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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 13, 20, 21 March 2018 and was unannounced. At the end of the first day we told the provider we would be returning to continue with our inspection.

Carlton 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. On the first day of our inspection 10 people were using the service but three people were in hospital. On the second day of our inspection a fourth person was admitted to hospital.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 relation 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 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 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 a comprehensive inspection in October 2017 to make sure the provider had met the legal

requirements found during our last visit. At this inspection provider confirmed the neighbouring property was no longer in use. We checked this during our visit. The provider told us they were applying to reduce the number of bed numbers at the service from15 to12 to reflect their existing position. This had not been completed yet and the service is still registered to accommodate 15 people even though it no longer has the capacity to do this.

During our inspection in October 2017, we found 10 breaches in 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.

During this inspection in March 2018 we found a continued eight breaches 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 continued to relate to safe care and treatment, the need for consent, good governance, safeguarding, person centred care, 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 found the provider had improved in two areas, staffing and failure to display a rating and had met the legal requirements in these areas. While we were conducting this inspection we met with the external consultant who had been employed by the provider, in February 2018, to help the service make improvements.

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.

Work had started on updating the risk assessments for one person. Other risk assessments and care plans continued to be out of date and, some risks to people had not been identified concerning peoples individual needs. Environmental risk was high. We found risks relating to excessive hot water in people's rooms and communal bathrooms. The risk had been noted but nothing had been done to keep people safe.

The service was not clean. People's rooms were dirty and in need of essential maintenance. There were no records of cleaning schedules for people's rooms and tasks were allocated to staff verbally so the provider was unable to evidence how they monitored the hygiene and cleanliness of the service.

The mix and number of people using the service and the new layout of the rooms continued to give 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.

There continued to be issues with people's medicine records. Information was still not available to staff to explain how people liked to take their medicine. Only one person's medicine profile was complete. This gave important information about the person, any allergies and the type of medicine they were taking. Staff were not checked to see if they continued to give people their medicines safely.

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. Only one person had a mental capacity assessment in place. There was confusion and lack of documentation around DoLS applications and a general lack of understanding had placed people at unnecessary risk.

There continued to be some concerns with people's healthcare needs. When people's health needs changed these were not always acted on. When healthcare professionals gave advice this was not always followed. The service had begun to record the choice people were offered for food and drinks but when people needed extra support with their nutrition their care records did not reflect this and the risk had not been identified.

We saw activities taking place at the service and people having access to the community. We were still concerned activities may be limited for some people who were less mobile. People had activity plans but there were no records of the activities people had taken part in so we were unable to confirm if sustainable improvements had been made.

The service continued to be 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. There were no robust systems to check the quality of the service.

The registered manager had continue to fail 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 continued to find the registered manager did not have the skills and competency to carry out her role.

After our last inspection the registered manager had told CQC about some important incidents that had occurred concerning people who used the service. However, we found incidents at not been recorded properly and we remain concerned about the lack of reporting to CQC.

The service had made improvements with staff training and staff had started to receive regular supervision to support them to carry out their duties. People were relaxed in the company of staff. Staff appeared to know people well although this knowledge was only reflected in some people's care plans.

The overall rating for this service remains 'Inadequate' and the service is therefore still 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 remained concerned safeguarding incidents were not always reported or investigated appropriately.

The service was not always kept clean and some areas were poorly maintained.

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.

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 follow the advice of others.

Improvements had been made with staff training and supervision.

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. However, 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. We were concerned there continued to be less engagement for those people who were less independent.

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.

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.

This service is in special measures and has been kept under review. This was a comprehensive inspection that took place as part of that review to see if improvements had been made.

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, communications with the local authority and healthcare professionals.

Two inspectors undertook the inspection which took place on 13, 20 and 21 March 2018. 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 four people who used the service, 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.

Inadequate

Is the service safe?

Our findings

At our previous inspection we were concerned because people were at risk from unsafe care and treatment. We found risks that people faced were not always identified, addressed or managed. Risk assessments were not reviewed in line with the providers procedures so when people's needs or risk changed there were no guidelines in place for staff to manage this and keep people safe. Staff were working excessive hours putting people at risk from unsafe care and treatment. People's medicines were not always managed appropriately to ensure people's safety and important information about people and their medicines were not available to staff. Staff had not received regular medicine competency checks to ensure their skills and knowledge were up to date.

We found strong cleaning chemicals had been left around the service that presented a risk to people. Hot water pipes and cylinders were easily accessible so people were at risk of burning themselves. We found people were not always cared for in an environment that supported their needs. Systems and processes did not always protect people from abuse and CQC was unable to monitor incidents and allegations of abuse because the provider failed to complete statutory notifications as required by law.

The provider sent us an action plan to tell us how they would make improvements to the service. At this inspection we found work had started on improving some people's records but progress had been very slow. We found some concerns we had identified in our last report had not been addressed and the risk to people remained because the risks to people who used the service had still not been fully identified, assessed or managed. We identified further issues that posed risks to people's safety.

During this inspection we found work had started updating one person's risk assessments. We were shown examples of two new risk assessments for the person for epilepsy and dysphagia. These had not been introduced into the person's care records and we found the risk assessment for epilepsy was not person centred but only gave a definition of the condition. There was nothing specific about the person's epilepsy, for example, the signs and indicators for staff to watch for so they would know the person was about to have a seizure. We found further risk assessments in the person's care record had not been updated to reflect their current needs. For example, care records contained a risk assessment for using bed rails, but the person no longer had bedrails in place. This meant people were at risk of receiving inappropriate care that was not specific to them.

At this inspection we found the provider had not reviewed or updated four people's risk assessments. These had remained unchanged since out last inspection in October 2017. Risks concerning four people's care had not been identified. For example, when two people's bed rails had been removed there were no risk assessments in place to guide staff on how to keep people safe from falling out of bed. At our last inspection we identified one person who was at risk in terms of nutrition but, there were no current risk assessments in their care records to reflect their nutritional needs and weight monitoring. Another person had returned to the service after a hospital admission. Hospital records clearly stated the reason why the person was ill but staff were unaware of the new diagnosis and risk assessments had not been put in place to monitor the person's health needs in this area.

When people behaved in a way that challenged others we did not always find guidance in place for staff to manage the situation in a positive way or give people the support they need. We were shown an updated guide for one person's behaviour that had just been completed in March 2018. However, when we looked at other people's care records there was no guidance in place to support people. For example, in March 2017 the provider was asked by healthcare professionals, to follow the personal behaviour support plan they had put into place for one person and to update all risk assessments in the person's care records to help staff manage their inappropriate behaviour. We could find no evidence that risk assessments had been updated or staff had been provided the guidance they needed to support the person with the advice given. We found the service had been informed about another person's behavioural changes with an increased risk of depression; however, there was no evidence of action taken to, update risk assessments or guidance to staff to reflect this change. This meant people were not always supported appropriately when their behaviour challenged others and staff did not always have the best guidance available to them to manage people's risk, wellbeing and keep people safe.

At our last inspection we were concerned because the risk associated with some people's behaviour to others living at the service had not been identified or recorded. We were also concerned that when incidents occurred or people presented with behaviour that challenged this had not been recorded so it was hard for staff to monitor a person's behaviour and look for signs or triggers. At this inspection we remained concerned about these issues. Only one person had a behavioural chart in place with three recorded events of when the person challenged the service. Each involved physical and abusive behaviour. We looked to see if an incident report form had been completed but could not find any. We asked the deputy manager if they felt these events should have been recorded as incidents and, they confirmed they should have been. We looked at the person's daily notes and found a further six occasions when their behaviour had challenged the service but had not been recorded on a behavioural chart or as an incident. We were concerned because staff did not have the systems in place to monitor or record people's behaviour which meant the provider did not have the information they needed to understand and reduce the cases of behaviour that could put the person or others at risk of harm.

People's risk assessments continued to state staff should receive training in positive behaviour support, however, there was no evidence that staff or managers had ever received this training.

At our last inspection we found people were at risk from receiving unsafe care and treatment from staff working excessive hours. The registered manager sent us an action plan in February 2018 to confirm this had been addressed during January 2018. We also received a further action plan during the inspection that confirmed the same. When we looked at staff rota's we found staff had continued to work excessive hours from January 2018 to March 2018. This involved staff working a waking night shift followed by a 12 hour day shift. Or a 12 hour day shift followed by a waking night. During this inspection the deputy manager told us this was no longer happening. The deputy manager confirmed staff signed in and out of each shift using the staff singing in book. When we looked at the rota for week commencing 12 March and compared the information with the staff signing in book we found discrepancies. The staff signing in book was different to the information we were given on the duty rota and suggested one member of staff had continued to work a 24 hour shift. We asked the registered manager why this was, they were unable to explain the discrepancies and thought it must be a mistake. However, records indicated the staff member was working additional hours to cover for those staff on training. We were concerned because this continued to put people at risk from unsafe care.

At our last inspection we found the provider did not always store people's medicines safely. People were at risk of receiving too much medicine or not receiving the medicine they needed because the provider could not always account for missing medicines. People's medicines preferences and risks associated to the

medicine they were taking were not documented. There was no guidance available to support staff to administer PRN or 'as required' medicine as the prescriber intended. Staff had not received regular medicine management competency checks to ensure their skills and knowledge were up to date. At this inspection we found the service had put some guidance in place concerning people's PRN medicine and when we looked at people's medicine administration records people appeared to receive the medicines that were prescribed to them. However, we found staff had still not received competency checks in their management of medicines and how people liked, or should take their medicine was still not being recorded. For example, one person was given their medicine daily but one day a week staff gave the medicine at another time to avoid counteracting against another medicine. This was against prescription advice. We were concerned because there was no guidance in place for staff to understand how they should administer this medicine in this situation. We saw one person had a medicine profile in place with a photograph, a summary of their medicines and any known allergies in line with current guidance. However no one else had this important information on their records. The deputy manager told us they hoped to have the others in place soon. We remained concerned that people were still at risk of not receiving their medicine safely and staff did not have the information eeded concerning peoples medicines.

We were informed after our last inspection that a fire safety inspection had highlighted some issues that needed to be addressed. During the inspection the deputy manager explained how they were working on making the improvements around the building and we saw evidence of this. We looked at the checks in place to ensure people's safety in the event of a fire and looked at the fire book, kept near the front door for easy access in the event of an emergency. We noted an allocated member of staff had carried out regular checks on call bells, emergency lighting and door closures. Fire drills had also been recorded. However, we found information concerning people that used the service was out of date and incorrect. Personal emergency escape plans had last been updated in 2014. People's room numbers were wrong and when people had moved rooms these had not been noted. One person had passed away several months ago but they were still showing as being in the building. This meant that emergency services may not have the information they need to keep people safe and people were at risk of not being assisted because emergency services may not know where people were.

During this inspection we looked around the building to check that the service was complying with health and safety standards. We looked in seven bedrooms and found the window restrictor in one room was inadequate and not fit for purpose. We looked at the opening of the window and found this exceeded the Health and Safety Executive recommended safe level of 10 centimetres. We checked the hot water in the sinks in people's bedrooms and the hot water in the communal bathrooms. Both the first floor and the second floor bathrooms had hot water temperatures that exceeded 50 degrees Celsius. In the first floor bathroom the bath taps were not labelled hot and cold. We asked the deputy manager how people would know which one was which. They explained everyone knew the hot water was on the left and the cold on the right. We checked and found this was not the case. We looked at the weekly hot water temperature checks recorded for people's bedrooms and communal areas. We found over 18 weeks the water temperature exceeded the Health and Safety Executive recommended temperature of 44 degrees Celsius. During seven of those weeks temperatures exceeded 60 degrees Celsius and over nine weeks they exceeded 50 degrees Celsius. We were concerned because although the temperature had been recorded, the risk had not been identified and no action had been taken to rectify the temperature. This meant people were at a high risk of scalding that may have caused severe harm. We raised our concerns with the registered manager and the deputy manager and provided the service with a copy of the Health and Safety Executive's guidance "Health and safety in care homes." When we returned on our second day of inspection, the deputy manager explained the water temperature had been adjusted and we were shown the hot water tap in the bathroom had been painted red to show staff and people using the service that this was the hot tap. We asked for an up to date check of the hot water temperatures and were given this on the third day of our inspection. This

indicated that temperatures were now all below the recommended maximum temperature.

People were at risk from unsafe care because the planning and delivery of care was not always carried out in accordance with the Mental Capacity Act 2005. One person was at risk of falls because bed rails had been removed. We were shown the consent form the person had completed and the registered manager told us they had the capacity to make this decision. However, when a mental capacity assessment was completed this suggested the person did not have to capacity to make his decision. After our inspection we found the person had a Deprivation of Liberty Safeguard
(DoLS) in place because they lacked capacity and a standard authorisation had been granted for this person from January 2018. This decision detailed the specific reasons why a DoLS had been granted including the need for bed rails to prevent falls.

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

Areas of the service were not kept clean and well maintained. One person was in hospital at the time of our inspection. We found the room was locked so other people using the service were not at risk. However, when we looked at their room we found it was dirty with stains and food debris on the carpet. This room had an en-suite toilet but the light was not working and the toilet seat was on the floor. The toilet and sink were dirty and the toilet door was broken. There was a cracked mirror on the wardrobe and a broken chest of draws that had sharp edges that could cause injury. The deputy manager explained the damage had been done during an incident with the person when they became upset. We looked for an incident report form but could not find one relating to this event. We were told the maintenance man was due to fix the damage before the person returned home. On the second day of our inspection we found maintenance was in progress, broken furniture had been removed and the room had been cleaned. We reminded the registered manager about the risk of having a cracked mirror in the room.

In another person's room we found an armchair with torn covering. When we lifted the cushion there was a large unsightly brown stain underneath with food and dirt accumulation. Another person's room had a broken radiator cover presenting a risk of burns. In the second floor bathroom there was an accumulation of hair and dust on the floor that indicated the room had not been cleaned for several days. On our second day of inspection we found these issues had been addressed. We asked to see a cleaning schedule but there was only a night cleaning schedule covering communal areas. There were no cleaning schedules in place for people's rooms. We saw a weekly health and safety check and deep cleaning schedule that had last been completed in 2016. The deputy manager confirmed these were no longer maintained. Staff allocation of tasks were not recorded so we could not see how the service monitored and ensured cleaning had been undertaken. This meant people were at risk from infection because the service had not been kept clean or hygienic.

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

Lessons were not always learned and improvements made when things went wrong. We continued to find examples where incidents had not identified or been recorded. For example, incidents of behaviour that challenged the service. Where incidents had been recorded we could not see evidence of sharing information, lessons learned, or improved outcomes for people. Where safety concerns had been identified, such as excessively hot water, we did not see how these had not been addressed. We asked to see the maintenance book to see if this issue had been identified for repair, but here was no evidence that this risk had been identified and acted upon. When we spoke to the deputy manager they were unable to explain

why action had not been taken. We were concerned because when things went wrong we did not see how the registered manager reviewed or investigated the cause so they could put things right.

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

At our last inspection we found systems and processes did not always protect people from potential abuse and neglect. We found some incidents had been reported to the local authority for alleged safeguarding but the provider had never reported these to CQC as they are required to do so by law. We were concerned about two people and reported safeguarding concerns to the local authority. We await to hear the outcomes of these investigations.

During this inspection staff told us of their responsibilities to keep people safe and report any allegations of abuse or concerns about people's safety. They told us they had received training in safeguarding and records we saw confirmed this had been completed in February 2018. We saw information in communal areas for people to follow if they had concerns and we saw safeguarding had been discussed during a staff meeting in January 2018. The provider sent in a revised action plan after our inspection and noted the service was working with their consultant to meet this breach and had a new revised safeguarding policy and procedures in place. However, we did not see any evidence of safeguarding concerns being raised since our last inspection and CQC had still not received any statutory notifications regarding abuse or allegations of abuse retrospectively. This included the safeguarding concerns reported by CQC at our last inspection.

We continued to have little assurance that systems and processes were in place to recognise, thoroughly investigate and immediately act upon any allegation or evidence of abuse and there was no evidence during this inspection that improvements had been made in this area.

These concerns constituted a continued breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection we found some cleaning chemicals were easily accessible to people, putting them at risk of harm. During this inspection we found all cleaning chemicals had been locked securely away. We saw the cupboard in the first floor bathroom, containing a hot water cylinder and hot pipework was now kept locked.

There were sufficient numbers of staff on duty to meet people's basic needs. During our inspection staff were visible and on hand to help people when they needed it.

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

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).

At our inspections in March 2017 and October 2017 we found the provider had 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 service had failed to comply with the MCA and this was a breach of legal requirements. Following our inspection an action plan was submitted by the provider in February 2018 stating mental capacity assessments would be "organised" for all residents with a time frame of one month and advised that all the assessments had been completed.

At this inspection we found one person's mental capacity assessment had been completed. The registered manager told us they were assessing one person at a time and so far had completed one. However, when we looked at the person's care records we found conflicting information and it was unclear if the person was able to make decisions about their safety or not. This gave us concerns about the registered managers understanding of the MCA and related regulations and the impact this had on people's safety.

At the last inspection we had concerns that 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. We were sent an email by the registered manager on 9 February 2018 that no one at the service was using bedrails and new risk assessments had been put into place. On 22 February 2018 we received an email informing us that one person, who had capacity to make a decision about bed guards had fallen out of bed because bed guards were removed against their will. We asked for more information to clarify the situation. The registered manager explained the person had previously been assessed for DoLS and this had been 'rejected' on the basis the person had capacity. They went on to say a recent visit from the best interest assessor with regard to the most recent DoLS application had also found this person had capacity. During our inspection we looked at the person's care records and found a consent form had been signed by the person on 26 January 2018 to have their bedrail removed. On 28 February 2018 we saw a mental capacity form completed by the deputy manager suggesting the person did not have capacity to make certain decisions regarding their health needs, for example with their own safety (mobility).

We asked the registered manager for evidence of the DoLS applications made to the local authority. She was unable to find them. After the inspection we contacted the local authority. They confirmed that a DoLS standard authorisation had been granted for this person from January 2018. This decision detailed the specific reasons why a DoLS had been granted including the need for bed rails to prevent falls. This meant people's human and legal rights were not always protected and a lack of understanding of the MCA and

DoLS legislation by staff put people at risk of harm. The local authority told us there had been a delay in sending the notification to Carlton House. After the inspection we received a copy of the DoLS authorisation letter dated 28 March 2018.

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

At our last inspection we found examples where people were supported to have access to healthcare services and observed staff supporting people to attend GP appointments but found other example's when people's physical or mental health care needs had changed but no contact with health care professionals had been made. We looked at people's hospital passports and found they were out of date and information was vague. Hospital passports are documents which are used to take to hospital or healthcare appointments to show staff how people like to be looked after. During this inspection we found hospital passports had been reviewed. However, we spoke to the deputy manager about irregularities we found that conflicted with information in people's care records. For example, it was unclear if one person liked to have sugar in their hot drinks or not.

We found information sharing with other services was poor and where information had been shared with the service the provider had not always identified the person's revised needs and treatment. We continued to find example's where people's healthcare needs had not been identified or where they had been identified the service did not act to change people's care. This meant people did not have the best possible health outcomes and there was a risk their health could deteriorate. For example, one person returned from hospital with diagnoses affecting their health. We could not see that records had been updated to reflect their new condition and when we looked at daily charts to monitor their health these were incomplete. We spoke to the deputy who told us the records we were looking at were not always right or up to date. There was no evidence that healthcare professionals had been contacted regarding the person's diagnoses and when we spoke to the registered manager and the deputy managers they seemed unaware of the persons condition or how to meet the person's needs.

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

People's individual needs were not always met by the adaptation, design and decoration of the premises. At our last inspection one person had moved into a small ground floor room and we were concerned this did not give enough room for the person to be comfortable and maintain a good quality of life. The room had previously been used as a staff 'sleep in' room. At this inspection we found the person had been moved in to a larger room on the ground floor that had become vacant. Staff told us the person appeared to be much happier now they were in their new room. The registered manager confirmed the small room was being used as a staff sleep in room again and would not be used as a bedroom in the future. After this inspection we were informed following a fall, one person was unable to return immediately to their first floor bedroom and this room was in temporary use once again. We will look at this issue again during our next inspection.

We remained concerned that there was a lack of bathing facilities and toilets in the building and the impact the environment may have on people using the service. When people were at risk from using the facilities these were not identified, recorded or monitored. For example at our last inspection we found there was no risk assessment in place for one person on the second floor who would either have to descend the stars to use the toilet on the first floor or enter the flat of another person to use the bathroom on the same floor. The person using the flat had a history of behaviour that challenged including physical aggression. The registered manager and one of the deputy managers told us there had never been an issue. However it was

clear the risk had not been identified and records did not confirm if people had been involved in this decision. At this inspection we found the same issues and no changes or improvements had been made. There continued to be no risk assessments in place or management plans for staff to follow should something happen.

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

During our last inspection we were concerned people did not always receive a choice of food. We did not see alternatives being offered and there was no menu information available for people to make a choice. During this inspection we were told about a new menu board in the dining room displaying the food options available. Unfortunately this did not seem to reflect the menu being served so we were unclear how people knew what they would be eating and the choices available to them. We were shown a new daily menu recording chart that had recently been introduced. This recorded the choices offered for breakfast, lunch and dinner and identified those people who needed a special diet. We looked at a sample of these documents and found some detail had been recorded but not all. For example, on one day no lunch had been recorded for any of the people and it appeared only a snack had been given for dinner. The deputy manager told us about the improvements they wanted to make and how they wanted to record the food and drink actually consumed by people in addition to the choices given.

At our last inspection in October 2017 we found 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 concern had also been highlighted at our last comprehensive inspection in June 2016. During this inspection we found improvements had been made. The provider was using an external training provider to provide training for staff and extensive support from the local authority had enabled staff to achieve most of their mandatory training in a relatively short space of time. Staff told us about the training they had received. One staff member told us, "It's been very helpful and there's more coming."

At our last inspection we found 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. During this inspection we saw evidence of regular supervision meetings. The deputy manager had created a matrix for recording supervision and from this we saw all staff had received supervision in January 2018. One staff member told us they had received supervision and told us, "It makes me know where I need to improve."

Requires Improvement

Is the service caring?

Our findings

At our last inspection we found the service cared for men and women of different ages and needs and the provider had not considered how to adequately maintain people's privacy when using bathrooms and shower rooms on different floors. We found a double room on the ground floor was shared by two people and staff told us they were happy to do so. However, we did not see any evidence to confirm these arrangements. During this inspection we were shown a form dated 2009 where one person had signed that they agreed to share a double room. We looked at other people's records but still did not see how people's privacy needs and expectations had been identified, recorded and met as far as reasonably possible. We did not see the individual privacy needs or choices of people recorded in their care records. We continued to remain concerned about the number of facilities available to people when the service was at full capacity and that people may not have the space for the privacy and dignity they may have needed.

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

People we spoke with indicated they were happy at Carlton House, they smiled and greeted us warmly. When we asked how people were they all smiled and nodded. One person told us about a visit to their relative's house and another spoke about the seaside. Another person told us, "I'm alright."

Interactions between staff and people using the service were warm and relaxed. People were comfortable and at ease. During lunch we observed people were offered appropriate encouragement and this was done in a caring and patient way. When people returned from their various activities they were greeted warmly by staff who asked people if they had enjoyed the day's activities. One staff member observed one person's bag had broken. They said, "Oh [name of person] look at your bag. Let me fix that for you." After they fixed the bag they took the person to their room to help them take their outdoor clothes off. On another day of our inspection it was one person's birthday. We spoke to the person who was excited and looking forward to a small birthday party they were having later. They spoke to staff about their plans for the day and their relationship with staff seemed positive.

Staff spoke positively about their work and the people they cared for. One staff member told us how happy one person was and how their confidence had grown since they had changed bedrooms on the ground floor. They told us, "[Name of person] is so happy and comfortable and they have just been to a club and you should see them… so happy."

Staff continued to know people well and told us about people's likes and dislikes. They knew people's daily routines, what people liked to eat and what may make people upset and angry. However, very little of this information had been written down so it was hard for new members of staff to get to know people and how they liked to be supported.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection we found 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.

During this inspection we found work had started on updating three people's care records to make them more person centred. For instance, one person's records stated the type of toiletries they liked to use. However, we found more work was needed to improve these records. For example, one person's updated records did not give the person's likes and dislikes regarding food, activities and we saw little information regarding daily routines such as, times people liked to wake up or go to bed, what they liked to watch on television or their favourite books or music. Although staff had used their knowledge to make these improvements there was little evidence of the people's involvement or involvement from friends and family.

We found the care records for four other people who used the service had not been updated since our last inspection and continued to be, irrelevant to the person's individual needs. For example, one person had 14 care plans in place that were last reviewed between 2015 and 2016 and no details of the person's changing care needs were evidenced in this documentation. We were concerned because people remained at risk of not having their needs met. The registered manager told us work had stopped on updating peoples care records since they had received advice from an external consultant and they were now trying to update one care plan at a time. At the time of our inspection they were working on one person's care records.

At our last inspection we found people's care records were not always accurate and complete. We had concerns that one person, at risk of pressure sores, was not being turned regularly because there were gaps of up to five days where turning charts has not been completed. At this inspection we found records concerning nightly checks, bowel movements and personal care were incomplete. For example, one person had returned from hospital at 3.40am and, night checks stated the same person was "asleep OK" at 12.30 am when the person was still in hospital. The same person suffered a fall later the same day. The deputy manager explained they would have been checked every half an hour, but there were no records in place to confirm this and night monitoring forms indicated the person was checked only twice after the fall. Two people's care records stated they liked to have a shower at least twice a week. However, when we looked at the records concerning people's personal care, over a period of 42 days, we found one person had received a shower once and the other person twice, on consecutive days. We also found there were gaps in records indicating no personal care had been given to anyone using the service for a period of 18 days. When personal care was recorded it was mostly a "wash". The deputy manager told us that staff would record a wash when people had a bath or a shower but the records gave us no assurance that people received the support they needed to meet their needs. Although people were well dressed in appropriate clothing we were concerned that people's records were incomplete and inaccurate and did not reflect the information provided in care plan. So we were unable to confirm if people were being cared for and supported in accordance with their choice and wishes.

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

At our last inspection we found 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 administrative tasks such as updating care records and making referrals to other health professionals. During this inspection staff appeared to have more time to spend with people but four residents were in hospital so long term improvements could not be confirmed. We spoke to the registered manager about her two deputy managers who were also keyworkers for three people. The registered manager told us she relied on her deputies to administer the day to day running of the service. We explained we were concerned that the deputies did not have the supernumerary time to undertake all the work they were required to do. We did not receive a response from the registered manager and will continue to monitor.

At our last inspection we found some people were not supported to follow their interests or take part in meaningful, person centred, social activities. We were shown activity planners for people but when we compared the activity with the day of our inspection the activity was not happening. We looked at staff duty planners. These recorded the activities that people had been involved with and the staff allocated for each activity. We found records were incomplete and suggested very little engagement for some people who were less independent and remained at the service during the day.

During this inspection three of the people we had concerns with at our last inspection were in hospital so we were unable to verify what improvements had been made for them. All but one of the remaining people at the service were mobile and active and, as in the last inspection, we saw these people coming and going from day centres and outside activities. We saw an arts and crafts session in house and on one day people went out for lunch. One person told us about their birthday party and another told us about a disco they had attended that week. The registered manager explained they had arranged for an outside activities coordinator to come in every second Sunday and we saw a timetable to confirm this. However, when we looked to see the recorded activities on the staff duty planners we were told this was no longer being recorded and staff were told verbally each day what they would be doing. Without any documentation we were unable to verify what activities people took part in, people's involvement in the choice of activity and if these were relevant to their hobbies or interests. Although we were told improvements had been made, the lack of recorded information and evidence to support these improvements meant we were not assured that any advances had been made at the time of our inspection.

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

At our last inspection we found people and their relatives did not always contribute to their planning of care and support. 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. During this inspection we did not see an improvement in this area. We spoke with the deputy manager about contact with one person's relatives while they were in hospital but we did not see evidence of relative involvement in people's care.

We saw a complaints procedure in place and an easy read, pictorial version for people using the service. 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. The registered manager showed us the forms used for recording a complaint. We saw the last complaint recorded was in February 2016 and had been resolved.

Inadequate

Is the service well-led?

Our findings

At our 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 provider's 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.

During our inspection in October 2017 we found governance arrangements were poor. 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 still not been completed. Information for people who used the service was limited. There were limited systems in place for staff to discuss issues and influence the operation of the service. The provider did not have appropriate systems in place to record and monitor staff training, supervision and appraisals. The provider had failed to record and act on important information such as incidents, safeguarding allegations and other safety issues such as the recording of medicine errors. We found CQC had not received statutory notifications. These contain important information the provider is legally required to report to us. We found the registered manager did not have the skills, knowledge or qualifications to demonstrate the competency required to manage the regulated activity. The provider was not displaying its CQC rating of performance in the service for people to see.

After this inspection the service entered special measures. We sent the registered manager information regarding special measures and what it means. We met with the registered manager in January 2018 to discuss special measures, the report we had written and what our expectations were. We also worked with the local authority and met jointly with the registered manager on several occasions to monitor any improvements made to the service and ensure people remained safe.

In February 2018, the registered manager sent us an action plan to tell us how they were planning to meet the regulations. The timescales for the completion of actions were between one month and three months, February to April 2018.

During this inspection we met a consultant who had been employed in February 2018 to help the service make improvements. The consultant explained progress had been slow and we were shown a new action plan based on the concerns raised at our previous inspection.

We found much of the actions specified on both action plans had not been completed. After our inspection the consultant sent us a revised action plan and agreed to record all progress made and update us each month with improvements made.

During this inspection in March 2018 we found timelines set for improvements in action plans had not been met and governance remained poor.

Work had started on updating one person's care records but this was not complete. We found people's care

records continued to be out of date, inaccurate and irrelevant. Records relevant to people's daily health were poor or non-existent, for example personal care records, records concerning people's continence needs and staff allocation sheets. When health and safety issues had been identified by staff, such as excessive hot water temperatures, these had not been addressed leaving people at severe risk of harm. Some incidents had not been recorded. There was no evidence of how the provider had improved the service in these instances. People's evacuation plans were out of date and had the wrong information. When people were no longer at the service or had moved rooms the information had not been updated. There were no cleaning schedules in place for people's rooms and little information about the cleaning of communal areas so people were at risk from infection because the service had not been kept clean or hygienic. When advice from external healthcare professions had been sought this was not always put in to practice. This could have a negative impact on people and increase their risk of harm. The provider continued to let staff work excessive hours and failed to monitor the duty rota to ensure people's safety.

The registered manager had made no improvements to how they assessed, monitored and improved the service. They showed us a care audit and action plan form they had completed on 5 March 2018. This gave details of areas or items reviewed a score of one to five. One was equivalent to "many significant shortcomings" and five being equivalent to "no significant shortcomings". There was no detail to show what records had been looked at to make a judgement and when action was required it was unclear who was responsible for this and how the registered manager would ensure changes had been completed. We looked at water temperatures and found the registered manager had scored this a four, "good practice outweighs shortcomings." This was concerning because records showed consistently high temperatures were being recorded. Window security had been scored as five "no significant shortcomings" which was contrary to our findings on the inspection. We asked if there was any backing documents or audits to accompany the form we had been given. The registered manager said there was not. We asked to see any previous quality audits undertaken by the registered manager and we were shown the document given to us at our last inspection dated 24 August 2017. There had been no other quality assurance audits between August 2017 and March 2018.

All the issues above meant there was a continuing 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. The provider had continued to fail to identify the shortfalls at the service and had not identified the concerns we found during this inspection

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

During our inspection in March 2017 and October 2017 we had continuing concerns that the registered manager may not have the skills, knowledge or qualifications to demonstrate the competency required to manage the regulated activity. We had 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. The last professional management training course attended appeared to be 12 years previously. We asked for evidence of any other continuing professional development to update her skills and knowledge but this was not provided. During this inspection we saw evidence the registered manager had attended the mandatory training required with her staff but we found no further evidence to demonstrate she had the appropriate skills or knowledge of the applicable legislation required to carry on with the regulated activity. Between the last inspection and this one we have received emails and action plans that continue to show a lack of understanding of applicable legislation including the Health and Safety Act, the Mental Capacity Act, The Health and Social Care Act and best practice guidance concerning medicine management and infection control. This lack of knowledge presented a real risk of harm to people using the service.

On the first two days of the inspection the registered manager spent time visiting people in hospital and taking people to and from activities leaving her two deputy managers to deal with the inspection and answer our questions. On the third day we insisted she be at the service so we could speak with her. We interviewed the registered manager at some length and we asked what the role of the registered manager was. We found she lacked the ability to describe her legal duties in any detail. We found both the written and verbal responses we received still did not demonstrate the registered manager had the necessary up to date qualifications, competence and skills to manage the regulated activity.

This was a continued beach under Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection we found information for people who used the service was limited and there was little evidence of how the registered manager engaged with people to get their views on how the service was run. The service user guide was directly copied from another provider and service user meetings contained little information about people's involvement and how suggestions made had been actioned. During this inspection we saw hand written minutes from a service user meeting held in February 2018. Although these indicated people had been involved in a discussion we did not see evidence of any action or how these minutes would be made accessible to people in a format they could understand. We saw a new service user guide had been introduced but this was not complete and more information needed to be added or changed to give people accurate information about where they lived.

At our previous inspections in March 2017 and October 2017 we found there were five occasions where the provider had not reported important events to CQC. These are required by law and are called statutory notifications. Since the last inspection we were sent three notifications involving incidents that had occurred from October 2017 to March 2018. We are currently considering criminal action regarding the incidents that were not reported to CQC. During the second day of our inspection we were told one person had fallen when coming down the stairs and sustained a cut. They were shaken up so were taken to hospital. On the 22 March we received a report from the Health and Safety Executive concerning the incident. This specified the person had fallen from a height and sustained a fracture. The regulations state the registered person must notify the commission of a serious injury "without delay". On the 3 April 2018 we became concerned about the delay so wrote to the provider to inform them they must send a notification informing us about the incident. Two days later we received a response from the consultant with an apology.

We remained concerned that the provider has continued to fail to provide statutory notifications and these issues amount to a continued breach of Regulation 18 Care Quality Commission Registration Regulations 2009.

At our last inspection the provider failed to display the most recent CQC rating of performance. During this inspection we found the rating was displayed and the previous breach in regulations had been met.

At our last inspection we found limited systems were in place for staff to discuss issues and influence the operation of the service. Staff meeting minutes were duplicated with no staff ideas or input recorded. Staff supervision had not taken place and there were no systems in place to record staff training. During this inspection we found handwritten minutes of staff meetings. These contained the views of staff members around various discussion points. We also saw a supervision and training matrix had been put into place to record and monitor staff development. We will need to check that these continue to be updated at our next inspection.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always have the care and treatment they needed to meet their needs. Care records were not person centred, did not reflect people's preferences and were not regularly reviewed. Regulation 9(1) (a)(b)(c), (3) (a)(b)

The enforcement action we took:

Cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person did not always ensure the privacy or dignity of the people using the service. Regulation 10 (2)(a)

The enforcement action we took:

Cancel registration

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. Regulation 11(1)

The enforcement action we took:

Cancel registration

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 in a safe way. Risks had not always been identified and assessments were not reviewed regularly. The registered person did not do all that was reasonable practicable to mitigate risk. The registered person did not ensure staff were working safely . The registered person did not ensure the proper and safe management of medicines. Regulation 12(1), (2)(a)(b)(c)(g)

The enforcement action we took:

Cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes did not always protect people from abuse and neglect. Regulation 13(3)

The enforcement action we took:

Cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises were not always suitable for the service provided.

The enforcement action we took:

Cancel registration

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. The registered person failed to identify risk to people and did not introduce measures to reduce or remove risk. The registered person failed to keep accurate and

up to date records. Decisions made on behalf of people who lack capacity were not recorded in line with the Mental Capacity Act 2005 and associated Codes of Practice.

Regulation 17(1), (2)(a)(b)(c)

The enforcement action we took:

Cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 7 HSCA RA Regulations 2014 Requirements relating to registered managers People were not cared for by a registered manager who had the skills, training or competency to manage the regulated activity. Regulation 7 (2) (b)

The enforcement action we took:

Cancel registration