Mrs Beebee Zareenah & Mr Mohammad Feizal Ruhomally

St Andrews Lodge

Inspection report

39 St Andrews Road
Burgess Hill
West Sussex
RH15 0PJ

Tel: 01444236805

Date of inspection visit:
22 December 2015

Date of publication:
29 February 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 December 2015. St Andrews Lodge is a care home without nursing that provides care and accommodation for up to seven people with mental health needs. At the time of our inspection there were six people living at the home. The age range of people varied between 55 and 75 years. People required support to manage their mental health needs and other medical needs.

The building was a large detached house in a residential area, arranged over two floors. The service had a registered manager who was also the owner of the service. 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. One of the registered providers was also the registered manager. The registered manager informed us that she was on planned leave since in September 2015 and had come in to assist with the inspection.

At the last inspection on 3 February 2015 we checked that the provider had made improvements in respect of the safety and suitability of the premises identified from a previous inspection in May 2014. We the inspection they had failed to make the necessary improvements to address the concerns The provider subsequently sent us an improvement plan in March 2015 to confirm the actions they would take to meet the regulations. At this inspection we found the necessary improvements had been made.

Risks to people were not consistently identified and managed, this meant that staff did not always have sufficient guidance to support the people they were caring for. The care record for one person identified that there was an ongoing risk of financial vulnerability however there was no risk assessment to indicate how significant the risk was and no strategies for staff to follow to support the person and reduce the risk.

The requirements of the Mental Capacity Act 2005 (MCA) were not consistently being met.
Consideration was not consistently given to when a capacity assessment should be considered, for example when someone had fluctuating capacity. Staff had not received MCA training and did not have sufficient knowledge. There were no records of capacity assessments or best interest decisions where needed, particularly in regards to taking medication. Some staff were not aware of Deprivation of Liberty Safeguards (DoLS) and the possible impact for their work. There were no people subject to DoLS at the time of our inspection. Consideration of someone's capacity and assessment where needed, ensures that their human

rights are being respected and decisions about their care and lives are made in accordance with the law.

Staff induction, supervision and appraisals were inconsistent and there was no training or development plan. None of the staff had received training in mental health awareness or any training specific to the needs of the individuals they were supporting. Staff records were not available for all members of staff so we were unable to confirm that the provider was following safe recruitment processes for everyone employed to ensure the safety of people.

People spoke well of the staff, saying they were approachable and friendly and that they liked living in the home. One person said, "The manager is always fussing, she wants us all to be happy, they are nice people," another person said, "I very much like living here, I've got all the things I need and my bed is very comfortable." Although people spoke positively about staff we found that some care practice did not promote choice and involvement in decision making. Some people told us they were not aware that they had a care plan others didn't know what a care plan was. Care plans had little information that described what was important to the person from their own perspective or how they would like to spend their day and individual preferences were not included. There did not appear to be a clear strategy in place for ensuring that people were supported to make choices. There was little evidence that people were involved in planning their care and people were not consistently consulted with about issues affecting their lives.

Care plans were not personalised or detailed enough to ensure that staff knew how to provide personalised care and were not thorough enough to reflect peoples' choices or preferences. There was no indication of how the person perceived their mental health needs or what might indicate a decline in their mental health or any triggers associated with this. Lack of detailed daily recording meant that people's assessed needs could not be accurately reviewed which included maintaining any mental health needs. Although it had been recorded that some care plans had been reviewed we saw no updates to the detail of the plans and information had remained the same therefore we were not assured that this reflected people's current needs. Records did not show people's individual preferences or aspirations nor how these would be met. This meant that people were not being supported to follow their interests and staff were not always responsive to peoples' needs.

People told us that they were having enough to eat and people's weight was being monitored. People were not effectively involved in making choices about food and they were unaware that they could access the kitchen during the evening. This is an area of practice that needs to improve in order that people's preferences are taken into account.

People and staff spoke highly of the registered manager saying that she was kind, caring and approachable. However we found that the service was not consistently well–led. The registered manager had reduced her hours significantly since September 2015. The arrangements to cover for the registered manager's leave failed to provide adequate managerial oversight and there was insufficient day to day management cover to supervise staff and care delivery. Quality assurance systems were not in place to monitor or analyse the quality of service provided and feedback was not obtained consistently.

People were receiving their medicines consistently and safely however, people were not being supported through a risk assessment process to be as independent as possible in managing their own medicines. Staff were aware of safeguarding procedures however, the policy and procedure in the home had not been updated to reflect the most recent guidance in the pan –Sussex procedure.
People we spoke with were positive about the staff, the registered manager and provider. One person told us, "They are all nice people, they do their best for us." People also said that they felt safe at St Andrews Lodge and one person said, "I very much like living here, I've got all the things I need and my bed is very

comfortable."

People were supported to access health care services and received ongoing healthcare support. A health care professional told us that the service was proactive about ensuring people had regular health checks and blood tests and that any health issues were referred in a timely way. People told us that they were supported to access health services when they needed to, one person said, "I don't go out on my own but if I need to see the doctor someone comes with me." Staff we spoke with described the people they supported in a kind and compassionate way," I like to make them laugh when we are playing games, I think taking their mind off their illness is important, it makes a difference. "

There was a complaints process but the registered manager said they had not received any complaints and there were none recorded. Similarly there had been no incidents or safeguarding alerts raised in the past year and staff told us that there were never any altercations with people living at the service.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risk assessments were not detailed and had not been updated to ensure that staff had the guidance in which to provide safe care.

Some areas of the home were in poor decorative state and dirty

Safe recruitment processes were not followed consistently

People told us they felt safe. Staff understood how to safeguard people from harm or abuse and there were safe procedures in place for the administration of medication.

Is the service effective?

Requires Improvement

The service was not consistently effective

There was no training plan in place, staff had not received training in mental health to equip them to meet the needs of people they cared for. Staff did not receive appraisals or regular formal supervision.

The requirements of the Mental Capacity Act 2005(MCA) were not always followed.

The menu lacked variety and people were not fully consulted about menu choices.

People were supported to access health care services and received on-going healthcare support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always supported and encouraged to make choices
about their care and treatment.

People were not consistently consulted with about issues affecting their lives at the home

People spoke highly of staff and said they were approachable and friendly

Is the service responsive?

Requires Improvement

The service was not always responsive to the needs of individuals

Care records were not personalised and people had not been consistently involved in developing and reviewing plans that reflected their needs, choices and preferences.

Lack of detailed recording meant that people's needs could not be effectively reviewed to ensure their care plans were responsive to their current needs

Opportunities for social activities or engagement were extremely limited and did not reflect people's interests.
People and staff felt able to approach the registered manager if they had any complaints or concerns.

Is the service well-led?

Requires Improvement

The service was not consistently well-led

Arrangements to cover the registered manager's leave had not provided adequate management oversight and leadership

There were not sufficient systems in place to monitor and assess the quality of the service and make improvements.

People and staff spoke highly of the registered manager and said she was approachable.

St Andrews Lodge

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 comprehensive inspection took place on 22 December 2015 and we gave the provider short notice because the care home was small and we wanted to be sure that people and staff would be available to talk to us. The inspection was undertaken by two inspectors.

Before this inspection we looked at previous inspection reports and the action plans that had been submitted around cleanliness and infection control, safety of the premises, record keeping and out of date policies. We also reviewed other information that we held about the home. We had received no notifications from the provider since the last inspection. A notification is information about important events which the provider has to tell us about by law.

We did not, on this occasion, ask the provider to complete a Provider Information Return (PIR) before our inspection. This is a form that asks the provider to give some key information
about the service, what the service does well and improvements they planned to make.

The previous inspection had taken place on 3 February 2015 and regulations around the safety and suitability of the premises were not being met. We reviewed the action plan submitted by the provider to ensure that we addressed potential areas of concern.

During the inspection we spoke with the provider /registered manager, and all staff employed. We spoke to five of the people living at the home. We looked at areas of the building including the kitchen, lounge and dining areas, bathrooms, hallways and some people's bedrooms. We spent time observing the delivery of care and support in communal areas, including lunchtime, and we looked at documentation including each person's care record, policies and procedures, accident and incident records, daily records, medication

records, the complaints book and activities book. We also looked at the rota for the last four weeks, the menu plan, one staff file and notes from house meetings. Following the inspection we also contacted two health care professionals to discuss their impressions of the service.

Requires Improvement

Our findings

At the last inspection in February 2015 the provider was in breach of regulation15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation of 15 the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because the provider had not ensured the safety and suitability of the premises as the stair carpet was worn and presented a trip hazard and the hallway, landing and stairs were in need of redecoration. An action plan was submitted that detailed how they would meet the legal requirement by the end of June 2015. At this inspection we found that the provider had followed their action plan and this breach had been addressed, the carpet on the stairs and hallway had been replaced and the hallway and landing had been redecorated.

The registered manager said that staff were responsible for encouraging people to be as independent as possible and this included supporting them to keep the house clean. We noted that one lounge was clean and bright and the kitchen was also clean and tidy. However, we noticed that there was an unpleasant odour on the first floor and a toilet brush in the shared bathroom was soiled and needed to be replaced. The chairs in the dining room had seat pads that were stained and dirty with dried food. Some areas of the house remained in a generally poor decorative state with dirty and chipped paint work and wallpaper. A records log was in place for staff to complete to monitor wiping door handles as part of infection control procedures, but we did not see any other cleaning rota or instructions for staff to help ensure consistent standards of cleanliness throughout the home. This is an area of practice that needs to improve.

People told us they felt safe living at St Andrews Lodge, one person said "I feel safe and secure here," another said, "I do feel safe, they don't let me go out on my own," a third person said " I go out every day, it's safe here, no one can just walk in." However we found areas of practice that were not safe and in need of improvement.

Risks to individuals were not consistently managed, some risk assessments had been completed for individuals but these were not comprehensive and they had not been reviewed or updated. For example, the care record for one person identified that there was an ongoing risk of financial vulnerability. However there was no risk assessment to indicate how significant the risk was and no strategies for staff to follow to support the person and reduce the risk. The care plan had a goal to support the person to "Remain independent with money" however there was no detail for staff about how to achieve this. A care plan review note stated that the person had "Declined any financial support from staff," but the care plan had not been amended or adjusted and there was no indication of any revised strategy to enable staff to work differently with the person. This means that the risks had not been properly assessed or managed and

although no incidents of financial abuse had been recorded, with no preventative strategy in place the risk could still occur.
Specific infection control risks associated with one person's behaviour were noted in their care records but there was no risk assessment in place for this, no clear guidance for staff in how to reduce this risk and no plan to support the person. Recording in daily notes indicated that the behaviour was continuing but there was no indication about how this was being managed. This meant that the person remained at risk of infection and staff were not equipped with a consistent strategy to minimise this risk.

The fire risk assessment had been reviewed in 2014 but did not reflect new arrangements around having a no smoking policy in the house. The registered manager was aware of this and told us that she was intending to update the risk assessment at the earliest opportunity.

There was not a robust system for assessing, recording and mitigating risks to people's health and safety, this is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The staff records for one member of staff confirmed that all appropriate checks had been made including a Disclosure and Barring Service (DBS) check, references and a work permit. A DBS check identifies if staff have a criminal record or are barred from working with children or people at risk. However staff records were not available for any other members of staff so we were unable to confirm that the provider was following safe recruitment processes for everyone employed to ensure the safety of people.

This is a breach of Regulation 19 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The registered manager told us that people living at St Andrews Lodge were very independent and needed minimal support with their care, she said "There's no hands- on care, it's about prompting and encouragement." The usual shift pattern was for one person to be on duty throughout the waking day and a sleep-in shift at night. The staff team consisted of the registered manager and three other people and was largely made up of the provider's immediate family. The staff rota for the previous four weeks showed that the registered manager was marked as absent on planned leave and on several days one member of staff had been working 12 hour shifts. The registered manager told us that she did not use a formal dependency tool to assess staffing needs, but made a judgement based upon any planned events such as medical appointments. She explained that when someone needed to be supported to attend an appointment, arrangements were made for a member of staff to support and accompany them if required. Care records confirmed this.

We asked staff to tell us what they would do if an emergency arose and they were on duty alone. They told us that they could contact the registered manager at any time and she would come in or offer support over the phone. The registered manager confirmed that she and a staff member are always available to be contacted should they be needed to come into work at short notice. The registered manager said that she was not currently working her usual hours on the rota as she had been on planned leave since September but she said she had continued to be involved in the running of the home and had continued to come in when required. We noted that there were some gaps on the rota giving the impression that some shifts had not been covered. We asked the registered manager about this and she gave us assurances that this was an administrative error and all the shifts had been covered.

We asked people for their views on the staffing levels. People told us that they did not always know who was on duty, one person said, "It would be good to know who is on duty as you don't know who is going to pop their head round your door." Some people told us that they couldn't go out when they wanted to unless

family or friends took them because there weren't enough staff. We told the registered manager about these concerns.

All the people we spoke to said they did feel safe at St Andrews and would speak to the registered manager if they were worried about anything. Staff told us that because people were independent at St Andrews Lodge the staffing levels were fine. One staff member said "I often work on my own, one night the fire alarm went off but I called the registered manager for support, it was fine. I know what to do in an emergency, if someone was ill I would call the registered manager and note it in the daily notes, if it was an emergency I would ring 999 and then let the manager know. "
The registered manager had a copy of the most recent pan- Sussex safeguarding policy however the home's own safeguarding policy and procedures had not been updated and still referred to the 2012 version this meant that staff did not have the most up to date procedure to guide them if a safeguarding issue arose. Staff we spoke to demonstrated a good understanding of general safeguarding issues and had received training, they said they would report any concerns to the registered manager. There had been no notifications of safeguarding alerts since the last inspection. Staff were not able to tell us if there was a whistleblowing policy and did not know what the term meant. However one staff member told us that if he had any concerns he would report it to the registered manager and another staff member said that if he had any concerns that he felt he couldn't raise with the registered manager he would report this to the local authority. Staff said that ensuring the safety of the people living at St Andrews Lodge was the most important part of their job. We found that staff did understand how to safeguard people from harm.

There were safe procedures in place for the management and administration of medicines. Medication Administration Records (MAR) were in place with photographic identification for each individual and any allergies were noted. An up to date record showed the names and signatures of staff competent to administer medication and staff we spoke to told us they were clear about the process. The medicines were kept in a locked cupboard in the kitchen, and the cupboard was above a kettle and the toaster. There was no system in place to monitor the temperature in the cupboard to ensure that the optimum temperature range for storage of medicines was maintained. Guidance from the Royal Pharmaceutical Society of Great Britain (RPSGB) states that "Medicines need to be stored so that the products are not damaged by heat or dampness" this is because changes in temperature and moisture such as steam can affect the efficacy of the medicine. Storage of medicines is an area of practice that needs improvement.
We recommend that the provider considers current good practice guidance regarding staff storage of medicines.
Incidents and accidents were recorded, there was only one record since the last inspection and this was for a minor scratch. Staff told us that there had not been any incidents or accidents in this period but that they would know where to record them and they would also alert the registered manager of any incidents of accidents when they occurred.

Requires Improvement

Our findings

People spoke well of the staff. One person told us that the "Staff are all nice," another person said, "They are all nice people, they do their best for us." However, we found that the care provided was not always consistently effective and this had an impact upon some people's quality of life.

Training opportunities for staff members were limited, there was no training plan in place and none of the staff had received mental health awareness or training specific to the mental health needs of the people they were supporting. The registered manager was knowledgeable about individuals, but staff demonstrated limited knowledge of the mental health needs of individuals or how these were met. We asked staff to describe how they supported people's mental health needs, they spoke about practical tasks rather than indicating an understanding of people's mental health needs .For example one staff member said, "I help them by keeping their rooms clean, playing games and talking to them, it's important to take their minds off their illness."

Another staff member gave an example of how they supported someone who was very indecisive, they said, "Putting pressure on them doesn't work, they need times to make decisions." A staff member provider described the model of care adopted at St Andrews Lodge as one of, "Maintenance, not recovery," and said, "We monitor people's mental health and their general health for any changes in behaviour. We note it and act accordingly by referring to their GP or to their care co-ordinator." Daily care notes did not reflect this, they lacked detail and were task focussed, for example "Prompted with personal care" and" Played dominoes "and" Went for annual health check. There was no commentary on whether they were displaying any symptoms indicative of their mental health problems or whether their daily pattern had changed in any way that might indicate a decline or improvement in their mental health.

Training records showed that one staff member had received safeguarding training, first aid and food safety when they first started. This member of staff could not recall having had any induction training and this was not noted on their staff file. They said that they had regular meetings with the registered manager, "every few months" but that they were not sure if this was recorded. There was no evidence to show that an induction process had taken place, no supervision notes were on file and the most recent appraisal was dated March 2014. Supervision is a formal meeting where staff members can discuss training needs, reflect on their practice and receive support from their manager. Supervision should be a useful tool for managers to address performance issues and provide support to staff members as well as gaining an insight into the challenges they face. Supervision is one aspect of staff development together with induction, training and support that enables staff members to be equipped to support the people they care for effectively.

A second member of staff, had provided the majority of care since the registered manager reduced her hours. They were working towards the National Vocational Qualification at level 3 for social care. The registered manager told us that they had been supervised throughout their induction period and that she considered the training they were receiving for the NVQ 3 was adequate to cover the training requirements for their role. There was no evidence to confirm the induction that they had received or what this had covered. There was no record of regular supervision, training or appraisals.
The failure to ensure staff received appropriate induction, supervision and training is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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. We checked whether the service was working within the principles of the MCA.

We asked staff about their understanding of the MCA. They demonstrated limited understanding, one staff member said, "It's important that people can make their own decisions and take risks." Another staff member also had a basic awareness of the MCA but could not give examples of when they would apply MCA principles other than to say that they, "Would help people to make informed decisions." One of the providers demonstrated a more in-depth knowledge of MCA, they gave an example of one person who would like to move, but a best interest decision had been made with involvement of the care co-ordinator that they should remain living at St Andrews Lodge. Some people's records had signed consent forms. People told us that the staff asked their consent before assisting them. Staff told us that they were there to support people to be as independent as possible and would always gain consent. One staff member described how they always check with one person before applying medical cream. Some capacity assessments had been undertaken by care co-ordinators, for example one person had a mental capacity assessment in their care record to establish that they had capacity to make the decision about whether they should remain at St Andrews Lodge. No MCA assessments had been undertaken by staff at St Andrews Lodge. Where MCA assessments were in place these had been undertaken by external professionals. There was no process in place in which staff assessed the capacity of people to support them to make decisions in their lives.

One person with enduring mental health problems was very independent and went out independently on most days. A number of factors had been identified that could put this individual at risk of harm including vulnerability to financial abuse. Their care record identified that they needed support to budget money, but a subsequent review had noted that they declined any financial support from staff. A recent review by a health care professional described them as having, "Fluctuating capacity" however there was no mental capacity assessment to determine whether they had capacity to manage their own finances now, nor any risk assessments or care plan to detail how best to support them with their finances.

Staff told us that nobody was able to self –medicate and staff were administering all medicines.
There was no evidence in people's care records about how this decision had been made or if people had been offered the choice to self- medicate or whether they had the capacity to understand the need to make. One person was managing their own medicines when they went to stay with family at the weekend, however there was no assessment in place to determine and mitigate any risks associated with this. There was not a clear process in place for ensuring that people's rights were protected when consenting to their care. This was a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Care Quality Commission has a duty of monitor activity under the Deprivation of Liberty Safeguards (DoLS). This legislation protects people who lack capacity and ensures decisions taken on their behalf are made in the person's best interests and with the least restrictive option to the person's rights and freedoms. Providers must make application to the Local Authority when it is in a person's best interests to deprive them of their liberty in order to keep them safe from harm. Staff had not received training regarding DoLS and were not aware of the implications for people they were working with however the provider did have an awareness and confirmed that nobody at St Andrews Lodge was subject to DoLS.

People did not tell us that they were consistently offered choices in relation to their food and drink.
The menu was on a two week rotation and there was no choice available for lunch or supper.
Staff said people could chose something different if they wanted to, there was no evidence to show how often this happened apart from one record that stated "Didn't want rice, gave him potatoes instead". Care records did not indicate peoples' likes or dislikes regarding food or any specific dietary needs and it was not clear how this was taken into account when planning the menu. There was no Christmas menu available but staff told us that a special turkey dinner was planned.

People expressed mixed views about the food, one person said, "The food's ok, you get a good choice," another person told us the menu had, "Stayed the same for years." There was some evidence that people were consulted in residents meetings about the menu, but notes indicated that people were asked if they were happy with the food rather than initiating a discussion about what else people would like to try. Some people said they would like to see different dishes on the menu and comments received included, "I'd like to have salmon on the menu sometimes, it's my favourite," and "I'd like fish and chips more often than once a fortnight but I don't think we're allowed." One person said they preferred to eat at the café in town where they could choose whatever they wanted. Dinner was served at 5.30pm and it was not clear if people had anything else to eat or drink after this. The registered manager told us that drinks and snacks were available throughout the day, however people told us that the kitchen was "off limits" in the evening. People were not effectively involved in making choices about food and they were unaware that they could access the kitchen during the evening. This is an area of practice that needs to improve in order that people's meal preferences are taken into account.

People told us that they served themselves at breakfast time, usually having cereal or toast, but that there was only one person allowed to use the kitchen at a time. We observed lunch and this was tinned tomatoes on toast. The meal was not a social event, food was passed through the serving hatch so there was little interaction between staff and people during meal time. We didn't witness anyone asking for a hot drink or snack at any time other than the designated meal times. The kitchen was found to be clean and tidy. One care plan specified, "One to one support to prepare meals in the kitchen." A note was made of a care plan review in May 2015 stating "Working well with 1:1 support in kitchen." It was not clear from daily notes how often this happened and if there was no more recent update. The evening meal was seen to be cooked by one of the people living in the home with a member of staff present in the kitchen. This had been identified as something that this person liked to do as part of maintaining an independent lifestyle and the person told us that they enjoyed cooking. Staff said that when the person was not there at weekend's staff did the cooking.

Peoples' health needs were being monitored. A Malnutrition Universal Screening Tool (MUST) was being used to identify if anyone was at risk of malnutrition and records showed that peoples' weight was regularly recorded. Many people needed regular blood tests and they were supported to attend these appointments. The registered manager ensured that people were attending their mental health and physical health appointments. They described how people's mental and general health needs were monitored for any

changes and GP or Community Psychiatric Nurse (CPN) reviews were requested if they noticed any changes in attitude or physical issues. We could not see where such changes were documented on people's daily records but we noted that health care professionals were consulted. For example one person had been supported to attend a GP appointment for an annual health check, another person's health needs had recently been reviewed by their GP and they also had regular contact with their care co-ordinator. People told us that they were supported to access health services when they needed to, one person said, "I don't go out on my own but if I need to see the doctor someone comes with me," another person said "They are good at dropping me to my appointments on time." After the inspection visit we spoke to two health professionals who confirmed that the registered manager was proactive about bringing people to the surgery for regular health checks and blood tests and that any indications of health issues were referred in a timely way.

Requires Improvement

Our findings

People spoke well of the staff, saying they were approachable and friendly and that they liked living in the home. One person said, "The manager is always fussing, she wants us all to be happy, they are nice people," another person said, "I very much like living here, I've got all the things I need and my bed is very comfortable." Although people spoke positively about staff we found that some care practice did not promote choice and involvement in decision making.

Some care plans were signed by individuals however there was little evidence that people had been fully involved in the care planning process. We asked people how they had been involved in the design of their care plan, some people said they were not aware that they had a care plan others didn't know what a care plan was. Care plans had little information that described what was important to the person from their own perspective or how they would like to spend their day and individual preferences were not included. We asked staff how they support people to make choices, one member of staff said, "I try and motivate one person by reminding them that it's important to keep active" another staff member said "I just try to be friendly and talk to them." There did not appear to be a clear strategy in place for ensuring that people were supported to make choices. Some of the people we spoke to indicated that they were not aware that some options might be available to them, for example one person was asked whether they had the opportunity to make themselves a hot drink they said "I didn't know I could ask for that, I don't think I'd be allowed." This means that people were not always supported and encouraged to make choices. This is an area of practice that needs to improve.

The registered manager told us that there were regular house meetings and people were involved in decisions which affected their care. However we saw notes of these meetings which indicated that people were not fully consulted about issues within the home for example a discussion had taken place regarding whether people wanted to have a Christmas Party. It was not clear if there had been a discussion about whether to invite friends and families to the party. We asked the Registered Manager about this and she said that people's family would be made welcome but they had not been invited because staff felt that they would not come. In notes from another meeting people were informed that the stairway and landing were to be decorated and re-carpeted. However the registered manager told us that people had not been involved in choosing the colour for the newly redecorated stairway and staff had chosen the carpet. This shows that people were not consistently consulted with about issues affecting their lives. We have identified these areas as needing improvement.

The registered manager said, "Because we are a small family run home we get to know the people living here really well. We try and encourage them to be as independent as possible and respect their wishes about how they want to live their lives." The registered manager was able to tell us about the people living at St Andrews Lodge and knew they personal histories. Other staff members were able to demonstrate a more limited knowledge. We saw that people who were able to go out independently did so and one person went out with a family member. One staff member told us that people could bring any furniture or personal belongings they wanted for their rooms and gave an example of one person who had bought their own television, chair and books.

Staff told us how they had developed positive caring relationships and described the people they supported in a kind and compassionate way, "I like to make them laugh when we are playing games, I think taking their mind off their illness is important, it makes a difference. " Another staff member said, "The service users here are a tight knit group, they like to talk and we have built up a bond, we sit and watch TV together and talk about the programmes." We observed very little interaction between people and staff but where we did see communication it was positive, for example one person was talking about catching a train to go to London, the registered manager was kind and attentive in her approach and said "If you do decide to go to London you must let us know, we would be worried about you."

People told us that their privacy was respected, one person said "I like my own space and the staff respect that." A staff member told us that "Respecting people's privacy and allowing them to have their own space is very important," the registered manager said "We always respect people's wishes." We observed that people were suitably dressed in clothing that was clean and of their choice. Personal information was stored in a locked filing cabinet and staff demonstrated a good understanding of the need to protect people's confidentiality. One staff member told us, "One person is really interested in what's going on, she enjoys personal information about other people and staff so we have to be really careful, I always try and change the subject, I know I can't tell her about other people's business."

The provider told us that everyone living at St Andrews Lodge had a care co-ordinator involved with their care and that they advocate on behalf of individuals. Some people had regular visitors and staff told us that there were no restrictions on relatives or friends visiting although they preferred people to let them know when they were coming so that they could let the individual know and prepare them for the visit.

Requires Improvement

Our findings

We found that St Andrews Lodge did not provide care that was consistently responsive to people's individual needs.

Care records did not contain sufficient detail to ensure that staff could provide care consistently. Care plans were based upon the assessments that had been completed by other health care professionals. For example the information provided in an assessment by the Community Mental Health Team had been transferred directly into the care plan for staff to work to. This meant that there were some broadly defined goals, but there was little detail about how staff should work with the individual to achieve these goals. Some care plans had not been updated for a considerable time, for example one care plan was dated 6-10-2002 and had a written note saying that it had been reviewed 6-6-2014 but no changes had been made. This meant that the care plan had remained the same for 12 years. Other care plans we looked at had similar review notes for example "neglectful of bedroom, and obstructing communal areas with belongings," however there was no indication that the care plan had been amended or supported changes in any way as a result of the review.

Care plans were not personalised or detailed enough to ensure that staff knew how to provide personalised care and were not thorough enough to reflect peoples' choices or preferences. There was no indication of how the person perceived their mental health needs or what might indicate a decline in their mental health or any triggers associated with this. Although it had been recorded that some care plans had been reviewed we saw no updates to the detail of the plans and information had remained the same therefore we were not assured that this reflected people's current needs. Daily recording lacked detail about the support that people had received, lacked information about people's mental health presentation and was mainly task focussed for example, "Prompted with personal care" and "Played dominoes" and "Went for annual health check" .This lack of detailed recording meant that people's assessed needs could not be accurately reviewed which included maintaining any mental health needs. Staff told us that the care plans lacked detail, one staff member said, "The care plans only give the basic information, it's because I know them (the people) well that I understand them." There was a lack of information about individual's personal life history, preferences, dislikes, faith needs, interests or aspirations and this meant that care plans were not personalised and lacked the voice of the individual. There was no indication about people's day to day routine or how they wanted to spend their leisure time, for example one care plan stated that the person "Likes to have a plan for the week" but there was no such plan included. This meant that records did not show peoples individual preferences or aspirations nor how these would be met.

Engagement with meaningful activities can help people feel valued, develop or maintain skills and provide structure in their day. For people with mental health needs engagement with activities can provide stimulation and promote well-being. Some people at St Andrews Lodge were able to go out alone but others were at risk of social isolation and loneliness. Where people were able to follow their interests staff told us that this was with the support of other agencies, "A worker from Community Mental Health Team (CMHT) supported [person's name] to attend the club to begin with, we haven't got the staff to do it. Now they can go on their own or with their friend." Some people told us that they could only go out if their friends or family took them. People who did not have a social network told us that they were reliant on staff to support them if they needed to go out but that having only one person on duty made this difficult.

Two staff members told us that one person didn't speak, one said, "They don't speak because of their mental health illness" another member of staff said, "I assess how they are feeling by using gestures and body language because they don't understand much English." The registered manager also commented that this person wasn't likely to talk to us and was very surprised to learn that they had spoken to us about their personal interests and their country of origin. Not only was most of this information not recorded or known about by the staff team it was clear that people were unaware that they were able to have a meaningful conversation with this person. This showed that staff were not responsive to this person's needs. Staff told us that this person spent most of their time alone, "just staring at the wall," and we observed this. Other people we spoke to said that they spent most of their time watching TV. One person told us that they liked singing and listening to hymns. However, they was not able to attend a church because they needed staff support to do so. There was no indication of this in their care plan. Another person told us that they liked horseracing and sport, this was not recorded and the registered manager told us she was unaware that people had these interests. Throughout the inspection we observed that most people remained in their rooms and they appeared bored, unmotivated and lacking in worthwhile stimuli. This meant that people were not being supported to follow their interests.

We saw no information about any planned activities in the home, and staff told us that people didn't want to go out as a group so there were no organised outings. Staff told us that there was a Christmas party planned for the next day. The activities record book showed that the only activities that people had taken part in over the previous 12 months were two board games. People's comments about these activities were also recorded in the activities book- these included "10/10 "and "I really enjoyed the game." Staff said that people looked forward to playing these games every day. One person cooked the evening meal for everyone and they said that they enjoyed having something purposeful to do. Staff told us that they engaged people in other household chores however we did not see evidence of this during our visit and this was not detailed in any care plans.

Due to the lack of personalisation in care plans people did not receive personalised care and support based on their assessed needs which reflected their preferences or wishes, we have identified this as a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There had been no complaints recorded this year. People we spoke to said that they had no complaints but that they would feel comfortable to speak to the registered manager if they did have any concerns. We did not see the complaints procedure but the registered manager told us that she dealt with any issues as soon as they arose.

Requires Improvement

Our findings

People and staff spoke highly of the registered manager saying that she was kind, caring and approachable. However we found that the service was not consistently
well–led.

On our arrival the registered manager told us that she was currently on planned leave since September 2015 and had come in to assist with the inspection. The staff rota for the previous four weeks showed the registered manager marked as absent on maternity leave. We asked how her role was being covered and she informed us that one member of staff, who had been employed as a care worker, was undertaking her role and had been working closely with her prior to her leave to learn the job. The registered manager had not formally notified CQC of her absence or of the management arrangements that had been put in place during her absence. The registered manager initially told us that this was an oversight. Subsequent to the inspection the registered manager informed us that although she had reduced her hours significantly she had remained involved in the day to day running of the home throughout her planned leave. She provided us with dates when she had attended meetings and appointments with the people living at St Andrews Lodge and said that she had not been absent for more than 28 consecutive days and therefore did not need to formally notify CQC of her absence. She said that the rota did not accurately reflect her continued involvement with the home and that she would amend this. The registered manager had significantly reduced her hours and although she was able to demonstrate that she had remained involved in some aspects of the running of the home, the arrangements to cover in her absence had not provided consistent visible leadership. The member of staff who was left in charge had no management experience and had received no training to equip them to undertake the necessary tasks required. The registered manager had failed to identify and address the lack of staff supervision, failed to address concerns relating to people's individual needs, there had been an absence of consultation and a deficiency in driving continuous improvements.

There were no systems in place to monitor or analyse the quality of care delivered and although some reviews of care plans had taken place before the registered manager's leave commenced, there was no evidence that there was an ongoing process of review to determine the effectiveness of care plans. No adjustments had been made to update care plans, sometimes for many years and recording in daily records lacked the detail needed to effectively review how people's needs were met, suggesting that there was not an effective system in place to audit and evaluate care delivery. We asked how people are encouraged to give feedback about the home and the provider told us that the registered manager used a questionnaire to

gather feedback from people, family members and visiting professionals such as social workers and health professionals. Results of a questionnaire were on display on a notice board in the hallway however the responses were dated 2007 and we did not see any other more recent responses.

The homes statement of purpose and a number of policies and procedures were not up to date and did not reflect legislative changes. For example the safeguarding policy had not be updated to reflect the current Pan –Sussex arrangements, the home's fire risk assessment had not been amended to reflect the new policy that there should be no smoking inside the house and other policies had a note attached dated 30-6-2015 stating under review. The registered manager told us that she was aware of this but due to her planned leave had not had time to update the information. This meant that staff did not have the most up to date information to guide them.
There were shortfalls in standards of record keeping and general cleanliness around the house which may have been a consequence of a lack of staff time available. The arrangements to cover for the registered manager's leave failed to provide adequate managerial oversight and these issues had therefore not been addressed. There was not an adequate process for assessing and monitoring the quality and safety of the services provided. These matters were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were no plans to increase staffing levels through recruitment, but the registered manager told us that she intended to increase her hours again and her plan included bringing a child onto the premises. The registered manager was not clear about how this situation would be assessed for any risks including when there was only one person on duty nor whether this was in line with the legal responsibilities as a registered provider or met their insurance conditions. We have asked the provider to keep us updated on this situation.

We spoke with staff about whistleblowing but they had not heard this term before and were not aware of any policy around this. Whistleblowing is the term used when someone who works for an employer raises a concern about malpractice, risk (for example about patient safety) wrong-doing or possible illegality, which harms, or creates a risk of harm, to people who use the service, colleagues or the wider public. Registered providers should have a policy that states to its workers the correct pathway to follow if they have a concern about the organisation.
We recommend that the provider considers the advice of the Public Concern at Work charity who offer support to employers in developing a whistleblowing policy.

One member of staff had a good understanding of the new Duty of Candour and was able to describe their obligations if mistakes were made. The registered manager had developed good links with the GP surgeries and the local community mental health centre. A health care professional told us that the staff were proactive in ensuring that people maintained these links. They also said that the registered manager had a good knowledge of each individual.

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Due to the lack of personalisation in care plans people did not receive personalised care and support based on their assessed needs which reflected their preferences or wishes

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent There was not a clear process in place for ensuring that people's rights were protected when consenting to their care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There was not a robust system for assessing, recording and mitigating risks to people's health and safety

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance

There was not an adequate process for assessing and monitoring the quality and safety of the services provided and there was not adequate managerial oversight

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed the provider was not following safe recruitment processes for everyone employed to ensure the safety of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff received appropriate induction, supervision and training