Mr David Hetherington Messenger

Carson House Care Centre

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

This inspection was carried out over five days between 16 and 20 January 2017. Our visit on 16 January was unannounced.

We last inspected Carson House on 31 May 2016. At that inspection we assessed the service as requires improvement in safe and well-led and good in effective, caring and responsive domains. We also identified breaches of two regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to infection control, cleanliness, safety of the environment, medication and good governance. We also made one recommendation to ensure the information and legibility of handover notes were improved.

Carson House is situated in the Stalybridge area of Tameside and provides accommodation for up to 45 people who require nursing and personal care. All rooms provide single accommodation and 43 rooms have en-suite facilities. Bedrooms are located over two floors and can be accessed by stairs or a passenger lift. Communal bathrooms and toilet facilities are available throughout the home. The home is divided into four units, two on the ground floor and two on the upper floor; each unit consists of a lounge, dining area and small kitchen facilities. One unit is dedicated to providing general nursing care, one unit provides specialist mental health nursing for men who have challenging behaviour (CBU) and the other two units provide mental health nursing for men and women in separate units.

The laundry and main kitchen are located on the lower ground floor. There is an enclosed patio area at the rear of the building that is accessible to people who use the service.

At the time of our inspection there were 41 people living at Carson House.

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

We carried out this inspection in response to information of concern we received regarding the safety of people at the home due to the unavailability of a hoist on the ground floor. At the time of the inspection a receivership company had been appointed to sell the home and an external care management organisation had been appointed to oversee the day to day management and care delivery at the home.

We identified multiple breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in relation to person-centred care, dignity and respect, consent, safe care and treatment, safeguarding, meeting people's hydration needs, premises and equipment, good

governance of the service, staffing and ensuring fit and proper persons are employed. You can see what action we told the provider to take at the back of the full report. We are currently considering our options in relation to enforcement in response to some of the breaches of regulations identified. We will update the section at the back of the inspection report once any enforcement work has concluded.

Some people, their relatives, and staff spoke highly of the service; one person's relative told us, "I can honestly say in the past three years I've never had anything to complain about." However, not all relatives were happy with the service and the home was dealing with a complaint during our inspection.

During this inspection we found that there were enough staff available to meet people's needs. However, the use of agency staff meant that people were not always being cared for by people who knew them or were fully aware of their individual care needs.

People were supported by staff who were mostly kind and caring. However, we found during our inspection that people were not always treated with dignity because staff did not always ensure people were left in a dignified state.

The staff files we looked at showed us that safe and appropriate recruitment and selection practices had not been completed by management to satisfy themselves that suitable staff were employed to care for vulnerable people.

Staff we spoke with were aware of how to safeguard people and were able to demonstrate their knowledge around safeguarding procedures and how to inform the relevant authorities if they suspected anyone was at risk from harm. However, we found that not all staff had received training at the home on safeguarding adults and staff had not identified and reported the safeguarding issues we raised during the inspection.

Documentation at the home showed that people sometimes received input from other health care professionals, such as dentists and podiatrists. However, we found that people had not always received the necessary care and support when they needed it.

We found concerns regarding the management and administration of medicines during our inspection.

Care files we looked at showed plans and risk assessments documenting people's specific care and support needs. These were detailed plans outlining how people needed to be cared for in an effective and safe way. However, they did not always accurately reflect people's current care needs as they had not always been kept up to date.

We found that although care and monitoring documentation was in place, these were not always accurate, effective and followed by staff; this placed people at risk of harm.

During our initial tour of Carson House on the first morning of our inspection, we saw that some areas of the home were not clean and several bedrooms had a strong malodour. We found a number of concerns with the general home environment, such as stained carpets, broken sinks and cracked window panes. These concerns had previously been reported on and an action plan put in place from the last inspection in May 2016, but had not been rectified. The enclosed outdoor area was dirty, unkempt and strewn with cigarette ends.

We found people's documentation to consent to care and treatment had been signed by family members who did not always have the legal right to provide this consent. The home had not checked with relatives to

ascertain whether these legal safeguards were in place.

During our inspection we raised multiple safeguarding alerts with the local authority. These pertained to our concerns relating to people's current care and support. We also reported our initial findings to the local authority commissioning team who arranged subsequent visits to the home by social work teams to conduct safe and well checks.

The overall rating for this service is Inadequate and the service is therefore 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.

Due to our findings during our inspection the provider invoked a temporary, voluntary suspension on new admissions to the home until the issues we had identified had been resolved.

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.

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

The home was not always clean and we found risks associated with infection control.

Safe recruitment practices had not always been followed to ensure that suitable staff had been employed to care for vulnerable people.

Risk assessments were in place; however, they were not up to date and did not reflect the current needs of people.

Monitoring charts were not effective, did not match care plans and were not always adhered to.

Is the service effective?

Inadequate

The service was not effective.

People were not always supported to have their health care needs met by health care practitioners and did not always receive prompt medical attention.

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

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

People's hydration and pressure care needs were not met.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives told us they were well cared for at Carson House.

People did not receive personalised care and support, specific to their preferences.

People mostly received support by caring staff; however, people were not always treated with dignity and had their privacy respected.

Is the service responsive?

Inadequate

The service was not responsive.

There were no activities provided and people did not receive any social stimulation throughout our inspection.

People's care plans stated their preferences; however, we did not see evidence that these were acted upon.

Nurses' written communication between shift handovers was not informative, effective, personalised or always acted upon.

Is the service well-led?

Inadequate

The service was not well led.

The acting manager and newly appointed clinical lead were inexperienced and were not familiar with the current regulations that govern CQC registered services.

Previously employed robust systems of audit and control had not been continued for a number of months and had led to a lack of managerial oversight and the failings identified during this inspection.

Staff did not feel supported in their role and felt uninformed and insecure regarding the future of their jobs and the people who lived at the home.

Carson House Care Centre

Detailed findings

Background to this inspection

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

This inspection took place on 16,17,18,19 and 20 January 2017 and day one was unannounced. The inspection was carried out by one adult social care inspector who was accompanied by an inspection manager on day five.

Before we visited the home, we checked information we held about the service including contract monitoring reports from the local authority and notifications sent to us by the provider. Statutory notifications are information the provider is legally required to send us about significant events that happen within the service.

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

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

During the five days of inspection, we reviewed a variety of documents, policies and procedures relating to the delivery of care and the administration and management of the home and staff. This included four people's individual care records, a sample of six people's administration of medication records and four staff personnel files to check for information to demonstrate safe recruitment practices, training and regular supervision had taken place.

As part of the inspection process we observed how staff interacted and supported people at mealtimes and

throughout the five days of our visit in various areas of the home. We spoke with people who used the service and three relatives. We also spoke with the acting home manager, the visiting quality manager, the clinical lead, the home administrator, the cook, one kitchen staff and three care staff members.

We also attended a safeguarding strategy meeting with various professionals held in response to safeguarding concerns raised during the inspection.

Inadequate

Is the service safe?

Our findings

At our last inspection in May 2016, we found that there was no dirty and clean flow in the laundry, which meant that clean laundry coming out of the dryer was carried past the dirty laundry waiting to be loaded into the washing machine and we found this area was not clean. We found that it was not always clean and multiple examples of rooms, furnishings and equipment throughout the home that required a thorough clean. There were a number of carpets that were heavily stained and required replacing, cracked window panes where they had been repaired using tape, and a broken sink unit in one bathroom. This meant that safe procedures to prevent and control risk of infection had not been followed and was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014.

Despite requirement notices issued to the provider and related action plans submitted to us, we found these issues had not been rectified during this inspection and areas within the home were still unclean.

We found people's clothes were ironed and sorted before being returned to individual rooms. We identified that metal trolleys used for transporting clean laundry back to the units were not clean; we asked laundry staff to clean them before they were used again.

We found that sluice rooms were not locked. This meant that harmful substances, such as chemical cleaners, and soiled items were accessible to people who lived at the home, some of whom live with dementia and mental health conditions. We found one communal toilet did not have a lock and we asked for this to be fixed to ensure people's privacy and dignity.

We found communal bathrooms and toilets to be clean and had full hand washing facilities; however, we found bins for disposal of continence products were broken and could only be used by lifting the lid manually. This meant that there was a risk of cross infection.

We saw throughout the inspection that staff did not always wear personal protective equipment (PPE) to minimise the risk of cross infection. We saw one staff member carry personal laundry out of a bedroom without wearing a disposable apron and gloves and another member of staff carried soiled clothing from someone's bedroom without wearing an apron; increasing the risk of cross infection.

One staff member we spoke with told us, "Cleanliness is not good. Some days there's a cleaner on the unit and some days there is not." They told us the care staff often had to clean the units due to the lack of a cleaner. We spoke with the acting home manager regarding staff vacancies and they confirmed they were in the process of recruiting to a vacant domestic post.

People's bedrooms were not always clean and we saw that some people's equipment, bedding, carpets and furniture were soiled. Two people's bedrooms were very untidy and housed oxygen equipment; neither room doors had the required oxygen warning sign to warn people of the danger from the oxygen cylinders. We visited a sample of people's bedrooms on the general nursing and CBU and found many had a strong

malodour. One person's room had such a strong malodour; we requested they be offered the opportunity to move to another room whilst there room was deep cleaned. This meant the person had been using and sleeping in an unclean room with an unpleasant malodour. We were subsequently informed that the bedroom flooring required complete replacement to remove the malodour.

We found Carson House Care Centre was not conducting their service in line with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections Guidance.

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

During our previous inspection in May 2016, we found a number of errors with the way medicines were managed. This meant that medicines were not managed safely and this was a breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) regulations 2014. As a result we issued a requirement notice and a received a subsequent action plan detailing what actions had been taken to rectify the shortfalls in the safe administration of medicines.

At this inspection we found the required improvements had not been met.

We looked at the way in which medicines were managed at Carson House to check that people get their medicines in the right way at the right time. There was a medication policy in place and PRN protocols. PRN medications are to be used "when necessary", for example, analgesia for when someone experienced pain. The home used a local community pharmacy to manage the stocks and deliver the medicines.

We found during our inspection that medicines were kept in medicine trolleys anchored to the wall on unit corridors. Medicines should be stored in areas with temperatures below 25 degrees, as high temperatures can compromise the quality of the medicines. We found that the medicine storage areas were not monitored for temperatures and no records were maintained. This meant there was a risk that medicines were not being stored safely.

We found on top of the medicine trolleys that pill crushers contained a significant amount of tablet residue left from previous uses. We found the residue of three different colours of tablet in one pill crusher. This meant that nurses were not washing the pill crushers between uses and carried a high risk of cross-contamination between medications; this placed people at the risk of harm. We also found the pill crushers were damaged.

We found two used, dirty syringes left on top of one person's bedside table that was also dirty. These syringes were being used for peg feed flushes and this was confirmed with staff. The use of unclean syringes for such procedures placed the person at risk of infection. We reported our findings to the acting manager who purchased new pill crushers and a supply of new syringes during our inspection.

During our inspection we observed staff, who were conducting the medication round, being frequently interrupted by people and other staff members during the administration of medicines. This practice can lead to mistakes being made in the administration of medicines to people.

We checked the medication administration record (MAR) sheets for a sample of six people and conducted a count of boxed medications where we checked balances to ensure that people have received the right amount of medication. We found a large number of inaccuracies in medication numbers in all of the checks we made. This meant that either people had not received the correct amount of medication or that

recordings were inaccurate. We saw that monthly audits of medication had been completed; however, no shortfalls had been identified during the last month's audit.

We did not find evidence that people had come to immediate harm; however, due to the large amount of errors in all of the medicine records we reviewed and the types of important medications the discrepancies concerned, we raised a safeguarding alert with the local authority. The acting manager told us they would request a medication audit to be conducted at the home by their pharmacy medication supplier.

We reviewed documents that confirmed that both the home's registered general nurses (RGN) and the registered mental health nurses (RMN) were registered with the Nursing and Midwifery Council (NMC). The NMC ensures that registered nurses keep their skills and knowledge up to date and uphold professional standards. However, we found that five out of eight nurses did not have up-to-date medication training in place and nurse competency checks had not been carried out since June 2016. This meant the acting manager could not be assured that nursing staff were fully trained and competent to carry out the safe administration of medication.

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

We looked at a sample of four people's individual care records and found that people had risk assessments in place. We found that not all risk assessments and associated monitoring, in people's files, had been reviewed regularly in recent months. For example, we found one person's falls diary stated they last had a fall in September 2016 and other documentation we looked at showed us they had fallen twice in October 2016. Another person's risk assessment for manual handling had not been reviewed since November 2016. This meant people were at risk of receiving care and treatment in a way that had not recently been assessed as appropriate.

During the inspection we looked at a sample of people's care files and found one person had not been regularly hoisted out of bed as per their risk assessment. The person had been living at the home since August 2016 and had a plan in place to regularly hoist them out of bed for bathing and also so they could sit out of bed for two hours per day. On review of this person's care documentation and from speaking to staff and family, we ascertained this person had not regularly been hoisted out of bed and had not been hoisted for a bath or shower since their admission in August 2016. The reasons given for not ensuring the person's plan of care was followed was the home did not have suitable equipment to safely bathe or shower the person and a daily assessment was made by nursing staff as to whether it was safe to hoist the person out of bed due to their behaviour. One nurse told us the person displayed challenging behaviour and was a risk to themselves, staff and other residents and therefore it was not always safe to hoist them out of bed and allow them to sit in the communal lounge. We reviewed this person's care plans and found this verbal information was not supported in the documentation. We did not find any decision-making process or rationale for this person to not be offered the opportunity to sit out of bed on a daily basis.

Another person had been nursed in bed since October 2016; this person had previously fallen at the home and suffered an injury requiring an operation and could no longer weight bear. Their care plan included an assessment by a physiotherapist and a manual handling risk assessment; both detailing how to safely hoist this person from their bed to a chair. However, this person had not been hoisted out of their bed. We asked carers, nursing staff and the acting manager at the home why this person had been nursed in bed and no staff were able to tell us the reason why this person had been in bed for three months. This placed the person at risk of social isolation, pressure sores, muscle wastage and other health complications.

We found that there were no staff at the home who were qualified to carry out manual handling risk assessments and a visiting professional was so concerned around the manual handling of one person they arranged for a qualified assessor from the local authority to come into the home carry out assessments on several people. When speaking with one member of staff they told us they were particularly concerned around the manual handling of one person and the use of a sling. We observed the moving of this person using a sling and found they were unable to be moved in an upright position. We checked the person's risk assessment and found there were no details documented around which specific sling should be used. We checked to ensure this person was on the list for reassessment of their individual care needs by the local authority assessor to ensure their safety.

We also found that people did not have update to date personal emergency evacuation plans (PEEPs) in place. A PEEP provides additional information on accessibility and means of escape for people with limited mobility or understanding and includes a plan specifically designed for an individual who may not be able to reach a place of safety unaided in an emergency situation, such as a building fire. PEEPs that were in place at Carson House Care Centre had not been reviewed and did not reflect people's current care needs. For example, one person's PEEP was from 2015 and stated they were mobile; however, they were now nursed in bed. This placed people at risk of inappropriate treatment in the event of a building evacuation.

The above examples of lack of appropriate risk assessments and doing all that is practical to mitigate risk demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Prior to this inspection we received intelligence around a lack of operational equipment necessary to keep people safe. We contacted the home and found staff had not had access to a working hoist for five days on the ground floor general nursing unit and the CBU. We telephoned and asked the home to make urgent arrangements to hire a hoist to ensure people were safe and could be moved appropriately. This was actioned and remedial action was taken to ensure the existing hoist was made operational.

During this inspection we found that the home did not always have suitable equipment in place in order to provide safe care. We found people who were at risk of falling from their bed, had slim gym mats placed at the side of their bed. However, these were unsuitable and did not provide the required protection in the event of a fall. We drew this to the attention of the acting manager who agreed the gym mats were unsuitable and people required the appropriate crash mats to help protect them from potential injuries caused by a fall from bed. We also identified that people's protective covers for bed rails were in poor condition and would not provide adequate protection in the event of people banging themselves. We asked the acting manager to conduct an audit of all bed rail protectors and crash mats throughout the home. This was completed and suitable replacements were purchased and fitted during our inspection.

During this inspection we observed a person being transported in a wheelchair that did not have a lap belt in place and we asked for one to be fitted before the person was moved. Three days later we again saw this person being transported in their wheelchair where they were not secured with a lap belt.

Where people were at risk of pressure sores and were nursed in bed on electric airflow mattresses we checked to see the assessed correct pressure levels were adhered to. Pressure levels are individual to each person and are calculated using individual care needs and the person's weight. Correct settings are required to ensure the effective and safe prevention of pressure sores in people who are at risk. One person's pressure care chart stated the pressure levels should be set at '52'; however, we were unable to find the mattress gauge to check the correct setting and engaged the assistance of a staff member. The gauge was found under the person's bed and the gauge options were 'soft to hard'. We asked care and nursing

staff what the specific setting should be for the person and they told us they did not know. This meant staff had not checked the correct pressure setting of the mattress and were unable to tell us what the correct setting was for the individual person. We spoke with the acting manager and we found two other people at the home who were being nursed on airflow mattresses where it could not be ascertained what the correct setting was for the person. The acting manager ordered three new appropriate pressure mattresses to enable nursing staff to calculate the correct setting for each person and ensure safe pressure care delivery. We found that equipment at Carson House Care Centre was not always safe, appropriate and not always used in a safe way placing people at risk of harm.

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

Relatives of people who lived at Carson House told us they felt their relatives were safe, one person told us, "Mum is safe." Another relative told us, "They're very safe."

Staff also told us they mainly felt people were safe at the home. One staff member told us they thought people were safe and told us, "I'm fully trained and my fire drills are up to date." However, another staff member told us that they had not had a comprehensive induction or training since they started working as a carer at the home. Although they had worked at the home for a short time, no training had been booked or discussed. Another staff member told us that although they thought people were safe, they had concerns over staffing levels, they explained, "We need more staff, especially on the nursing units; it can be very challenging when we've only got two carers. Some people have quite demanding behaviours and a lot of people require two to one staff. If we need to take someone to their room to de-escalate the situation then other people are left alone."

We looked at staffing numbers at Carson House to ascertain if safe and appropriate levels of care and nursing staff were on duty during the day and night. During the inspection we observed there were usually staff around the home when people required assistance; however, we were unable to locate staff on two occasions and we observed one instance where the call bell was sounding for approximately 10 minutes before we had to find a staff member and ask them to attend to the call for assistance. We found a high use of agency staff, both in care and nursing cover. Staff we spoke with told us they were not happy with the high agency use of staff as they did not know the people for whom they were caring for and therefore, were not able to identify when the person may be ill. They told us, "Some (agency) haven't a clue." They also told us of specific problems they encounter with agency staff, such as, staff doing very little work and were ineffective in care delivery. One staff member told us that some agency nurses "Just do the meds and then disappear. It's also difficult with agency carers." One relative told us they also were not happy with the high use of agency staff and explained, "Mum has to learn new faces."

We saw that there were several agency staff working at the home during our inspection and existing staff told us they did not know who they were as they had never seen them before. We found the agency worker had not had a full induction nor had they been given the care plans of the two people they would be supporting that day on a one to one basis. One person had particularly high support needs and lived within the challenging behaviour unit. This meant there was a risk the people would not receive safe and effective care from carers who knew them and knew how to ensure they were kept safe. We spoke with the acting manager about our concerns and they acknowledged there were issues which they were addressing through current recruitment to the vacant posts.

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

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

Arrangements were in place to safeguard people from potential abuse; a safeguarding policy was in place and training was provided for staff. However, the home's training matrix showed us 28% of staff members did not have up-to-date training in the safeguarding of vulnerable adults. We spoke with staff around how they would safeguard the people they cared for at the home, staff were able to describe how to identify abuse and how to act upon any potential concerns. Despite some staff having up-to-date training in place and being able to explain how to identify abuse, staff had not identified and acted upon the concerns we found during this inspection.

On the first morning of our inspection, we visited several people in their bedrooms. We found one person to be in need of acute medical attention as they were visibly suffering from an eye infection. Additionally, they had dry, cracked lips and a visibly dry mouth and tongue. We reported this immediately and the acting home manager told us they had asked a nurse to request a GP for the person's infected eyes four days previously; however a GP had not been requested and the person had continued to suffer. We requested the person be offered a drink immediately and that a GP was contacted. The person was later diagnosed with an infection of both eyes and treatment prescribed.

We found another person in bed with their bare feet pressed up against an unprotected wooden footboard leading to a potential risk of pressure sores. Their toenails were very long and overgrown and required attention to prevent harm. We requested the person was repositioned safely and that attention was sought from a podiatrist. The home's administrator arranged for a podiatrist to visit the same day and the person's toenails were made safe.

As part of the inspection, we look at the nurses' handover sheets between shifts. During a review of these documents we saw that earlier in the week it had been noted that one person who was taking antibiotics was suffering from a "smelly, sore and red" area on their body. We looked at this person's care records and other documentation where this information may have been followed up to see if medical attention had been sought. Staff told us the person had received attention, however, we did not see evidence of where further investigations had been made or medical attention had been sought.

The above examples that actions required to ensure the health, safety and welfare of people requiring support from other professionals was not made in a timely manner, demonstrate a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment

During the inspection we looked at four staff personnel files to check that safe recruitment practices had been undertaken. We reviewed these files to check they contained required information including, a full work history, photographic identification checks, health information, a minimum of two references from previous employers and checks from the Disclosure and Barring Service (DBS). The DBS carries out checks and identifies to the home manager if any information is found that could mean a person may be unsuitable to work with vulnerable adults. We found that none of the personnel files contained all the required information and three of the four files did not contain information that DBS were either in place or current. This meant that the acting home manager did not have assurances that robust and safe recruitment practices had been followed to ensure that suitable staff had been employed to care for vulnerable people. We asked the acting manager to conduct an audit of all personnel files to check that the relevant documentation was in place for all employees.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Fit and proper persons employed

We reviewed the safety check systems the home operated to ensure the safety of premises and equipment.

Carson House had a fire safety records book detailing essential, regular safety checks, such as, fire drills, fire system weekly checks, emergency lighting and fire-fighting equipment. We saw that these checks had previously been completed regularly; however, we found that many of these important checks had not been completed for several months. For example, we found the weekly fire alarm tests and fire door checks had not been completed since November 2016. During the initial tour of the building, we found the fire escape on the CBU had been locked with a large, overhead bolt. The acting manager did not know why this fire door had been bolted. We immediately unbolted the fire escape and informed the acting manager that essential fire checks had not been completed. The fire alarm was tested during our inspection.

A fire risk assessment had been in December 2016 identifying a number of concerns, which had been previously identified in the assessment undertaken in 2015. We spoke with the acting manager regarding our concerns around the fire safety of the home and they told us they would be implementing the recommendations from the risk assessment report.

Other safety check systems for the home, such as, emergency lighting and gas boiler checks were in place and mostly up to date. However, we found that some safety reports had found concerns and we did not find evidence that these findings had been acted upon. For example, the lift maintenance report identified necessary improvement that had not been actioned since 2015. We found the electrical installation report stated that essential safety improvements were required and had deemed the installation as "unsatisfactory". We did not find evidence that these repairs had been carried out and the acting manager was unable to confirm to us that the work had been completed.

We found the checks on the health and safety of the building and the subsequent actions and necessary improvements, as recommended in a variety of reports, had not been acted upon to ensure the safety of the people at the home.

The above examples of building safety issues demonstrate a continued breach of Regulation 12 of the 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 2016, we found that despite having knowledge and information about the diabetic needs of people at the home; the kitchen staff did not provide alternative meals to meet the diabetic need of people. We had discussed this with the then registered manager during the last inspection and reported the concern in last inspection report. However, at this inspection we found that people were still were not given diabetic alternatives and the meals being served at the time we visited the kitchen were the same for everyone living at the home. This meant that six people who were living with diabetes at the home had a very limited choice around diabetic options.

As part of this inspection, we looked at the menus and food choices available to people living within the home. The cook told us there was a two week rolling menu and that people were regularly consulted on what meals were offered. We saw that a periodic dining experience survey and monthly meals audit was in place and had previously been completed; however, this had not been carried out since October 2016. Kitchen staff told us they had stuck with the same two-week menu for a long time.

We spoke with relatives and received mixed views on the quality of the food served at Carson House Care Centre. One visitor told us their relative had said, "Sometimes it's not so clever." However, another visitor told us, "The food is all okay. He usually eats all his meals."

Staff we spoke with told us they felt the food was repetitive, for example, beans or spaghetti on toast is often served two or three times per week and more variety is needed for people. One staff member told us, "It depends who is on (kitchen staff), sometimes it's okay and sometimes not…it's rubbish."

We observed the mealtime experience on the general nursing unit and CBU over breakfast/ lunch/ teatime on the third day of inspection. We found that on both units people were served their meals on plastic plates and bowls and hot and cold drinks were served in plastic mugs and cups. We spoke with staff about the use of plastic plates and cups and they told us it was because sometimes people and staff on the CBU may be at risk if someone threw an item. However, not everyone living on the nursing unit and CBU was at risk of throwing an item and this meant that people were not given choices to have their food and drink served in normal cups and bowls. The generic use of these plastic implements throughout the general nursing unit and CBU showed us that people were not given choice or being treated as individuals and in an appropriate and dignified way.

At this inspection we found the hydration needs of service users were not being met by way of effective hydration measures. We noted throughout the inspection that people on the general nursing unit and CBU, who were nursed in bed, did not have access to a drink.

On the first day of our site visit we visited one person in their bedroom and found they had very dry lips, tongue and mouth and requested assistance for the person. We looked this person's care files and found they were being monitored by the way of hydration charts. On the fourth day of inspection we visited this

person at 9.40am and again found their mouth and lips to be dry. We checked this person's hydration charts and saw that they had not been offered a drink since 20.15 the previous evening; we requested the person be offered a drink immediately. We reviewed hydration charts from the previous seven days. We found there was no calculated target fluid intake for each 24 hours and the amounts recorded were too low for one person to sustain good health. The person only received a drink when offered by a member of staff as they were nursed in bed. The person was offered a drink five times per day. Over the previous seven days the lowest amount of fluid recorded in 24 hours was 650mls and the highest amount was 1200mls and is inconsistent with sustaining good health.

We found that people's health and wellbeing was put at risk from insufficient hydration measures. We spoke with the acting manager and requested that measures be put in place immediately to ensure the people living at Carson House Care Centre received sufficient hydration.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Meeting nutritional and hydration needs

The home's administrator printed the staff training matrix, this showed us what training staff had undergone and when refresher training was due. We saw that some staff had undergone the required training, for example, first aid, moving and handling, food hygiene and safeguarding. However, we found there were large gaps in the completion of training for recently appointed staff and gaps in the refresher training required to ensure existing staff keep their skills and knowledge up-to-date, for example we found that 45% of staff had not received refresher training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). There was no evidence that any audits or reviews had recently been undertaken to assess the individual training needs of staff and to identify areas of development to ensure staff had access to the necessary support and training to carry out their job roles safely and effectively.

Carson House Care Centre is home supports people who have mental health nursing needs; however, less than half of staff who provided direct care had completed up-to-date training on mental health awareness.

One recently appointed staff member we spoke with told us that they had not had a comprehensive induction or any training and this was verified by the training matrix. No training had been booked for this person, no competency checks had been carried out and they were working unsupervised within the home.

We spoke with the acting manager about our concerns with the shortfalls in up-to-date staff training. They told us they currently did not have a training provider for the home and would ensure they would source one immediately to address the gaps in staff training. This meant there was a risk that people were being cared for by staff who did not have knowledge and an understanding of legal safeguards and of people's mental health support needs.

We reviewed four care staff personnel files, supervision files and appraisal records looking for evidence of a robust system of induction, supervision and staff development. We found evidence that induction, supervisions and personal development had previously been in place; however, this had not been maintained for several months. For example, we found one person had received supervision in February and May 2016 and then this had stopped. Another staff member had received supervision in January and April 2016 and then stopped. We reviewed the staff appraisal file and found that some staff had received an appraisal in the last 12 months; however, this did not include all staff. We found that staff who had recently been employed had not had supervision or any competency checks.

One staff member we spoke with told us they had received supervision and felt supported in their role by

other staff. However, they told us they did not feel temporary management were very good and they said, "We've no idea what is going on."

The above examples demonstrate a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Staffing.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be made in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find.

We looked at whether Carson House was working within the requirements of the MCA and DoLS. We found that DoLs applications had been submitted to the local authority for relevant people living at the home. A tracker document showed information on applications submitted and approvals received so that at a glance, staff knew who had a current DoLS in place and when a new application needed to be made.

During our observations we saw that people were asked their consent before providing care and support. One staff member we spoke with told us how they would always ask consent before providing care and support to people, they told us, "I knock on the door and ask if they need any help."

We reviewed the care plans of four people who lived at Carson House Care Centre and found that consent forms, confirming the person's consent to the care being provided had not always been signed by people who had the legal right to do so. We found the care documents for two people had been signed by a relative. Staff and the acting manager did not know if the relatives had the legal right to do so and it was not documented in files. We requested that this information be obtained. We asked the acting home manager if anyone living at the home had a person who held power of attorney (POA) for them for either financial reasons or for health and welfare. Power of attorney gives a person the legal authority to act on the behalf of someone else. The acting home manager did not know if anyone held POA for the people living at the acting manager was not aware of the need for POA for health and welfare. Staff and management at Carson House had not sought confirmation that people making decisions around resident's consent to care had the legal right to do so. This meant that consent to care had not been provided in accordance with the requirements of the Mental Capacity Act 2005 and associated Codes of Practice.

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

During this inspection we reviewed four people's personal care files to check if people were supported to maintain their health and well-being. One relative we spoke with told us they were made to feel welcome and said they are kept informed of their relative's condition. They told us, "They keep me informed yes. If they are concerned they will let me know. They are approachable in the office. I can go in and talk to them any time."

We saw people were supported to access other health care professionals, such as the community psychiatry service and dieticians alongside other services, such as, an optician. Although we could see evidence in people's care records that they had previously received input from other healthcare professionals, we found that the medical needs of some people were being neglected during our inspection, this is reported on further in Safe domain of this report.

During mealtimes we saw that people on the general nursing unit and CBU were served their meals on plastic plates and bowls and hot and cold drinks were served in plastic mugs and cups. We spoke with staff around the use of plastic plates and cups and they told us it was because sometimes people and staff on the CBU may be at risk if someone threw an item. However, not everyone living at the home was at risk of throwing an item and this meant that people were not given choices to have their food and drink served in normal cups and bowls. The generic use of these plastic implements throughout the general nursing unit and CBU showed us that people were not given choice or being treated as individuals and in an appropriate and dignified way.

Requires Improvement

Is the service caring?

Our findings

Visitors we spoke with told us they felt their relative was well cared for at the home. One relative told us, "Everyone is so nice. I give them 10 out of 10. They've done a good job. I've never found anything wrong. I could not have got (Name) any better care. There's a nice atmosphere." Another relative agreed and told us, "Care is good. I've never been concerned. (Name) gets care when they need it."

We observed throughout the visit that staff talked kindly to people and were encouraging when providing assistance. It was clear through observations that there were established, positive relationships between some staff and the people who lived at the home.

Staff were mainly attentive and responded to people in a sensitive, kind and caring manner. We observed positive interactions; including laughing, chatting and we saw one staff member sat talking to one person who liked to be surrounded by teddy bears. The staff member knew the names of each teddy bear and where the person liked to have them placed.

We observed one instance where staff were assisting someone to use the hoist. Staff were kind and caring whilst offering reassurance and explanations. Staff ensured the person was happy before each manoeuvre whilst gently touching the person's hand.

We also saw some examples where agency staff were not attentive or caring in their support of people. We observed one 1-2-1 session where the agency staff member did not interact or speak to the person throughout the 1-2-1 session other than to assist the person to eat their lunch. The person was not asked if they liked the food or if they were ready to be served some more.

As part of our inspection we spoke to staff and they demonstrated a good knowledge of the people who lived at Carson House Care Centre. Staff told us they treated people with dignity and respect by respecting their wishes and promoting choice and independence. We asked staff how they felt about the care delivered at the home. One staff member told us, "Care is brilliant" and they would be happy to have a family member living at the home.

Another staff member told us they thought the care was good but that people were not treated well in terms of resource. They told us, "I can't fault any of the carers, but I wouldn't have my relative living here. Christmas day was very upsetting for staff because nothing had been provided to make it special, such as napkins, crackers or tablecloths. It was just like a normal Sunday dinner."

During our inspection, we saw that people and their belongings were not always clean and their dignity was not always respected. We saw several occasions where staff did not knock on people's door before entering their bedroom and we found during reviews of care plans, that people were not always addressed by their preferred name.

We found several people's bedrooms to be untidy, unclean and with malodour. We visited one person in their bedroom on the first morning of inspection and found their bed rail protectors to be worn and soiled. The person also had long, dirty finger nails and staff had left a used, wet flannel on their bed. We raised a safeguarding alert with the local authority and reported this to the acting home manager and asked them to take immediate action to ensure the person was clean and safe.

We visited one person in their bedroom and found they were lay on top of a bare airflow mattress wearing only a t-shirt that had ridden up to expose their underwear and continence products, they had no blanket to cover their dignity.

We found that there was a failure to ensure people's privacy, choice and hygiene needs were met and this meant that people were not always treated with dignity and respect.

The above examples demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect

Inadequate

Is the service responsive?

Our findings

At our last inspection in May 2016 we found that communication between staff shifts was poor and we made a recommendation that the then registered manager ensure handover notes contain pertinent and legible information to ensure effective information exchange between staff shifts.

At this inspection, we reviewed the nurse's records for handover notes for the previous three days and we found that the structure of the form had been improved. They now included a set format of information to be recorded for each person this included; presentation, change of treatment, professional visits and any tasks to be carried forward to the next shift. However, we found these forms did not contain comprehensive information and only one of the four sections had been completed on all forms, the date was missing on two forms and there was no completed form for one shift.

We asked staff we spoke with how people's current care needs were communicated between staff. One staff member told us they thought communication between staff at shift handover was good. However, another staff member told us that communication between permanent staff and agency staff was not always good. They told us that occasionally there are problems with agency staff because sometimes there is a language barrier, they told us, "Some (agency staff) say they don't understand."

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

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

We reviewed four people's care documentation and found that they included care plans and risk assessments which covered all aspects of the person's care needs, including health care needs, likes and dislikes, hobbies and interests. However, we did not see evidence where people had been supported to follow their interests and how people were supported in their aspirations and what they liked to do. Staff we spoke with told us they had not read people's care plans.

We looked at the activities provided for people who live at Carson House Care Centre. People who lived on the men's or women's mental health units had access to more activities and many people left the units regularly. One staff member told us they regularly involve people on these two units with tasks such as cleaning, they told us, "We try to promote the independence of the people on the unit and try to get people involved in everything we do, such as, tidying, hoovering and washing."

However, people living on the general nursing unit and CBU were mainly left in their bedrooms or lounge areas with nothing to do. Research has shown that people who are not given the opportunity to participate in meaningful activity have a poorer quality of life. The National Institute for Health and Care Excellence

(NICE) has produced a number of quality standards to optimise the mental wellbeing of older people in care homes and promote that "Older people in care homes are offered opportunities during their day to participate in meaningful activity that promotes their health and mental wellbeing."

We reviewed the care plans of one person on the CBU unit and saw that their interests included, 60s music, comedy, watching television and sitting in the lounge with others. During the inspection we visited this person on several occasions and did not find them participating in any of their interests. . We also found they had a preferred name; however, we did not see any staff refer to the person by this name.

Care files contained a sheet named "Make a Wish" used to record people's wishes; however, this person's form was blank. This meant that although documentation was in people's care files, it was not acted upon and steps had not been taken to ensure people's wishes were taken into account during care delivery.

Another person's care plans documented how the person liked singing and listening to music. We visited this person in their room, as they were nursed in bed, and found them on several occasions lay in their bed in silence. We asked staff to play some music for the person. The staff member put the radio on and left the room; however, they had put a talking programme on and the radio was not tuned in. We reported this to the clinical lead who told us they would rectify this immediately.

People's care plans contained information about their life story and their interests and hobbies. However, staff we spoke with told us they had not read people's care plans. This meant that there was a risk that care may be delivered that was not to the individual person's needs or preferences.

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

As part of our inspection, we looked at how complaints were responded to and managed at the home. We saw evidence that any complaints were responded to and acted upon. There was information displayed in the reception area of the home informing people how they could complain about the service along with a suggestion box. We reviewed the service's complaints file and found this included a complaint register which included a running log at the front and a detailed monthly analysis chart for each month. This file contained comprehensive information around the recording of complaints, verbal or written, any investigations, any actions taken, the outcome and if the complainant was satisfied with the outcome. We found the complaints file was disorganised and there was no overall analysis of complaints completed to identify any trends.

One relative told us that they had not had cause for complaint, but would feel happy to do so, they told us, "I would definitely tell them if something was wrong." Another relative we spoke with told us they had never complained but they felt confident they would be listened to if they needed to complain.

Inadequate

Is the service well-led?

Our findings

At our last inspection in May 2016, we identified a breach of Regulation 17 of the Health and Social care Act 2008 as although the registered manager had identified and reported shortfalls in the service, the provider had not acted to remedy these identified concerns and placed people at risk from these identified concerns.

At this inspection we found there was a lack of oversight and inadequate monitoring of the quality and safety of the service provided. We did not find any evidence to support that existing governance systems were being effectively utilised to assess, monitor and improve the quality of the service on a regular basis. Safety checks had not been completed regularly and training for staff was not up to date.

Current risks to the people and service, as found during the inspection, had not been identified or by the acting manager, or external care management company appointed.

Structured processes in place for regularly auditing care plans, staff training, staff personal flies, complaints, safeguarding, accidents and incidents, infection control, medication administration and general cleanliness of the home and all aspects of the medication administration records, in place at our last inspection in May 2016 had not been utilised over the past few months and standards had fallen. For example, monthly meal audits had not been completed since October 2016, monthly hoist audits and pressure sore audits had last been completed in November 2016.

We found serious concerns with care and support delivery at the home that necessitated several referrals to the local authority safeguarding teams to ensure people's safety. These shortfalls had not been identified by the current management team.

People who use the service personal information, such as, care plans, were stored in the nursing stations and doors were either wedged open or unlocked throughout our inspection. This meant that this private information was not kept secure and accessible to anyone living at or visiting Carson House Care Centre.

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

The home did not have a manager in post who had been registered with the Care Quality Commission (CQC) since July 2014 at this location. The home was being managed by an acting manager from a care management organisation that had been appointed by the home's receivers. The care management company had been appointed in September 2016. The previous registered manager had left in December 2016. At the time of our inspection a clinical lead nurse had been appointed and had been in post for two weeks.

Staff we spoke with gave us mixed opinions about the current management arrangements. They expressed concerns around their jobs and the future of the people living at the home due to it being in receivership.

One staff member told us, "They're not very good; it isn't proper management. We were reassured at first that everything would be okay, but now we've no idea what's going on." Another staff member told us the acting manager walks around the home each day and speaks to staff and residents and said they if they had any concerns they would speak to the clinical lead because, "They are lovely."

As part of the inspection we looked at how information was communicated from management. We reviewed the staff meeting file and saw that regular meetings had taken place and minutes were available. On the last day of inspection we also saw that the acting manager had called a "Flash" meeting, this is where a meeting is called at short notice for staff currently on shift. Items that were discussed included those issues highlighted during the inspection, such as, immediate staff level increases, the importance of the completion of monitoring charts, staff to read and sign people's care plans, introduction of keyworker system and an acknowledgement that staff had been busy. This meant the acting manager was taking immediate steps to mitigate the risks to people from our inspection findings.

Throughout the inspection we fed back to the acting manager our findings, who put into place measures to remedy the identified shortfalls. For example, new airflow mattresses, bed rail protectors, crash mats and pill crushers were ordered, a deep clean was organised and more staff were brought in to be on shift.