire drills are undertaken. We knew from the serious incident meetings with the local authority there had been a fire in one of the bedrooms on the first floor since the last inspection. This bedroom had not been refurbished and showed clear signs of fire damage. The person had been moved to another room.

Although we saw some improvements had been made in this area, the property was not properly maintained and therefore this continued to be a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Premises and equipment.

We checked the progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 19, Fit and proper persons employed. During this inspection we found improvements had been made in this area.

We looked at three files relating to staff employed in the last 12 months. Each contained acceptable references, proof of identity and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helped to ensure people employed were of good character. This confirmed recruitment procedures in the home helped to keep people safe.

Inadequate

Is the service effective?

Our findings

We checked the progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

One person told us, "food is a bit better here than my old place." A relative told us, "The food is very good." The manager showed us a copy of 'A small scale report of individual resident's needs.' This report was in regard to people's nutritional needs and gave useful information on what was best for each person to eat to improve their health. We did not see this information anywhere on people's care records. We did not see any evidence of the recommendations at the end of the report being implemented. These included, 'A new menu needs to be created taking resident's dietary requirements into consideration. [And] Residents need weighing monthly to monitor weight loss and gain.' Registered providers must make sure that they assess each person's nutritional and hydration needs to support their well-being and quality of life.

We saw the menu plans in the kitchen; these were very similar to what we had seen at previous inspections. There was not much variety and a lot of processed food on offer. We saw one person come downstairs for breakfast. They were not asked what they wanted to eat and were given a bowl of cornflakes with milk. We observed lunch being served. This was a relaxed affair with people coming and going. Not everyone came to the dining room for lunch and care workers did not tell those absent but in the building that lunch was being served. We did not see any meals or drinks being taken to people who stayed in their rooms. Everyone in the dining room was given soup and a sandwich. During the lunchtime meal and throughout the afternoon care staff asked people when they came into the dining room if they wanted spaghetti bolognaise for tea. They did offer alternatives, such a sausage and chips or eggs on toast if people initially said they didn't want any tea. Where food and/or drink are provided for people, they must have a choice that meets their needs and preferences as far as is reasonably practical.

There was a chalkboard in the dining room with space to write down the options available for each meal. We saw this was left blank on both days of our inspection. The kitchen continued to be inaccessible to people living at Carrwood House as the kitchen door could only be unlocked by a member of staff.

We saw there was a thermos of coffee available in the dining room alongside milk and juice in a table top fridge. There was no thermos of tea available and staff told us people only had to ask if they wanted a cup of tea. There were no snacks readily available to people, such as fruit or biscuits. Again staff told us people only had to ask if they wanted a snack. We saw a sheet of paper on the wall to be signed to track when the thermos of coffee was refreshed but this had not been completed since February 2017. The table top fridge temperatures were in range when recorded, however there were gaps on 23 March 2017 and from 27 March 2017 onwards. In the kitchen there were two full size fridges. We saw the temperature records for these fridges also had gaps and for one week in March one of the fridges had temperatures recorded outside of the safe range. There was no evidence of any remedial action taken to reduce the temperature of this fridge. This meant food and drink was not always stored properly and therefore may not have been safe to consume.

We found the registered provider had not ensured service users' health and well-being when meeting their nutritional and hydration needs. This continued to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

We checked the progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

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

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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 did not observe any restrictions or restraints in place at Carrwood House. This meant that no-one living at Carrwood House was deprived of their liberty. Staff we spoke with did not know what a DoLS was nor did they demonstrate an understanding of the principles of the MCA and what it meant in practice. We asked the manager if they felt anyone should be on a DoLS and their answer implied a lack of understanding in this area as they thought a person who had capacity should be subject to a DoLS. Care staff we spoke with told us they had not received any training in this area, training records we looked at confirmed this.

Since our previous inspection on 27 and 29 April 2016 none of the care records we looked at had been updated to reflect the person's level of capacity and possible impact on their care and treatment. It continued to be the case where there were capacity assessments on a person's care record they did not include reference to any involvement of the person in the process, and were not always signed or dated.

We found it was not always clear whether the care and treatment of people living at Carrwood House was provided with the consent of the relevant person. This continued to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for consent.

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

One of the care workers we spoke with had been employed by the service within the last 12 months. They told us they had an induction, which included a walk around the premises and shadowing a more experienced member of staff for a week. This care worker's file contained an induction programme and presented as reviewed within the four and eight week timescales as described within the induction process. However, on checking this person's start date with the service the induction programme had been completed over three months later.

We looked at the file of another care worker who had been employed within the last 12 months. This care worker's file also contained an induction programme. Neither the four week nor eight week review had been

completed. This member of staff had been employed at the service for over four months at the time of our inspection. We saw written evidence this care worker had their practice observed by a senior member of staff during which several areas for improvement were identified, including 'more training and to read care records.' There was nothing else on file to indicate that these recommendations had been actioned.

During our last inspection we saw the induction programme included guidance to staff on general housekeeping issues. Under the health and safety section it stated that, 'It is your responsibility to ensure that you familiarise yourself with the following… including safe manual handling' amongst other things. There continued to be no guidance as to how staff might do this and no references anywhere in the induction pack to any training or how to access it.

The manager showed us the training matrix they had completed to identify what training staff had already undertaken and where there were any gaps. The manager told us training was an issue which 'needed addressing.' There was no training policy available for us to look at. We saw that two longstanding members of staff were recorded as not undertaking any training in over two years. The most recent training anyone had recorded was for July 2016. There were significant gaps in training identified, for example three members of staff were recorded as not completing any safeguarding vulnerable adults training and no one was recorded as having ever undertaken any training on mental health awareness.

The service did not have a supervision and appraisal policy available for us to look at. In the previous twelve months staff had been supervised by up to three different managers (including the deputy manager). Supervision is regular, planned and recorded sessions between a staff member and their manager to discuss their work objectives and wellbeing. This variation was reflected in the staff files we looked at. One care worker's file held a supervision contract and evidence of regular supervisions up until December 2016. Only one of the staff files we looked at contained evidence of supervision taking place this year, this was in February. This supervision session recorded the supervisee stating, '[Name of person living at Carrwood House] scares me. [Name] needs more help.' As there was no record of any further supervision there was no evidence that this concern had been followed up.

Two of the four files we looked at contained a record of an appraisal taking place. The other two files related to staff who had been employed in the last 12 months so we would not have expected to see an appraisal record. An appraisal is an annual meeting a staff member has with their manager to review their performance and identify their work objectives for the next twelve months.

We found staff were not receiving such appropriate support, training, professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform. This continued to be a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing.

Requires Improvement

Is the service caring?

Our findings

During both days of our inspection we saw care staff spend most of their time in the dining room sitting at a table chatting to each other and updating people's daily records. They did interact with people as and when they came into the dining room, we saw people come over to them to instigate conversation, rather than the other way round. We observed the rest of the care workers' time was mostly spent cooking, cleaning and undertaking laundry. This meant care staff came across more as housekeepers than support workers. We saw their role was maintaining the status quo in the home rather than proactively supporting people to increase their independence and promote their health and wellbeing.

We saw one care worker ask a person if they wanted to play draughts before lunch. This took less than five minutes and the care worker was distracted talking to another member of staff for the duration of the game.

The weather was warm on both days of our inspection. We heard two people living at Carrwood House comment on this to staff on both days. We did not see staff respond to their comments other than to agree with them. They could have opened the French doors in the dining room and encouraged people to go outside into the garden.

We were told one person's health had recently deteriorated, they had seen their GP and they were now receiving end of life care. There was nothing in this person's care record to reflect this and what this meant in terms of appropriately supporting the person. This meant any new staff or staff returning from leave would not have access to the most up to date information about each person living at Carrwood House .

There was no statement of purpose or a service user guide. This would have enabled people and their relatives to understand what the service was striving to achieve with people living at Carrwood House and how they were trying to do this.

One person we spoke with told us the staff were alright. A relative told us, "Staff are really good, staff are sociable."

We saw staff engage with people in the lounge and dining room. We heard friendly chatting and staff clearly knew people well. We saw a care worker take a person's hand and talk to them calmly. This person was clearly comfortable in the member of staff's company. We heard a care worker ask a person if they wanted spaghetti bolognaise for their evening meal. This person said they didn't want anything. The care worker then offered a number of alternatives they thought the person might like until the person agreed to eat something for their evening meal.

A relative told us that people living at Carrwood House had keyworkers and he understood their role was to make sure people had clean clothes. They said, "[Name] always looks smart, clothes are kept nice and clean."

Improvements were required in this area.

Inadequate

Is the service responsive?

Our findings

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found breaches of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person centred care.

Care workers told us the people currently living at Carrwood House did not want to do any activities. There was an activities board on the wall in the dining room, which listed every day of the week with space for activities to be recorded alongside each day. There were no activities written next to any of the days.

We saw the daily record for one person, which had been completed every day in March 2017 by care staff. There was space to record what the person had done each day. For every day it had been recorded the person '[had] breakfast,' 'meds,' 'watched TV' and 'smokes.' On three days the additional activity of 'been out to local shop' was recorded and we saw there was an occasional reference to playing board games. There were no other activities recorded for this person in March. We looked at the daily record for another person for March 2017. There was one outing recorded for a hospital visit. Care staff told us it was difficult to support people to go out with the current staffing levels. The lack of meaningful activities available to people can impact negatively on a person's quality of life.

Everyone living at Carrwood House had a care record in the office on the ground floor. In addition there were daily records for each person held in the dining room. The care records contained information about the person's health and social care needs, likes and dislikes, and a social history. The daily records were completed throughout the day for each person and included any areas of personal care they had required support with, what they ate and what they had done each day.

We saw people's care records had not been updated to reflect the advice given at the health or social care appointments people attended. We knew this as we saw there was some information recorded in people's daily records. This information hadn't been transferred to the person's care record. We were told the daily records were archived at the end of each month so it was difficult to ascertain any history or continuity of when people had seen professionals involved in their care and any actions to be taken as a result. This showed there was a risk that people may not receive appropriate care to meet their needs.

People's care had not been planned or delivered in a way that ensured it met their needs and reflected their preferences. This continued to be a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Person-centred care.

All of the care records we looked at had a booklet entitled 'My Life' at the beginning of the file. This book was designed to give an insight in the likes/dislikes and history of the person. We found that the majority of the booklets were blank and some of the ones that were filled out were brief, so they offered no real insight at all to the person it related to. This meant it could be difficult for any new staff to engage with people as they wouldn't know very little about them.

None of the three care records we looked at during both days of our inspection had been updated since October 2016. Care records contained different sections relating to different areas of needs, for example, personal care and maintaining a safe environment. At the end of each section there was a copy of a review form which stated it was to be completed every three months. Reviews of the different sections of the care records were recorded as taking place in June and October 2016. There was no evidence of the person or their relatives being involved in any of the reviews. The October 2016 review recorded in two of three care records we looked at stated, 'care plan no longer fills the care requirements for [Name].' Nothing else was written and there were no records of any further reviews, or an updated needs assessment taking place.

We spoke to the manager about this and we were shown a box of new files held in the office upstairs and we were told these were in the process of being updated for everyone living at Carrwood House. We cross referenced one of the new files with the current care record for the same person. The information in both was exactly the same. The manager confirmed this was the case and told us the new care records, "Were in the process of being introduced."

On the second day of our inspection we spoke with the registered provider's legal representative who told us they thought the care records had been updated. We agreed they could email these updated records to CQC when they could be located. We received seven 'care plan summaries' the following week. There were all dated as being completed in March2017 and due for review in April 2017. The summaries gave clear information about people's support needs in all areas of daily living. However, there was no corresponding information on how to meet these needs. For example, 'I do not like to go in the bath or shower…I refuse assistance or prompting.' None of these summaries were signed by the person or their representative to confirm they had been involved. During both days of our inspection we did not see this information on anyone's care records. The manager was not aware of its existence when we asked if there were any up to date care records we could look at.

As the service did not maintain accurate, complete, and contemporaneous records in respect of each person living at Carrwood House this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance .

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

A relative told us, "I have never had cause to complain but I would arrange to meet with the manager if I needed to."

We saw the service had information on how to complain displayed in the reception area. This gave addresses and telephone numbers of who to contact to make a complaint and who to contact if people were unhappy with the original response. The procedure needed updating to include the name of the current manager.

There was not a complaints policy available for us to view on either day of the inspection. There was no log of any complaints received about the service. We asked the manager if they were aware of any complaints being made. They told us they had received one verbal complaint and this had not been recorded.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Receiving and acting on complaints.

Inadequate

Is the service well-led?

Our findings

It is a condition of registration with the Care Quality Commission that there is a registered manager in place. 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. At the time of our inspection there was not a registered manager in place. There was a part-time manager who told us they had been in post for four months and was in the process of applying to CQC for registration. Our records show the previous manager had also in the process of applying for registration, but they left the service before this could be completed. The service last had a registered manager in 2011.

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

A care worker told us they thought managers could be available at the service more, but they were always on the "end of the phone." We asked two relatives of people living at Carrwood House whether they thought the service was well-led? Their comments included, "[I] don't think management changes have made a difference," and "[Carrwood House] needs a lot of improvement. Staff not really an issue, more a management problem. No stability with managers." The manager did show us three letters from different relatives of two people living at Carrwood House. The letters were complimentary about the service their relatives received.

We asked if people living at Carrwood House and the staff who worked there were asked for their views on the service provided and to make any suggestions for improvement. The manager told us there were no processes in place to receive feedback from people living at Carrwood House. The manager did show us five responses to a recent staff survey undertaken while the deputy manager was in post. There was no record of any feedback to staff or analysis of the results.

The manager told us there were no residents or relatives' meetings planned. A relative told us there had been a meeting with the registered provider in September 2016 to discuss the previous CQC report. The relative told us there were no minutes from this meeting and they hadn't received any further communication from management. This shows the registered provider and manager did not communicate effectively or regularly with people and their relatives.

We asked the manager if they met regularly met with staff. They told us staff meetings were monthly where possible and deputy manager had met with staff recently. We asked to see records of these meetings and we were shown hand written notes from a staff meeting. These were not dated and hadn't been circulated. We were told there were no further staff meetings planned.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and

governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. We asked the manager what systems were in place. They told us the daily communication book was used by all staff to record any jobs that needed to be done on the premises, for example, changing a light bulb. The maintenance person employed at the service would then look at this book to see what needed doing. There was no other way of tracking what needed to be done and when, or if this was ever completed.

We asked the manager if any more quality assurance processes were in place, such as care plan audits or medicines audits. These could have possibly addressed some of the issues we identified during this and previous inspections. The manager told us there weren't any in place. This showed the registered provider had not ensured that systems or processes had been established to assess, monitor, and where required, improve the quality and safety of their services.

We saw there was a policy and procedure file in the reception area. This contained information regarding the Mental Capacity Act and South Yorkshire safeguarding adult procedures. We asked the care staff if there was any more information about policies and procedures available and we were told if there was, it would be in the office on the ground floor. It wasn't there. On the second day of our inspection we asked the registered provider's legal representative if they knew where this information was held. They told us the policies and procedures had all been recently reviewed and updated and they would email CQC a copy. An email was received with the subject heading, 'Policies and procedures Carrwood House,' but nothing was attached. We replied to the registered provider's legal representative to this effect. No further information was subsequently received.

The service has been rated as inadequate since December 2014. Since the last inspection on 27 and 29 April 2016 the service remained in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15, Premises and equipment, Regulation 18, Staffing; Regulation 9, Person-centred care; Regulation 11, Need for consent; Regulation 17, Good governance; Regulation 12, Safe care and treatment; Regulation 16, Receiving and acting on complaints; and Regulation 13, Safeguarding service users from abuse and improper treatment. We have continued to find systems were not established and operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This continued to be a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17, Good governance.

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found the provider was failing to send notifications for reportable events or incidents.

A notification should be sent to the Care Quality Commission every time a significant incident has taken place. Prior to this inspection on 30 and 31 March 2017 the local authority made us aware of a number of notifiable incidents at Carrwood House. These included an incident when the police needed to be called, a fire at the premises, several allegations of abuse, and changes to management. We asked the manager about this who told us they were not aware these types of events needed to be reported to CQC or there were specific forms to be completed and submitted for each of these types of events.

This continued to be a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents and a breach of Regulation 15, Notice of changes.

We checked progress the registered provider had made following our inspection on 27 and 29 April 2016 when we found a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014, Requirement as to display of performance assessments .

It is a requirement of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 that a service displays their most recent rating on their premises and on every website maintained by or on behalf of any service provider. On arrival at Carrwood House on the first day of our inspection we saw the current rating was clearly displayed in reception. Prior to the inspection we checked the registered provider's website to see if this now also clearly displayed the rating for Carrwood House. We saw 'The site carrwoodhouse.co.uk has been disabled.'

This meant the provider was no longer in breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Requirement as to display of performance assessments.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 Registration Regulations 2009 Notifications – notices of change Failure to notify CQC of changes to management.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Failure to notify CQC of a number of incidents at Carrwood House. These included an incident when the police needed to be called, a fire at the premises, and several allegations of abuse.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered provider had not ensured service users' health and well-being when meeting their nutritional and hydration needs. People's care had not been planned or delivered in a way that ensured it met their needs and reflected their preferences.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent It was not always clear whether the care and treatment of people living at Carrwood House was provided with the consent of the relevant person.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider had not ensured medicines were managed, stored or administered in a safe way.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered provider had not ensured the systems and processes in place were operated effectively to ensure people were protected from abuse and improper treatment.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The property was not properly maintained.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints There was not a complaints policy available for us to view on either day of the inspection. There was no log of any complaints received about the service.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service did not maintain accurate, complete,

and contemporaneous records in respect of each person living at Carrwood House.

The service has been rated as inadequate since December 2014. Since the last inspection on 27 and 29 April 2016 the service remained in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 15, Premises and equipment, Regulation 18, Staffing; Regulation 9, Person-centred care; Regulation 11, Need for consent; Regulation 17, Good governance; Regulation 12, Safe care and treatment; Regulation 16, Receiving and acting on complaints; and Regulation 13, Safeguarding service users from abuse and improper treatment. We have continued to find systems were not established and operated effectively to ensure compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The enforcement action we took:

Cancellation of registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had not ensured there were sufficient numbers of competent, skilled, and experienced staff deployed to meet the needs of the people living at Carrwood House. Staff were not receiving such appropriate support, training, professional development, supervision and appraisal as is necessary to carry out the duties they were employed to perform.

The enforcement action we took:

Cancellation of registration.