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Carlton House

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

Summary of findings

Overall summary

Our inspection took place on 4, 5 and 9 October 2017 and was unannounced. At the end of the first day we told the provider we would be returning the next day to continue with our inspection.

Carton House is a residential care service that is currently registered to provide 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 11 people were using the service.

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.

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

In March 2017 the Local Authority contacted us because they had concerns with health and safety issues at a neighbouring property which was also being used to accommodate people. They were also worried about how the service treated people who lacked the capacity to make decisions about their care and treatment.

We undertook a focused inspection on the 23 March 2017. We had not been aware the provider was using the neighbouring property. We found four breaches of legal requirements in relation to safety of the premises and of people using the service, how people gave consent to care and records relating to this, how the service was managed and a failure to notify the CQC of specific incidents. The provider was rated as inadequate in two key questions, safe and well led. The provider sent us a plan to tell us about the actions they were going to take to rectify each breach of the regulations. They told us these would be completed between May and July 2017.

Following this inspection in March 2017 the CQC began to investigate concerns about the registration of Carlton House. We were concerned the provider may not have been registered properly and may have been providing care outside of our regulated activities. This meant we were unable to inspect the service to make sure people were receiving the care they should have. We took action and met with the provider to make sure they understood how serious the situation was. We asked them to provide us with information to clarify their registration position. During this period we worked with the local authority to ensure people remained safe. The provider's registration is now correct and they are registered with us as a partnership. We carried out this inspection in October 2017 to make sure the provider had met the legal requirements found during our last visit. At this inspection in October 2017 the provider confirmed the neighbouring property was no longer in use. We checked this during our visit. The provider is currently applying to reduce the number of

bed numbers at the service from15 to12 to reflect their existing position.

At this inspection, in October 2017, we found breaches in 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. The breaches related to safe care and treatment, the need for consent, good governance, safeguarding, person centred care, staffing, failure to display a rating, requirements relating to a registered manager, premises and equipment and dignity and respect. The service continued to be in breach of the four regulations found in March 2017.

We are considering what action we will take in relation to these breaches. Full information about the CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Risk assessments and care plans continued to be out of date, some risks to people had not been identified, including risks relating to the storage of cleaning materials. Where a risk had been noted little had been done to reduce that risk.

The provider had changed the layout of the rooms and, one person had been moved to a room on the ground floor that had previously been a staff sleep-in room. The room was very small and we were concerned about the person being comfortable or maintaining a quality of life in this small space. The mix and number of people using the service and the new layout of the rooms gave us concerns about the number of toilets and bathing facilities available and accessible for people. Men and women used the service and moving from floor to floor to use bath shower rooms and toilets impacted on people's dignity and privacy.

Some important information was missing from people's medicine records. Staff did not always know how people liked to take their medicine and there was no information to tell staff when 'as required' medicine should be given. One person's medicine had not been recorded on their records properly so it was hard to tell if they had been given their medicine or not.

Staff we spoke with knew about safeguarding people from abuse and neglect but we were concerned because the provider had failed to report, act upon and investigate some incidents.

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 carried out and there were no records of best interest meetings.

Staff did not always receive the appropriate support, training, supervision and appraisal to support them to carry out their duties.

The provider did not always give people the necessary support in relation to eating and drinking. We were concerned that two people's nutritional needs had not been assessed by healthcare professionals and the support was not in place to make sure they received adequate nutrition or hydration.

People were relaxed in the company of staff and told us they were happy at the service. Staff appeared to know people well although this knowledge was not reflected in people's care plans.

Activities at the service were limited for some people. People had activity plans but there was little evidence

of activities taking place.

The service was poorly 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.

Our findings suggested the registered manager did not have the skills and competency to carry out her role.

We found that the registered manager had not told the CQC about important incidents that had occurred concerning people who used the service, which we were required to know about by law so we can monitor the service properly.

The service was not displaying its rating of performance from the last CQC inspection, as required by law.

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.

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. Some risks to people had not been identified. Some risk assessments were out of date.

Some important information about people's medicine was not recorded.

We were concerned safeguarding incidents were not always reported or investigated appropriately.

The provider had effective staff recruitment and selection processes in place and there were enough staff on duty to meet people's needs.

Is the service effective?

Inadequate

The service was not effective. Some staff had not received mandatory training and many staff members required refresher training to keep their knowledge and skills up to date. Supervision and appraisals were out of date.

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

Some people received the support they needed to maintain good health and wellbeing. Other people did not. Staff worked well with some health and social care professionals but failed to contact others.

People were not always protected from the risks of poor nutrition and dehydration.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring. We could not see how people were involved in making decisions about their care, treatment and support.

The care records we viewed contained generic information with

little detail about what was important to people and how they wanted to be supported.

Staff had a good knowledge of the people they were supporting. The lay out of the building and facilities had an impact on people's privacy and dignity.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Most people did not have person centred care records some records were out of date and others had not been reviewed.

Some important records relating to people's health care needs were not always completed.

Some people were involved in activities they liked in the community. There was very little for others, who were less independent, to do.

Is the service well-led?

Inadequate

The service was not well-led. There was a registered manager who was supported by two deputy managers who managed the day to day running of the service.

The quality assurance system in place did not identify issues with the service.

Information for people using the service was limited and sometimes incorrect.

The service did not report on incidents as it was legally required to do so. The registered manager had not kept up to day with their skills and qualifications. Ratings from the previous CQC inspection were not displayed.

Carlton 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.

Before our inspection we reviewed the information we held about the service which included any statutory notifications we had received in the last 12 months and spoke with one relative of a person using the service.

One inspector undertook the inspection which took place on 4, 5 and 9 October 2017 and was joined by a second inspector on 5 October 2017. The first day was unannounced. At the end of the first day we told the provider we would be returning to continue with our inspection.

We spoke with six people who used the service, a healthcare professional, a visiting hairdresser two staff members, both deputy managers and the registered manager. We conducted observations throughout the inspection. We looked at seven people's care records, three staff records and other documents which related to the management of the service, such as training records and policies and procedures. After the inspection we spoke with another two healthcare professionals and three relatives of people using the service.

Inadequate

Is the service safe?

Our findings

At our previous inspection we had concerns relating to health and safety issues at Carlton House and the neighbouring property which at the time was being used to accommodate one person using the service. Risks had not always been identified and assessments not regularly reviewed. The registered manager did not do all that was reasonably practicable to reduce risks, and health and safety concerns were not always recorded in people's care plans. Following the inspection the registered manager sent us an action plan to detail how the service would meet its legal requirements. However, the registered manager did not understand why they were not meeting this regulation and felt people were safe in the service.

During this inspection we found the service was no longer using the neighbouring house so the environmental safety issues related to that property were no longer relevant. However, the registered manager and the provider had not addressed all of the issues identified at our last inspection.

We found the risk to people had increased because the risks to people who used the service had still not been fully identified, assessed or managed. This meant people were at risk from unsafe care and treatment. One person had recently become aggressive while in the community. Records indicated there had been several incidents of aggressive behaviour. Staff were able to explain their thoughts on why this had happened and how they managed the risk by not allowing the person to watch violent DVD's as they had found these could make them more aggressive. The person's risk assessment confirmed this and stated that they "can harm others whilst in the home" but there was no written risk management plan in place to guide staff on how to manage the risk. We looked at other people's risk assessments who were at risk from this person's behaviour but found this risk had not been identified so there was a danger that they could be harmed because staff would not know what to do or look for signs and triggers. The deputy manager told us they had not kept behavioural charts because they had not been asked to. So staff were unable to monitor this person's behaviour.

The provider did not always review risk assessments annually, in accordance with their procedures so when people's needs or risk changed there was no guidance to staff on how to manage this. So people may not receive the care they need to keep them safe. For example, we found, one person's risk assessment was last reviewed in 2015 and another in July 2016. Where people's risk assessments had been reviewed within the last 12 months they did not always reflect the person's current needs. Two people were receiving a soft diet, however, we could not find a risk assessment explaining why they needed a soft diet or what staff needed to do to support the person to minimise the risk of choking. Another person's risk assessment was reviewed in June 2017 but had not been updated to reflect their needs. For example, the risk assessment spoke about shopping in the community but the person no longer went outside and stayed in bed most days. The same person required two staff members to move and transfer them and the person was at an increased risk of pressure ulcers. There were no risk assessments for this person's mobility needs or for their skin integrity. So there was no information for staff on how to transfer safely or reduce the risk of pressure ulcers. The deputy manager told us what they did to keep this person safe and help reduce risk but we could not see how other staff would know when the information was not recorded. The deputy manager later showed us some hand written notes they had made with guidance for staff on how to care for this person and told us they would

incorporate these notes into the persons care records.

Peoples individual risks were not always identified so staff did not have the information they needed to keep people safe. The provider did not always ensure risk assessments were specific to individuals. Risk management plans had been copied for different people. For example, two people had identical risk assessments for "Feeling angry and upset". One person's assessment for risks relating to hot weather inappropriately referred to another person using the service on it. It was clear this document had been copied from a different person's records instead of focusing on the individual risk for that person. The provider had not provided staff with the training identified on people's risk assessments. For example, risk assessments stated all staff must have positive behaviour support training and risk assessment training. However, from records provided only one staff member had attended training in positive behaviour support in 2011. There was no person centred information telling staff how they could support people as individuals when they felt anxious or upset. There were no positive behavioural support plans in place to help staff recognise triggers or situations that they needed to be aware of.

People were at risk from receiving unsafe care and treatment from staff working excessive hours. When we looked at the staff rota we noted that at least two members of staff were working excessively long hours without adequate breaks. For example, on eight occasions in September and October 2017 one staff member worked a total of 23 hours in a 24 hour period, including waking nights. We looked at the rota going forward and noticed one of the deputies had also been rostered in to work 23 hours in a 24 hours period, including a waking night on two occasions. We expressed our concerns that staff may be too tired after working these long shifts to provide safe care to people. The registered manager told us staff were allowed an hour break to go outside and do what they needed to do before starting their next shift. However, we found this would be insufficient to overcome tiredness from working a waking night followed by working the next day or a day shift followed by a waking night.

The provider did not always store people's medicines safely. We looked at how the service managed people's medicines to make sure processes were in place to ensure people's safety. Most people's medicines were stored appropriately in a locked secure cabinet. However, we saw one person had prescribed creams in their bedroom which were freely accessible to any other person who entered the room. This was a risk to others who may try to use or swallow this medicine. We asked the registered manager if the risk to others had been identified, they did not think it had and didn't seem sure, they removed the creams from the room. On day three of our inspection we noticed the creams were back in the person's room and again easily accessible to anyone who waked past the open door. We checked people's care plans but could not see any risk assessment in place for them concerning risks relating to this type of medicine. We discussed or concerns with the registered manager and the deputy manager and they told us they were looking at fitting a secure cabinet to the person's bedroom wall to keep the medicine safe.

People were at risk of receiving too much medicine or of not receiving the medicine they needed because the provider could not always account for missing medicines. Most medicine administration record sheets we looked at were fully completed with a weekly stocktake conducted by one of the deputy managers. However, one person's 'as required' medicine was not correctly recorded so there was a risk that person may have the incorrect dose of medicine at the wrong time. We counted the medicine remaining and three tablets were unaccounted for. Staff were unable to tell us why. Later in the inspection staff told they had identified when the tablets were given, however, this only accounted for one of the missing tablets and there was no record of when the other two tablets had been given.

People's medicines preferences and risks associated to the medicine they were taking were not documented. This meant staff may have been unaware of how to safely give medicines to people or know

how people liked to receive their medicine. The deputy manager knew how people liked to take their medicine and what to do if people refused their medicine, however, there was no written guidance available to staff. For example, the deputy manager told us and medicine records confirmed that one person often refused their medicine because they did not like the taste of one tablet; we were told if staff offered tablets in a different order the person would be more likely to take them. Another person could only take medicine in a liquid form and another person was prescribed a drug that prevented them from having certain food or drink. Although staff knew this information it had not been written down so there was a risk that people may not receive their medicine safely.

There was no guidance available to support staff to administer PRN or 'as required' medicine as the prescriber intended. This should include information such as, how much medicine should be given, signs to look out for and when to offer the medicine, including verbal and non-verbal cues and if there are any alternatives to PRN. Without this information staff may offer PRN inappropriately or fail to give PRN when people needed it.

Not all staff received regular medicine management competency checks to ensure their skills and knowledge were up to date. The deputy manager explained only those staff who had received regular training in medicines management were able to administer people's medicines and refresher training was provided every two years. In between training the deputy manager explained that regular competency checks were completed to ensure staff handled people's medicine safely but they confirmed these were not formally recorded so we could not verify that these had been completed, the timescales involved and what, if any, issues had been identified. The service had a policy and procedure in place detailing the need for recording staff competence in medicine management. The registered manager agreed they would start putting this into practice in line with their own polices.

These concerns constituted a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe Care and Treatment.

We were concerned that some of the people who used the service may not be safe as some strong cleaning chemicals were easily accessible to them. We noted most cleaning chemicals for the service, were stored and locked in the laundry room and the cellar. However, we also found cleaning fluids accessible to people in various parts of the premises. When we raised these issues with the registered manager they did not appear to share our concerns about the risk to people but they did remove the products and asked staff to lock them away. We also noticed the cupboard in the first floor bathroom was unlocked. This contained the hot water cylinder and pipework that was hot, we asked the registered manager to lock the cupboard as there was a risk of people burning themselves.

We looked at the room layout and facilities available as the provider had moved people to different bedrooms to accommodate the person that previously lived in the neighbouring property. We found people were not always cared for in an environment that supported them to stay safe and met their needs. We looked around Carlton House to ensure adequate support facilities and amenities were provided. There were a total of 10 bedrooms, two of these were double rooms with a view of accommodating 12 people in total. The ground floor had two single rooms and one double room, currently being used by two people who had apparently shared for many years and were happy to do so. We were concerned about the size of one bedroom as it did not provide enough usable floor space for the person to be comfortable and maintain a quality of life. We could not speak to the person because they were very anxious at the time of the inspection. Staff told us the person had moved fairly recently from a larger room but they were not sure if the move had caused anxiety. We asked the provider to give us the room measurements and after the inspection they confirmed it was 358 cm by 190 cm or 6.8 square meters. This is far lower than the national

standards of 10 square meters for existing care homes as laid down by the Department of Health's National Minimum Standards.

We were concerned that there was lack of toilets and bathing facilities in the building to accommodate the needs of people using the service. The ground floor had the only shower room with toilet at the service. We were told by staff that this was used by all 11 people when they wanted a shower instead of a bath. This was also the only toilet for the four people who lived on the ground floor and for those who were using the lounge during waking hours.

The second floor had a single room, a small kitchenette and a small flat with a small dining room, a settee, a single bedroom and a bathroom with toilet. We were worried about the person in the single room on the second floor as they would need to descend the stairs to use the toilet and bathroom on the first floor and we did not consider this was safe. The registered manager explained that this person could use the bathroom in the flat on the same floor and did not recognise this as a safety issue. The layout of the chairs and tables in the lounge/ dining room appeared cluttered and did not allow for many people to sit comfortably and for example, to watch the television. There were two dining room tables but not enough chairs or space for everyone to eat a meal together if they wanted to.

Five people were on the first floor accommodated by four single rooms and one double room. One of the single rooms had its own toilet and there was a separate toilet for communal use but all of the rooms shared one bathroom.

The exterior of the building and surrounding gardens were adequately maintained to keep people safe. However, the internal décor needed modernising. The bathrooms on the first and second floor needed updating. The first floor bathroom had a bath chair so people were able to sit while bathing, but there were no shower attachments, only a plastic jug for pouring water so it was hard to see how staff could assist people adequately while bathing.

These concerns amounted to a breach in Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Premises and equipment.

Systems and processes did not always protect people from potential abuse and neglect. Three relative's we spoke with felt their relatives were safe and their family member enjoyed living at the home. We heard how one family had provided a mobile phone to their relative so they could phone when they were out and about and keep in touch with them and the service. However, a fourth relative explained they had concerns about the safety of their relative and described an incident with another service user verbally threatening their relative. They also told us of another example where one person had threatened their relative with a knife. The person's relative said, "They [the manager] told us they would move [the person who was exhibiting threatening behaviour] but they haven't." We saw an incident report had been completed with a note that it had been reported to the local safeguarding authority and details that one to one support should be provided. However, we did not see provision on the duty rota for one to one support. The registered manager wrote to us after the inspection to explain that the person had mostly remained in their room so did not receive one to one support during our visit. We did not see any investigation report or action taken to help staff manage the person's behaviour when it challenged the service or the systems in place to protect those people at risk.

Generally staff we spoke with were aware of their responsibilities to keep people safe and report any allegations of abuse or concerns about people's safety and there was information in communal areas for people to follow if they had concerns and we saw safeguarding was an agenda item at staff and resident

meetings. However we did not find any robust procedures in place to record, report and act on safeguarding concerns.

We noted several incidents had been reported in the past to the local safeguarding authority. The CQC had not received any statutory notifications regarding these incidents so we had been unable to monitor the significance of each event and what the provider had done to reduce risk and protect people. This is discussed more in the well led section of the report.

During our inspection we became concerned about two people who used the service. We were concerned about their health and that staff had not acted quickly enough to ensure healthcare professionals had assessed their condition. We spoke to staff about our concerns and we reported our findings to the local safeguarding authority so they could investigate. Although the service had a policy in place for protecting people we had no assurance that systems and processes were in place to thoroughly investigate and immediately act upon any allegation or evidence of abuse.

These concerns constituted a continued breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safeguarding service users from abuse and improper treatment.

There were sufficient numbers of staff on duty to meet people's basic needs. On the day of our inspection we were told there were four staff on duty in the morning, three in the afternoon and nights were covered by one waking and one sleeping staff member.

The service followed appropriate recruitment practices to keep people safe. Staff files contained a checklist which clearly identified all the pre-employment checks the provider had conducted in respect of these individuals. This included an up to date criminal records check, at least two satisfactory references from previous employers, photographic proof of their identity, a completed job application form, a health declaration, full employment history, interview questions and answers, and proof of eligibility to work in the UK.

Inadequate

Is the service effective?

Our findings

At our last inspection in March 2017 we found the provider had not carried out a mental capacity assessment in relation to the use of bed rails for one person when staff had told us they lacked capacity to consent to this. The provider had no records of best interest meetings having taken place in relation to the decision to provide bed rails to this person. The service had failed to comply with the Mental Capacity Act 2005 (MCA) and this was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following our inspection an action plan was submitted by the provider, this detailed how the service planned to meet their legal requirements. The timeframe given by the provider to complete these actions was July 2017.

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).

During this inspection we found the provider had still failed to assess the capacity of people to make decisions relating to their care. People lacking capacity were at risk of being restricted of their liberties unlawfully. The registered manager told us they had made a blanket DoLS application to the local authority for everyone living in the service, even though some people required no restrictions on their movement to keep them safe. At the time of our inspection the local authority had not assessed the applications.

We observed three people were using bed rails but records did not tell us if people had consented to bedrails or if the decision had been made on their behalf because they lacked capacity. The deputy manager told us that one person had fluctuating capacity and would sometimes refuse treatment that was important for them. Staff explained that they knew the signs when the person was liable to refuse treatment and what to do in this situation. However, when we looked at the person's care records there was no information about the person's capacity to make decisions about their care and no records of the person ever refusing treatment. There was no written information to guide staff on what signs to look out for or what they should do if the person's capacity fluctuated and they were unable to give their consent to treatment. This meant there was a risk the person may not receive the support they needed when they needed it. The provider had detailed a policy and procedure in place from 2016 giving guidance on what the service need to do to meet the requirements of the MCA but this had not been actioned.

These concerns constituted a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Need for Consent.

Staff did not always receive the training they needed or refresher training to give them the necessary skills and knowledge to meet people's needs effectively. Many staff required refresher training as previous courses

had expired. This was highlighted at our last comprehensive inspection in June 2016. During this inspection we asked to see the records kept by the registered manager to ensure staff had received their training and that refresher training was kept up to date. We were told this information was out of date and we gave the provider the opportunity to provide us with updated information. The deputy manager also told us of the training due be completed with the Local Authority and this included deprivation of liberty safeguards, person centred care, dementia and infection control.

We looked at the updated training matrix and found there were three staff members had received little training. For example, the matrix showed these staff had not received manual handling, fire safety and awareness, first aid, infection control, dementia, safeguarding and nutrition. After the inspection the registered manager wrote to us to tell us four staff members had started to work at the service less than two months previously and had been booked to attend the Local Authority training. However, other staff had not completed refresher training in the timescales required by the provider in areas including fire safety, first aid, safeguarding, dementia, MCA, nutrition, falls and dignity, amongst others. We were concerned because without updated skills and knowledge in key areas there was a risk that people may not receive safe and appropriate care and support.

Staff did not receive the appropriate support needed to carry out their duties. Staff told us they felt supported by their manager but we found supervisions were irregular and annual appraisals had not been completed. It was hard to see how the service made sure staff had the knowledge, skills and experience to deliver effective care and support. The registered manager told us staff had supervision "quite often" and the deputy manager confirmed this should be at least every two months. They explained they had a matrix for recording supervision but this had not been used yet. Staff thought they had received supervision but when we looked at records we found these had not been completed in line with the provider's requirements. We found no records of annual appraisals.

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

People did not always receive a choice of food. People appeared to enjoy the food they were given. One person told us, "The food is not bad…I'm not sure what we've got today but the portions are too big." The menu was displayed but did not provide people with a choice or correspond with the meals offered by staff during our inspection. We observed the lunchtime experience for people during the three days of our inspection. People were served their meals with no choice given as to the food or quantities being provided. We saw one person was served their lunch in a plastic box as they came down the stairs. We asked a staff member and the registered manager why that was but they were unable to give an explanation or evidence this was the person's preference for eating their meals. On day three of our inspection, one person said to the registered manager, "If you haven't got enough to go round, can I have just veg please?" There was no further communication with the person to give assurance that there was plenty of food to go around or to offer alternatives.

People were at risk of eating food that may be unsafe. In the fridge, some food items had expired or not been labelled after opening. This was not in line with food safety guidelines and could place people at risk. We saw there was limited food available for people if they wanted snacks outside of mealtimes and were hungry. Food safety refresher training was out of date for nine staff members. So they may not have the updated knowledge and skills needed to prepare and serve food in a safe way. Following our feedback on their third day of our inspection we found additional food was in the fridge and opened items had been labelled according to their opening date.

We saw examples where people were supported to have access to healthcare services and observed staff supporting people to attend GP appointments during our inspection. We saw that the service was working with the local hospice to help them care for one person that was nearing their end of life. A healthcare professional told us they felt they had a good relationship with the service and that the deputy managers listened and reacted to their advice. However, we looked at four people's care records and found there was no contact with health care professionals when their physical or mental health care needs changed. For example, following one incident, the service had requested help in July 2017 from one healthcare department but had been asked to go to another service first for an assessment. When we asked if this had been done we were told by the deputy manager that they didn't think so and we witnessed them making enquiries for further information, during our inspection. Another person was very upset and anxious but staff did not know if that person was still registered with their psychiatrist or had been discharged. We were concerned because the service was caring for people with varied and complex health conditions and although contact with some healthcare professions was good there was a delay in other areas, this meant people may not receive the care and support they needed when they needed it.

People had hospital passports in place, these documents are used to take to hospital or healthcare appointments to show staff how they like to be looked after. However, we saw at least two examples where information was vague and had not been updated to reflect people's needs. We spoke with the deputy manager about this and they assured us they would update these documents as soon as possible.

The issues above relate to a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance

Requires Improvement

Is the service caring?

Our findings

The service cared for men and women of different ages and needs and provider had not considered how to adequately maintain people's privacy when using bathrooms and shower rooms on different floors. On the ground floor we observed the window of the wet room was clear glass and people's privacy may have been compromised when they were using the facilities. We spoke to the registered manager about this who told us there should be curtains. On the third day of our inspection the registered manager had put obscure glass in to give people privacy. The ground floor being used by four people accommodated by two singe rooms and one double room. The double room had a privacy curtain was in place to be used to maintain people's dignity. Staff told us the people sharing were happy to do so. However, we did not see evidence in their care records to confirm this. On the first floor there were five rooms one with a separate toilet. People shared the communal toilet and bathroom. The second floor contained a flat with its own bathroom and dining area and single room and another single bedroom was on the same floor. We were concerned that the number of facilities available to people did not give them the dignity and privacy they may have needed. We did not see the individual privacy needs or choices of people recorded in their care records.

These concerns amounted to a breach in Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and Respect.

When we asked one person if they liked living at Carlton House, they smiled and told us, "I'm ok". Another said "I'm happy living here. The staff are kind." We spoke with one person who told us about their birthday party the previous weekend, they said, "We had cake, it was good." Relatives told us, "Staff are very good to [my relative]", "Carlton house is the only place that have provided [my relative] with a lifeline when other homes gave up on [them]…they have taken the time to understand [them] as a person" and "On the face of it all the staff are very pleasant." We spoke to the hairdresser who was visiting the service, they told us "It's like a family really, it's really lovely…the staff and everyone."

We observed interaction between staff and people using the service was warm and relaxed. People were comfortable and at ease. Staff were patient when supporting people and responded quickly to people's requests. Staff knew people well and were able to tell us about people's individual needs, preferences and personalities. For example, one staff member explained the things one person liked to talk about and how it made them feel less anxious. However, very little of this valuable information had been written down so it was hard for new member of staff to get to know people and how they liked to be supported.

When people returned from their various activities they spoke to staff about their day and what they had done. We saw one person liked to go to the shops and would talk to staff about what they wanted to buy. Another person was talking to staff about their collage course and why did no longer wanted to attend on one day. However, for those people who remained at the service, we saw little activity taking place and little choice offered in how people had their leisure and social needs met. We saw that interactions were often brief and functional. Most people spent the day in front of the television or in their rooms. When we spoke to staff they explained this was people's choice and they did not want to go out. However, we did not see evidence to support this in people's care plans and when we spoke to one person they told us how much

they would enjoy an outing.

People were not always able to tell us if they were offered choice in their day to day routines. However, we observed that those who were able to left and returned to the service independently. People at the service appeared to be able to go to bed when they wished and get up when they wanted to. During our lunch time we did not see that people had a choice of main meal but staff appeared to already know what people liked and didn't like, although this was not always written down. The majority of interactions between staff and people using the service during lunch were brief and task orientated and did not positively impact on people's wellbeing. For example, lunch was served to people with little engagement or conversation .One staff member started to use their fingers to serve one person's food, we did not know if this was normal practice or if the staff member was nervous. One person who refused their meal was offered a sandwich which they accepted.

We saw that some people had made advance decisions about their end of life care, the deputy manager explained how after attending one person's funeral people had been prepared to talk about their end of life wishes and she had recorded these. One person was receiving end of life care, we spoke with a healthcare professional that was supporting and advising the service with the person's care, they felt staff were, "Really caring and obviously very fond of [the person]."

People were supported to maintain relationships with their family and friends. Relatives told us they visited at any time and knew the staff team well.

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inappropriate care because their care needs were not always reviewed in a timely way and staff did not have accurate information about how to support their individual needs. There was no evidence that the daily notes or handover records kept by staff were being used to inform regular evaluations of each person's care plan. People's care records were mostly reviewed yearly. However, we saw at least three examples where this had not happened. One person's risk assessment for personal care was last reviewed in 2014 and did not show the persons current support needs. Another person had a special diet because of health concerns but their care plan had not been updated to reflect this and was last reviewed in July 2016. Staff told us one person was at risk of choking and needed a soft diet. The persons care plan was last reviewed in November 2016 and held no information about the need for a soft diet or that the person was at risk of choking. The deputy manager told us that records were often updated on the computer, we asked to see the updated records but the new records could not be found. Staff we spoke with told us they would always go to the paper file for information. We were concerned because people's care records held incorrect information and were out of date so staff did not always have the details they needed to give people the right care.

Peoples care records were not always accurate and complete. One person who was unwell was being treated by the district nurse for pressure ulcers, we saw the district nurse kept details of a wound care plan and the person had specialist equipment in place to help reduce the risk of further injury. Staff told us they turned the person regularly. However, when we looked at the persons turning charts we noticed they had not been completed between 17 and 21 September 2017 and from 29 September 2017 onwards. We looked to see if there was any information in this person's care plan about the personalised care needed. We saw a health action plan mentioned using cream for "the sores under my feet" but we did not see written information for the person's current condition. The deputy manager had made some hand written notes detailing the person's needs and later in the inspection we saw these notes had been stored in the person's care plan.

The issues above relate to a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

Staff did not always have the time or resources to provide person centred care. We found the various complex needs of people using service and the distribution of other duties such as cleaning and cooking gave staff little time to provide person centred care for everyone using the service. The registered manager and both deputies included themselves on the rota and during the inspection we observed they had little time to fulfil their caring duties or the other important administrate tasks such as updating care records and making referrals to other health professionals.

Not everyone was supported to follow their interests or take part in meaningful person centred social activities. One relative told us, "There is very little going on…no activities, no music…only the TV." They told us that sometimes the deputy would take people out and how much this was enjoyed by people but said "things don't seem to happen." We observed those people who were able coming and going from the

service attending various day centres or GP and hospital appointments.

A visiting hairdresser told us they came in regularly to provide a hairdressing service and on the occasional weekend to entertain people with Karaoke. They obviously knew people well and had built up a good relationship with people. However, over the three days we were inspecting there appeared to be very little else for people to do when they remained at the service. There were no planned activities and people either watched television or stayed in their bedrooms. One person told us," I don't go our much because I'm not good on my feet. I'd like to go shopping but haven't been out for a long time." When we spoke with the deputy and registered manager about the lack of activities for people they appeared surprised.

We were shown activity planners for people but when we compared the activity with the day of our inspection the activity was not happening. Staff told us people did not want to do their planned actives because they were feeling tired. This was not recorded anywhere so we looked at the daily notes for one person to see what activities they normally did. Over a period of nine days they went outside once to visit the GP the rest of the time their activity was watching television or staying in the lounge. This person had previously told us they liked to go out and staff confirmed this was the case. We looked at staff duty planners for five days, these named the staff on each shift and the activities people did. We saw that for two of the days no activities were listed for anyone, a birthday party was the main event for everyone on another day. The final two days noted people had gone to various day centres while the remaining people at the service "rested, relaxed and watched TV". We were concerned that some people were not being supported to follow their interests or take part in activities that were relevant and appropriate for them.

These concerns were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Person Centred Care.

People and their relatives did not always contribute to their planning of care and support. Relative views were mixed when we asked about their involvement in their relatives care. Two relatives we spoke with told us they had never been involved or asked to contribute to their relatives care plan and another two relatives told they felt fully involved and were invited to attend regular care reviews. One relative spoke positively of the service and told us how well staff knew their relative and were able to recognise and manage their behaviour and defuse situations. They told us, "There are three or four people in Carlton House with very challenging behaviour, they will take people on when others give up on them." Another relative had observed how good staff were with people when they became angry or upset. They said "Staff are amazing with other people who can be a bit difficult, I couldn't fault them."

Care records were sometimes signed by people using the service but there was little information to show how they had been involved in their care development. Care records provided little information about people's preferences or personal history. We saw evidence of keyworker meetings with some people, however, there was no information to show that ideas or changes people had requested were actioned.

Although staff had a good knowledge of the people they were caring for we did not see any detailed written guidance for staff on to how to communicate effectively and engage positively with individuals. The deputy manager did show us some recent hand written notes they had made of the personal knowledge they had about three people, their likes, dislikes, daily routines and how staff could support them. We discussed how this good piece of work could be expanded across all people using the service and how this information could be incorporated into people's care records so it was meaningful and useful to people and staff. Daily handovers were completed as were daily notes of people's care. When we asked about people's care these were often referred to and seemed to be the most up to date information available to staff.

Relatives we spoke with told us they had no need to make a complaint but they would complain to the deputy managers if they needed to. We noted information for people on how to make a complaint was in the service user guide and on the notice board in the reception area.

Inadequate

Is the service well-led?

Our findings

Following our last inspection the CQC began to investigate concerns about the registration of Carlton House. The provider was registered with the Commission as a partnership but was operating as a Limited company. We met with the provider to make sure they understood the situation and asked them to provide us with information to clarify their registration position. We have now established the registration status is correct and the provider is registered as a partnership.

At our last inspection in March 2017 we found health and safety issues had not been identified, risk assessments and care plans had not been reviewed within the providers specified timeframe and were not up to date or relevant. We found decisions made of behalf of a person who lacked capacity were not recorded and there was no evidence to suggest these had been made in line with the requirements of the Mental Capacity Act. Following this inspection the provider submitted and action plan detailing how the service would meet their legal requirements. They told us this would be completed by July 2017.

During this inspection in October 2017 the provider confirmed the neighbouring property was no longer in use and we checked this during our inspection. At the time of our inspection the provider was in the process of applying to reduce the number of beds from 15 to12 to reflect the change in accommodation. Many of the health and safety risks identified in the neighbouring property were no longer relevant and we noted that some health and safety checks at Carlton House such as hot water checks were now being completed on a regular basis. However, we found other checks had not been completed. For example, weekly and monthly deep cleaning schedules were out of date having last been completed in June 2017.

The provider had not taken enough steps to assess, monitor and improve the quality of the service. People's care records continued to be out of date, inaccurate and irrelevant and people's mental capacity assessments had not been completed. The registered manager showed us a yearly quality check completed during August 2017. Notes had been completed, for example, "some care plans need to be updated" but there was no information detailing where the evidence came from so we did not know what care plans the registered manager was referring to and what updating was required. One person's pressure sore had been identified as "under control", however, the next review date was August 2018 and we could not see how the provider could monitor this situation in a safe way. There were no action plan in place and yearly reviews did not give an appropriate timeframe to make necessary improvements to the quality and safety of the service for the people living there. The registered manager relied on her deputies to ensure records were complete and correct and health and safety checks were completed.

Care records viewed were mostly standardised with duplication found in five of the care records we looked at. Not all records were complete, accurate or fit for purpose. This meant that people may not always care or treatment that was personalised and specifically for them.

Information for people who used the service was limited, there was little evidence of how the registered manager engaged with people to get their views on how the service was run and the how suggestions made were acted upon. We were shown a copy of the most recent service user meeting minutes, this was held in

May 2017. There appeared to be little input from people and when people had made suggestions we did not see how these had been actioned. People were not given the information they needed that was relevant to where they lived. We were shown a copy of the service user guide and told this was given to people when they first started to use the service. It gave important information about the service and what people should expect. However, the document had been copied from another provider's guide and the old provider and service names were still in place. The document was incorrect and spoke about a registered manager applying to be registered with the CQC and completing a registered manager's award in addition to receiving a higher diploma in care. This document was last reviewed on 22 September 2017. It was clear the service user guide had not been updated and people were not given accurate information about where they lived and who was caring for them.

There were limited systems in place for staff to discuss issues and influence the operation of the service. One staff member told us they felt involved in the development of the service but we couldn't see how staff influence had effected change. We asked about staff meetings as these are often a good forum to exchange ideas and improve the running of the service. We were told staff meetings should happen every other month. After our inspection the registered manager sent us minutes from the last two staff meetings, dated 3 March 2017 and 6 August 2017. We noted these had not occurred within the timescales suggested and the body of the minutes were exactly the same, word for word, with no variation, staff ideas or input recorded.

Staff files identified that formal supervision meetings had not always taken place regularly. These meant systems were not in place to monitor staff development and make sure that staff was able to meet people's needs safely as discussed in effective. The provider did not have appropriate systems in place to record staff training. For example, training certificates were stored within individual staff files and the matrix to monitor the number of staff that had completed all the necessary was out of date at the time of inspection. It was therefore not clear how the provider made sure staff were up to date with their skills and knowledge.

The provider had failed to act on important information such as incidents that had not been recorded, safeguarding allegations that were not reported and other safety issues such as the recording of medicine errors had not been completed. The lack of transparency and openness to listen to, act upon and report issues or concerns raised meant we were concerned that the provider could not evaluate information, learn from experiences and use this information to improve the quality and safety of care for people using the service.

All the issues above meant there was a lack of systems in place to check that people's needs were being met, records were inaccurate, out of date and there were no robust monitoring systems in place. We did not see how the provider listened to people or staff and how their views were acted upon to make improvements. The provider had failed to identify the shortfalls we found during this inspection and had not addressed the concerns we found at the previous inspection.

The issues above relate to a continued breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

At our previous inspection in March 2017 we found the CQC had not received statutory notifications required to provide by law from the provider. During this inspection, we became aware of five incidents that had occurred that had resulted in the local authority safeguarding team being contacted. The CQC had not received notifications informing us of these safeguarding concerns. When we spoke to the registered manager they told us that these incidents had been before the last inspection and they had not completed notifications to us retrospectively. We knew of one incident that had occurred after our last inspection in June 2017 where the police had been called. We had not received a statutory notification from the service

and we could not find evidence that the incident had been recorded at the service during our inspection. The registered manager explained they had not completed an incident report or a statutory notification to the CQC as this had happened away from the service and they did not think they needed to.

These issues above relate to a continued breach Regulation 18 Registration Regulations 2009. Notifications of other incidents.

During our previous inspection and at this inspection we were concerned that the registered manager may not have the skills, knowledge or qualifications to demonstrate the competency required to manage the regulated activity. For example, when we asked how the registered manager was going to meet the regulation for safe care and treatment at their last inspection they wrote in their action plan, "This regulation was met and am not sure which area we did not meet the regulation." This was concerning because it was clear from our report how the service was not meeting its regulations and indicated the registered manager had a poor understanding of their responsibilities under the Health and Social Care Act 2008. We asked to see evidence of the registered manager's qualifications because we were concerned they may not have kept up to date with their training and skills. We received evidence of a Level 4 NVQ in registered manager (Adult) issued 4 August 2006, a certificate from Carshalton college for achieving a certificate in management studies for care service managers, undated. A certificate in hoist instruction refresher course awarded July 2017 and a "high speed training certificate" for safeguarding vulnerable adults completed after our inspection on 11 October 2017. We were also sent evidence of a membership with the chartered management institute. When we asked if any continuing professional development was required to maintain its membership we were told, "I attend courses of interest relevant to my business". We were concerned that the registered manager had not kept her skills and training up to date and this reflected on the day to day running of the service and ultimately impacted on people's care.

The responses we received from the registered manager throughout our inspection, the written responses in the form of the action plan for our last inspection and the lack of up to date training did not provide us with assurance that they had the necessary up to date qualifications, competence and skills to manage the regulated activity.

This was a beach under Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirements relating to registered managers.

We asked where the service displayed its CQC rating of performance. The service does not have a website so we looked around the communal areas but could not see a rating displayed at the service. We were shown an easy read report that was attached to a notice board and told this had been shown to people who used the service and discussed at resident meetings. It is a requirement to display the performance assessment.

This was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Requirements as to display of performance assessments.

During our inspection we referred to the Statement of Purpose for Carlton House. 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 last 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, we found there were still areas within the statement of purpose that were incomplete. For example, the statement of purpose makes it clear the service cares for people with learning disabilities however during our inspection we saw people living at Carlton House had a wide range of needs including mental health, autism, learning disability, end of life, older adults and those with other complex

healthcare needs. We were unsure from the statement of purpose how the service intended to cater for such a diversity of needs, while giving person centred care.