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Carlton House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 and 3 February 2016. A breach of legal requirement was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements and we undertook a focused inspection on 16 June 2016 to check that improvements to meet legal requirements had been made.

During March 2017 we received concerns from the Local Authority. We undertook this focused inspection on the 23 March 2017 to look into these concerns. This report only covers our findings in relation to the concerns found. You can read the report from out last comprehensive inspection, by selecting the 'all reports' link for Carlton House on our website at www.cqc.org.uk.

Carton House is a residential care service that provides housing and personal support for up to 15 adults who have a range of needs including mental health and learning disabilities. At the time of our inspection 10 people were using the service.

At our previous inspection when we asked to look around the premises we were shown the bedrooms and communal areas of number 30 Chatsworth Road, the registered location. In March 2017 the Local Authority contacted us after they had visited the service and discovered the provider was also using the property next door (28A) to accommodate people receiving care and support. They told us they had concerns about health and safety issues with the neighbouring property and also how the service treated those people who lacked the capacity to make decisions about their care and treatment.

The service had a registered manager in post. 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. The registered manager was not present during our focused inspection.

People did not always receive a service that was safe. The property at 28A did not have important safety features in place to protect people from the risk of harm. Overloaded extension cables posed a risk of fire. Risk assessments and care plans were out of date, some risk to people had not been identified and where risk had been noted little had been done to stop or reduce that risk. Important health and safety checks to keep people from harm were not being carried out.

The service was not working within the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected. Where decisions had been made in people's best interest, no mental capacity assessments had been made and there were no records of best interest meetings.

The service was not well led. Systems were not in place to identify health and safety issues that could put

people who used the service and staff at risk. The registered manager failed to ensure care plans and risk assessments were up to date and accurate and when people lacked capacity to make some decisions there were no checks in place to ensure the correct legislation and guidance had been followed.

We found that the registered manager had not told the CQC about an important incident that had occurred at the service which we were required to know about by law so we can monitor the service properly.

After our inspection we identified some registration irregularities that will be investigated separately by the Commission.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breech of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of this report.

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

Aspects of the service were not safe. We had concerns about health and safety issues that could put people at risk of harm. Risk assessments were out of date and incomplete; there was no evidence that risk was being managed properly.

Important health and safety checks were not being carried out.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider was not following the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to help ensure people's rights were protected.

Is the service well-led?

Inadequate

The service was not well-led. Health and safety issues that could put people at risk has not been identified, managed or reduced.

Important information had not been sent to the CQC so we were unable to monitor the service properly.

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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 was an unannounced inspection which was completed on 23 March 2017. The inspection was conducted by one adult social care inspector. The last comprehensive inspection of this service was in February 2016. At the time we found one breach of Regulation 18 of the Health and Social Care Act 2014. This was followed by a focused inspection in June 2016 to check that improvements to meet legal requirements had been made.

Before this inspection we spoke with two health and social care professionals from the local authority to obtain their views on the service and the concerns they had found.

During the inspection we looked at two people's records, staffing rotas and checks relating to the running of the home.

We spoke with the two deputy managers on duty at the time, one being the shift leader and two people using the service.

We looked around the service and communal areas, we looked at one person's room because we had concerns about their immediate safety.

After our inspection we asked for the providers statement of purpose. This identified some registration irregularities that will be investigated separately by the Commission.

Inadequate

Is the service safe?

Our findings

At our previous inspection when we asked to look round the premises we were shown the bedrooms and communal areas of number 30 Chatsworth Road, the registered location. In March 2017 the Local Authority contacted us after they had visited the service and discovered the provider was also using the property next door (28A) to accommodate people receiving care and support. They told us they had concerns about health and safety issues with the neighbouring property.

During this inspection we asked to see 28A. Staff accessed this house via the back garden of number 30, using fire escape stairs to a door on the first floor. This led directly to a small kitchen. Staff told us one person was using 28A at the time of our inspection and they had been living there since 2015. Staff confirmed the person would use the front door of 28A to leave and enter the property and that staff used the fire escape to access the property to provide meals, care and support for the person. The person using the service at 28A was not present on the day of the inspection so we were unable to speak with them. Staff told us the person was moved to 28A after an incident occurred at number 30 between the person and another person who used the service. It was decided by staff that the person would be better off living on their own with staff support. We asked to see the incident form that resulted in this action being taken. It was dated 30 August 2015, details of the incident were recorded. The police and an ambulance were called and staff told us they had contacted the local safeguarding authority. We asked the deputy manager to show us evidence to confirm the local safeguarding authority had been informed. We also asked to see the Care Quality Commission's statutory notification that the registered manager is required, by law, to send to us in these circumstances. Staff looked but could find no evidence of these records. Later we checked our records, we could not find a notification regarding this incident.

The deputy manager showed us the property known as 28A. We checked the hot water in the bathroom but it was cold, the deputy manager told us the boiler was switched off during the day when the person using the service was out. We asked for the boiler to be switched on so we could check the water temperature. The deputy manager was unable to do this and seemed unsure about how the boiler worked, we checked the boiler again towards the end of our inspection, it was still not working. The deputy manager said they would get an engineer out to look at the boiler as soon as they could. We were concerned because there was no assurance that the person living at 28A had any hot water or heating.

We looked at two empty rooms on the first floor and found there were no window restrictors and no radiator covers to keep people safe. We asked to see the room of the person who used the service as we were concerned about safety measures in their room. The person's room was furnished with their personal belongings and had a large television, DVD player and other electrical equipment. We saw there was a four gang electric extension cable that was being used to power the electrical equipment including a small fan heater. We noted there were no radiator covers or window restrictors in the person's room.

We looked around the kitchen on the first floor, we looked under the sink in the kitchen and found a four gang extension cable was directly under the kitchen waste pipe; this was being used to power the fridge and washing machine. We spoke to the deputy manager about the fire risk of over loaded extension cables and

the additional risk of an extension cable being in a potentially wet environment. During our inspection the deputy manager tasked a maintenance man to put an additional electrical socket into the person's room and in a safe place under the sink. It was not clear if the maintenance man was also a qualified electrician.

We saw there was very little food in the cupboards and the fridge was mostly empty, staff explained that the person's meals were brought from number 30, this concerned us because the dining area of 28A was on the ground floor, staff would have to navigate two flights of stairs to get food to the person in the dining room, hot food may be cold, staff may be particularly susceptible to trips and falls while carrying food this far and there was little evidence to how the person could make meal choices or be involved in meal preparation. One staff member told us the person had a choice of breakfast cereals, but we did not see this. Another staff member told us they had to take food away from the kitchen because it was a risk to the person using the service. We looked at the persons care file but could not find any information or guidance covering the need to remove food or the risk faced by the person.

Downstairs on the ground floor was a small lounge/dining room. In the porch, by the front door was another door leading to another area of the ground floor. We asked to see what was in the room, the deputy manager told us this area was locked and used by the manager, and they told us they did not know what was in the space but believed it was being used for storage. We were concerned that such a large area had been portioned off from the ground floor, was inaccessible and could present a fire risk. Unfortunately the registered manager was not available to show us the content of the locked area and no attempt was made to contact the registered manager to allow us access.

We looked at the risk assessments for the person using 28A. Records indicated and staff confirmed that risk assessments were reviewed yearly unless the person's needs changed in the meantime. Four of the risk assessments we looked at had been due to be reviewed on 9 March 2017 and two further risk assessments were due for review on 21 March 2017. Two care plans covering support with daily living skills and personal care were last reviewed in August 2015. We asked staff if they had any more up to date documents on the computer and they told us they did not.

We noted one risk assessment dated 21 March 2016 covered the person at 28A 'escaping from the house'. This mentioned the need for staff to check windows and doors at all times. We were concerned as there was a recognised risk for the person to try and leave the service without staff but window restrictors had not been fitted to help ensure their safety.

We looked at the person's care plan for personal care, it stated that staff needed to check the water temperature when bathing and this should be no more than 43 degrees centigrade. We asked to see the water temperature checks for number 30 and 28A. We were shown checks for 30 Chatsworth Road, staff told us these were conducted weekly but were unable to find the records for every week. The most recent hot water checks were on 21 February 2017, 9 and 17 March 2017. Water temperatures regularly reached 47 degrees and 50 degrees in the kitchen. Staff confirmed that no hot water temperature checks had been completed for 28A.

This amounted to breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Following concerns from the Local Authority we checked whether the service was working within the principles of the MCA. During our last comprehensive inspection we found there was little documentation in place to assess people's capacity and we recommended the service referred to current guidance for good practice in relation to The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). At this inspection we asked to see people's mental capacity assessments but none were available. We were told that two DoLs applications had been made to the local authority in May 2016 but no attempt had been made to follow these up and there was no evidence of a decision having been made.

The service had made a recent application for DoLS following the advice from the Local Authority when they visited the service and noted that the person living at 28A appeared to be under constant supervision.

We saw one person was using bed rails, staff told us that on return from hospital the person was always trying to get out of bed so they had called the community nurse and bed rails had been put in place. We asked staff if they thought the person had capacity to make everyday decisions. Staff felt the person did not and the bed rails were put in place because of safety reasons. Staff confirmed there was no mental capacity assessment or a DoLS in place for this person. We were concerned because there was no evidence of the person giving consent to having bedrails, nor was there any evidence that this action was taken in the person's best interests. This meant that the provider could not demonstrate that they were acting with proper legal authorisation under the MCA, and there was a risk that the safeguards for the person with respect to being deprived of their liberty were being breached. Staff further told us that there were no notes from the assessment made by the community nurse as contact had been made over the telephone.

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

Inadequate

Is the service well-led?

Our findings

There was a registered manger in place at the time of our inspection and they were supported by two deputy managers who were responsible for the day to day running of the service. The registered manager was not available at the time of our inspection so we spoke with both deputies' one of which was a shift leader. During our inspection it became apparent that the deputy manager in charge of the shift was unsure how to operate important appliances, such as the hot water boiler, was unable to grant access for inspection purposes to a large area in 28A and was unsure what the area was used for. We were concerned the deputy manager was therefore unable to fully carry out the role of having day to day responsibility for the home.

During our inspection we found health and safety issues had not been identified or addressed in 28A and were concerned the person using that building may be at risk of harm. The provider had not assessed, monitored or mitigated any risk for service users or staff with regard to the use of the 28A.

We found risk assessments and care plans had not been reviewed with in the providers specified timeframe and were not up to date or accurate. We found decisions made on behalf of a person who lacked capacity were not recorded and there was no evidence to suggest these decisions had been made in line with the requirements of the Mental Capacity Act.

This amounted to breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Records were incomplete or missing, statutory notifications that the provider must complete by law could not be found. This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

During our inspection we asked for a copy of the Statement of Purpose to be sent to us. A statement of purpose for a business describes what you do, where you do it and who you do it to. The law requires this to be kept under review and updated when required. When this document was sent to us we found it was inaccurate and out of date quoting old legislation and guidance, the provider later updated the document and returned this to us. However, as a result we found some registration irregularities that will be investigated separately by the Commission.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person failed to notify the commission without delay of specific incidents. 18(1), 18(2)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent When people were not able to give consent the registered person did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice. 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not being provided is a safe way. The registered person did not follow nationally recognised guidance to deliver safe care and treatment. 12(1). Risks had not always been identified and assessments were not reviewed regularly. 12(2)(a) The registered person did not do all that was reasonably practicable to mitigate risk. Relevant health and safety concerns were not always recorded in peoples care plans. 12(2)(b)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

The registered person failed to assess, monitor and improve the safety of the service. 17(2) (a).

The registered person failed to identify risk to people and did not introduce measures to reduce or remove risk. 17(2)(b)

The registered person failed to keep accurate and up to date records. Decisions made of behalf of people who lack capacity were not recorded in line with the Mental Capacity Act 2005 and associated Codes of Practice. 17(2)(c)