St Andrews Lodge

St Andrews Lodge Care Home

Inspection report

24 St Andrews Road
Paignton
Devon
TQ4 6HA

Tel: 01803559545

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

St Andrews Lodge Care Home is a care home for people who are experiencing severe and enduring mental health conditions. The home provides accommodation, personal care and support for a maximum of 21 people. People who live at the home receive nursing care from the local community health teams.

The home did not have a registered manager, although, at the time of our inspection, one of the providers was in the process of applying to become the registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This inspection took place on 9 and 10 August 2016 and both days were unannounced. At the time of our inspection there were 19 people using the service. This inspection was the home's first comprehensive inspection following a change in their registration.

The people living at St Andrews Lodge Care Home ranged in age from, 27 to 72 years old. Some people were more able than others, with six people requiring personal care and some people had needs relating to their mobility. Almost every person had needs relating to their mental health conditions and some required support in relation to alcohol and substance abuse. A number of people required support in relation to their behaviours which presented risks to theirs and others' safety.

People who lived in St Andrews Lodge Care Home were not always safe. People had been exposed to harm from others whilst living in the home. People living in the home expressed concerns about this, with several people telling us they did not feel safe at the home. Where people had been harmed by others, staff had not always identified these as significant incidents, had not taken sufficient action to protect people, and had not reported them to appropriate agencies such as safeguarding or the police.

Appropriate action had not always been taken to protect people from the risk of harm. Risk assessments were sometimes not completed, or were very basic and did not instruct staff on how to minimise or manage risks. This included risk of suicide, risk of falls and risk of harm to self and others.

Decisions relating to the management of some risks were not always made in conjunction with outside professionals where required. It was not always clear how some decisions had been made, and some decisions that had been made exposed people to increased risk. For example, the decision not to monitor one person who was at risk of causing harm to themselves. This decision was not discussed with the registered provider, any outside professionals and no other protective measures were put in place to safeguard this person.

Staffing levels at St Andrews Lodge Care Home were not adequate to meet the needs of the people living in the home. During the day there were two members of care staff and the registered provider caring for the

needs of 19 people. During the night there was one member of waking staff and one sleeping staff. People told us they felt there were not enough staff. People said "Staff sometimes are not always around" and "Sometimes you can't find them". Some staff raised concerns about the staffing numbers stating they felt these were unsafe. During the day staff had to tend to some people's personal care needs, support people with any outings, appointments and activities, spend time with people and prepare all the meals for the home.

People at the home were not protected from discrimination and we identified concerns relating to the culture in the home. People were not always treated with respect and some comments used about people were degrading.

Staff had been using a behaviour management technique inappropriately in relation to one person. Where this person displayed behaviours, such as being verbally aggressive, staff instructed them to go to their bedroom for a 'time out'. This technique, whereby a person is encouraged to manage their own behaviour through quiet reflection and time alone, was in this case used as a punitive measure and did not demonstrate respect for this person or their rights.

Staff did not have a good understanding of the Mental Capacity Act 2005 (MCA), and relevant mental capacity assessments and best interests decisions had not been completed. Blanket restrictions were applied to people without any reference to the individuals lacking the capacity to make the decision. Where people did lack the capacity to make certain decisions, there was no evidence of decision specific best interests decisions being made. Some of these rules were unnecessarily restrictive and qualified as restraints under the MCA.

People did not receive care which was person centred and reflected their individual needs. People were not involved in the planning of, and decisions about, their care. People's care plans did not contain sufficient detailed information for staff to meet people's needs. For example, where people had specific needs relating to their behaviours, staff did not have information about what triggered these behaviours in people, how they presented themselves, how they should best communicate with people and what actions to take to distract or manage people.

There were restrictive practices in relation to access to hot drinks. The registered provider had organised for 'tea rounds' to be conducted several times during the day and people had been instructed not to ask for hot drinks outside of those allocated times.

People's support did not encourage development or recovery. People did not have personal goals they were working towards or plans to develop new skills or regain skills. Actions relating to improving people's well-being or ensuring people felt comfortable in their home, had not been identified or acted upon.

The systems in place for assessing and monitoring the quality and safety of the care at the home had not been effective in identifying the issues we found during this inspection. There was a lack of oversight in relation to risks and protecting people from abuse. Records for people were not always accurate or up to date.

People spoke highly of the registered provider and felt they were approachable and would listen to concerns. People told us they enjoyed the food and we saw some nice interactions between people and staff.

There were safe processes in place to manage the administration, storage and disposal of medicines and

there were safe staff recruitment processes in place.

In light of some of the significant concerns we identified relating to people's safety, we made alerts to the local safeguarding team. Since the inspection the local safeguarding team, the local authority and commissioners have been working with the provider.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not always being protected from harm and people's records not always being accurate or up to date. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Inadequate' and the service is therefore in special measures. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

Following the issuing of this report we served the provider with a notice to cancel their registration. The provider made representations in respect of this which were reviewed by an independent person within CQC. They upheld the notice of proposal. The provider did not take up their right of appeal to a tribunal so the notice took effect and the provider's registration was cancelled as a result.

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.

People were not protected from physical abuse, discrimination and risk of harm.

Action was not always taken to respond to identified risks.

There were insufficient staff on duty to respond to people's needs.

There were safe processes in place in relation to the management of medicines.

Is the service effective?

Inadequate

The service was not effective.

People had their rights restricted and staff used punitive and unnecessary control to manage one person's behaviours.

Decisions were made for people without either their consent or best interests decisions taking place, because of a lack of understanding of the Mental Capacity Act 2005.

Staff did not have the training and skills needed to meet the needs of people who lived in the home.

People enjoyed the food

Staff received regular supervision and yearly appraisal.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff did not always demonstrate respect towards people.

People's wellbeing was not valued and staff did not take action to improve this.

We observed some positive interactions between people and

staff.

People's privacy was respected.

Is the service responsive?

Inadequate

The service was not always responsive.

People did not always receive care which met their individual needs.

People's care plans and risk assessments did not provide staff with sufficient information to meet people's needs.

People did not benefit from sufficient meaningful activities which reflected their interests.

People were not supportive in a way which promoted development, independence and recovery.

There was a complaint policy in place and people felt comfortable raising concerns.

Is the service well-led?

Inadequate

The service was not well led.

The systems the provider had in place to assess and monitor the quality and safety of care had not identified the concerns we found during our inspection.

The culture at the home did not demonstrate respect for people, their wellbeing or their safety.

People's records did not contain up to date and accurate information.

People spoke highly of the registered provider.

The provider sought feedback from people, relatives and staff in order to improve the service.

St Andrews Lodge Care Home

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection visit took place on 9 and 10 August 2016 and was unannounced on both days. The inspection was carried out by one adult social care inspector and a specialist advisor on the first day and one adult social care inspector on the second day. The specialist advisor who supported the inspection had specialist knowledge in the care of people with mental health diagnoses. Prior to the inspection we reviewed the information we had about the home, including notifications of events the home is required by law to send us.

We spoke with almost all the people who lived in St Andrews Lodge Care Home. On this occasion we did not conduct a short observational framework for inspection (SOFI) because most people were able to share their experiences with us. But we did use the principles of this framework to undertake a number of observations throughout the home. This helped us understand the experiences of people when they were not able to communicate with us. We spoke in depth with six people who lived in the home, the registered provider and five members of staff. We also obtained feedback from three healthcare professionals about the home and people's care.

We looked around the home, spent time with people in the lounge, in their rooms and in the dining room. We observed how staff interacted with people throughout the inspection and spent time with people over the lunchtime and evening meals. We looked at the way in which medicines were recorded, stored and administered to people and reviewed the processes in which people's monies were managed.

We looked in detail at the care provided to seven people, including looking at their care files and other

records. We also looked at some records relating to a further three people. We looked at the recruitment and training files for three staff members and other records in relation to the operation of the home, such as risk assessments, policies and procedures.

Inadequate

Is the service safe?

Our findings

During our inspection we found people who lived in St Andrews Lodge Care Home were not always safe. We found concerns relating to the management of risks to people's welfare, inadequate staffing levels, and issues relating to safeguarding incidents not being reported as necessary, to help keep people safe.

People had not been adequately protected from violence, aggression or self-harm. For example, one person displayed behaviours which posed risks to others. People and staff had experienced harm because of the actions of this person. People said they were frightened and sufficient action had not been taken to protect them. The registered provider had requested this person be reviewed by the mental health team; no other actions had been taken to protect people. For example, no plans or instructions were in place to assist staff in supporting this person and protecting others from these behaviours. Staff did not have information about how to recognise triggers and signals of these behaviours or what actions to take to prevent these. Following our inspection a safeguarding referral was made and people's care needs were being reviewed.

One person had a significant history of suicide attempts and self-harming at identified times. Staff had been instructed to check this person every hour during these times. Staff did not have any guidance on what actions they should take should the person display any self-harming behaviours, how the person would present or what the triggers to these behaviours were. Staff told us they checked this person to see whether they were experiencing high anxiety but told us they did not know specifically how this person exhibited anxiety. One staff member said "I know general signs. I don't know specific triggers". Staff told us they had not been given any guidance on what to do should they find the person had self-harmed or was highly anxious apart from basic first aid training and challenging behaviour training.

One week after this person's move into the home staff started asking the person whether or not they wanted to be checked during the night. This was confirmed by staff and the person's records. On some occasions they stated they did not want to be checked and on others they asked to be checked less regularly. Staff respected the person's choices without assessing the risk to the person. One member of staff said "Staff are not checking him at night because he doesn't want to". Staff did not seek advice from outside healthcare professionals about this action and did not put any other protective measures in place to ensure this person's safety. Following our inspection this person harmed themselves.

Other risks to people were not always well managed. For example, one person had suffered a fall which had resulted in a head injury prior to moving into the home about three weeks prior to our inspection. Following their admission to the home this person suffered a fall from their bed. No action had been taken to understand what was causing the falls, or to minimise the risk of this person falling again. A GP had not been contacted and the person's mobility had not been medically reviewed. The registered provider told us they had not thought about introducing measures to prevent them from falling again or seeking further advice from external healthcare professionals. One staff member told us they were not aware this person had fallen and did not have specific instructions on how to reduce risks to this person.

People's bedroom doors had a latch system which enabled people to lock their doors from the inside. Once

locked from the inside, staff did not have the means to unlock the doors from the outside. This presented a risk to people in the possible event of a fire or a person harming themselves. Following our inspection we made a referral to the local fire service as we had concerns about people's safety. Although the fire service informed us of some good practice at the home in relation to fire safety, they attended the home and requested the provider remove the locking system on the doors. The provider ensured this was completed.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection we received information of concern in relation to people's safety, the management of people's money and the management of medicines. These concerns have been shared with the local safeguarding team.

Action was not taken to safeguard people from the actions of others. Incidents were not reported to the safeguarding authorities as they should be to help protect people from harm. Records, including people's daily notes (communication sheets), showed that people had been kicked in the chest, been punched in the face, had cups of tea and buckets of water thrown over them by other people living in the home.
Staff told us they had received training in safeguarding and knew how to recognise harm or abuse and how to report it. However, staff were not recognising these incidents as harm or potential abuse and had not been reported them as required. The processes in place were not effective in protecting people from abuse or ensuring incidents were reported and appropriately investigated. The registered provider told us incidents were recorded within the accident and incident book, which they reviewed once a year to look for patterns and trends. We found, however, that incidents were not always being recorded in this book, and therefore the registered provider was not always aware that people were being harmed and not being safeguarded. This meant the systems and processes in place to prevent, act on and report abuse were not effective.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staffing levels at St Andrews Lodge Care Home were inadequate. During the day there were two members of care staff and the registered provider working to support people and prepare all meals. At night there was one member of waking staff and one sleeping staff. The home had very recently gone from accommodating 14 people to accommodating 19 people. In response to this the registered provider had recruited a housekeeping staff member who worked 16 hours a week. Staff told us a cleaner had been hired to work 16 hours each week around three weeks prior to our inspection, however, care staff numbers had not been increased.

A number of people living at the home displayed behaviours which posed a risk to themselves and others. Six people also required differing degrees of personal care and one person was non weight bearing. Some people at the home were independent and could come and go as they pleased but others relied on staff support to take part in activities, take trips out of the home for leisure or to complete errands. Staff were also required to manage challenging situations in the home between people as well as providing people with

support to manage their anxieties. Care staff prepared all meals for people during the day and acted as some people's key worker. This entailed staff spending one on one time with people, reviewing their care plans, making phone calls and supporting people with medical appointments during their shift.

If one person required one to one assistance from staff at any point during the day or when staff prepared meals, this would only leave one member of care staff and the registered provider to care for 18 people.

People told us there were not enough staff. People said "Staff sometimes are not always around", "I think they could do with one more" and "Sometimes you can't find them".

Staff told us there were restrictive practices around times people could have access to hot drinks because of the number of staff that were available. One member of staff expressed significant concerns to us about the staffing levels and told us they felt they were unsafe. They said "With two staff you can't keep an eye on everyone. I'm concerned that something serious will happen". We spoke with the registered provider about the staffing levels and they had a tool they used to calculate staffing numbers, however, they had not used this to review staffing numbers following new admissions to the home. They told us they would review the staffing numbers following our inspection.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

For some people staff had sought advice and support from external agencies to respond to specific risks. For example, one person could display behaviours which could put themselves and others at risk. The registered provider had organised a smoking ban within the house and had sought guidance from the person's GP and other specialist healthcare professionals in order to work with the person to reduce the risks. This work was ongoing.

All the people who lived in St Andrews Lodge Care Home received full support from staff to take their medicines. No one was working towards being independent with their medicines. There was no evidence of this being by their own choice and the registered provider told us they would review people's development plans and discuss options with people.

People received their medicines safely and at the time they needed them. The home used a monitored dosage system where medicines were pre-packed each month by the local pharmacy. This system was designed to minimise the risks associated with medicine administration. Staff received training in the management of medicines and were supervised by senior staff until they were confident to administer the medicines without supervision. Competency forms were completed by senior staff to ensure staff followed best practice. There was evidence of safe practice in the recording, storage and disposal of medicines. Each person's medicine chart had a photograph of the person, which is good practice in the prevention of errors.

Safe staff recruitment procedures were in place. Staff files showed the relevant checks had been completed to ensure staff employed were suitable to work with vulnerable people. This included a disclosure and barring service check (police record check). Proof of identify and references were also obtained, this protected people from the risks associated with employing unsuitable staff.

Inadequate

Is the service effective?

Our findings

People who lived in St Andrews Lodge Care Home were having their rights restricted. We identified a number of concerns relating to one person being subjected to unnecessary control, one person not being protected from discrimination and blanket rules being applied to people without their consent. There was also a lack of understanding on behalf of the registered provider and staff in relation to the Mental Capacity Act 2005.

Staff had been using a 'time out' technique on one person inappropriately, without oversight or review. This person's care plan instructed staff to use the technique without any guidance on when it should be used, what alternative, less restrictive measures could be used or how to manage this person's behaviour any other way. Staff gave us mixed responses about when this 'time out' technique was being used, one telling us it was used regularly, one telling us it was very rarely used and one telling us it had not been used in a number of months. The registered provider also told us this technique had not been used for a number of months and had only ever been used to ensure the person's safety on those occasions. Records, however, showed this technique had been used in the weeks prior to our inspection and had been used in response to this person's behaviour being 'bad' and 'atrocious'. Records showed that this person had not been displaying behaviours that could pose a risk to themselves or others but had used offensive language. This was a disproportionate control measure which had been used in a punitive way. The 'time out' technique can be effective in giving a person a quiet space for them to calm down when experiencing agitation. However, this technique needs to be used as a proportionate response to a risk of harm, to the person or others, and not as a punitive measure. When discussing this person's behavioural management with one member of staff they said they would sent this person to their room and say "Spent 20 minutes in there and think about your behaviour".

One person had been the victim of a number of racist comments since moving into the home. From our observations during the inspection and records in people's daily notes we saw this person was made to feel unwelcome in the home by other people who lived there and their mental health had deteriorated since moving to St Andrews Lodge Care Home. During our inspection we observed hostility towards this person by other people. When we broached this subject with the registered provider and staff we were told the racist language used was not acceptable and people were reminded not to use that type of language. During our conversations with staff, two staff members referred to this person using an unacceptable term. The registered provider had not taken steps to seek guidance or advice relating to this situation and had not taken appropriate action to ensure this person was not subjected to discrimination at the home.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff did not have the training and skills required to meet the needs of the people at the home. Some people had needs relating to substance and alcohol misuse. Staff had not received adequate training to provide people with the support they needed in these areas and protect other people in the home with historical addictions from potentially having access to illegal drugs. The registered provider confirmed staff did not have the skills or knowledge necessary to provide the support required in relation to substance misuse. One

person had a history of taking intravenous drugs and following our inspection had suffered a relapse at the home. Staff told us they did not have any training on how to manage the needs of people under the influence of drugs. Some staff did not seem to have a good understanding of how to employ infection control procedures in relation to people who may use intravenous drugs or may have infections.

Staff had received training in the Mental Capacity Act 2005, challenging behaviour, mental health awareness and infection control. Although staff had received this training we did not always see them demonstrating this knowledge when supporting people. When speaking with us, some staff did not express a clear understanding of these areas. Staff had also received training in first aid, fire awareness and medicine management. The registered provider told us staff had access to learning resources in relation to specific mental health conditions and this was confirmed by staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most of the people who lived in St Andrews Lodge Care Home had enduring mental health conditions. These conditions may have affected their ability to make specific decisions at specific times. We therefore checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA). The 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.

We found a significant lack of understanding in relation to the MCA and the five statutory principles of the MCA on behalf of the registered provider and the staff. The five principles of the MCA include that all individuals are presumed to have capacity; an action taken on behalf of a person must be in their best interests and regard must be had as to whether an act or decision is the least restrictive of a person's rights and freedoms. The registered provider was not following these principles with regards to people who may lack capacity to make certain decisions. Blanket decisions and restrictions were applied to people without any detectable consideration of whether individuals might lack the capacity to make the decision. Where people were presumed by staff to lack capacity to make a certain decision, staff had not completed the two-stage assessment of capacity relating to that particular decision. Some people had generic mental capacity assessments within their care plans. These did not relate to specific decisions at a specific time as they should do. They were generalised, and unclear. No best interests decisions had been made following these assessments so it was not clear what the assessments related to. Restraint had been applied to people who lacked capacity without the registered provider having regard to the Mental Capacity Act code of practice. For example, the majority of people who lived in the home, including those who had been assessed as lacking capacity, did not have a key to unlock their bedroom door and therefore access it when they wanted. People's bedroom doors locked automatically when they closed the door. This was a restriction on people's freedom of movement and is defined as a restraint by the MCA. The registered provider had not followed the required process to ensure that restraint placed on people was in their best interests and was a proportionate response to risk. Other blanket restrictions which had been applied to people with no regard for the MCA related to people's access to their own money, people's access to the kitchen, access to hot drinks when they wanted them and the management of their medicines.

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 authorisation procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). If a person is under continuous supervision and control, is not free to leave to live elsewhere and does not have the mental capacity to consent to these arrangements, they are being deprived of their liberty. An application must be made to the local authority for legal authorisation. Some people who lived in St Andrews Lodge Care Home were under constant supervision and control and were deprived of their liberty to leave the home on their own. The registered provider lacked full understanding in this area, evidence of this is that they had had made an application for one person to the local authority which was refused because the person had mental capacity for the relevant decisions. The registered provider had made an application for a different person which had been granted.

This was a breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person was subject to a community treatment order, under the Mental Health Act 1983. The registered provider was knowledgeable about this.

Practices at the home in relation to access to hot drinks did not promote person centred care and did not meet people's individual needs and preferences. Hot drinks were only provided to people at certain times, and the kitchen was locked outside of those times through the day and during the night. The registered provider had organised for 'tea rounds' to be conducted several times during the day and people had been instructed not to ask for hot drinks outside of those allocated times. This message was reinforced during a 'residents meeting'. Staff told us some people had kettles as well as tea and coffee making facilities in their rooms, where they had been risk assessed as being able to. However, people were required to purchase these items, including tea bags and coffee, themselves. Where people were not able to have these items in their rooms, staff told us they could ask for hot drinks outside of the set times. This contradicted the message given to people during the 'residents meeting' and when we observed a person asking for a cup of tea on the day of our inspection this was not provided for 25 minutes, after the person had asked three separate members of staff.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we observed the lunchtime and evening meals on the first day. People were very complimentary of the food with comments such as, "That was a lovely dinner" and "You can never complain about the food here". On the first day of our inspection a person who lived in the home and who was interested in cooking had been supported to prepare the lunchtime meal. This meal consisted of pie, potatoes and vegetables. People enjoyed the meal in the dining room or in their bedrooms depending on their preferences. Cold drinks were available throughout the day, with a jug of squash being on display in the dining room for people to help themselves from. Staff had sought some people's preferences in relation to food and there was a list of these in the kitchen, however, this list only contained 16 names and there were 19 people living in the home.

Staff were encouraged to progress and some were working towards diplomas, such as National Vocational Qualifications. The registered provider had not yet introduced the care certificate but told us they planned to review this.

Staff received regular supervision and annual appraisal. During supervision, staff had the opportunity to sit down with the registered provider to talk about their job role and discuss any issues and further training wants and needs.

There was evidence the registered provider and staff regularly sought advice from external healthcare professionals for some people. There was evidence people had met with GPs and social workers. Staff discussed with us how they had referred one person to a specialist healthcare professional for a specific condition to be monitored.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with respect. We identified concerns relating to the language used about one person in their records.

Records showed that staff regularly used descriptors to describe people in ways which were not respectful. For example, staff had referred to people in their daily notes as being 'annoying', 'well behaved', clingy' and 'bothering'. This did not demonstrate respect for this person. We spoke with staff who again used those terms when speaking about this person with us. We raised these concerns with the registered provider who told us they would raise it with their staff. Staff spoke to use about other people in disrespectful terms. For example, calling one person a 'nightmare' and 'spoilt'. One member of staff stated that if they gave people everything they wanted then "you would have lunatics taking over the asylum".

Staff did not always show respect for people's experiences and well-being. One person was regularly being insulted with racial slurs and was made to feel unwelcome in their home by other people. When this was discussed with staff they told us the person 'goaded' people and at times it was 'half of one and half a dozen of the other'. One member of staff stated this person 'played the race card'. There had been no action on behalf of staff or the registered provider to improve the situation for this person or spend one on one time with them to improve their well-being. Staff regularly told people not to use offensive language but had not sought to mediate or promote harmony within the home.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People spoke highly of the staff. Comments included "I haven't been this happy in ages, the staff and the residents are nice" and "I get on with all the staff here".

The atmosphere in the home was warm and welcoming and we saw plenty of pleasant conversations, laughter and warmth between people and staff. The décor in the home lacked homeliness. It did not pay respect to people as individuals and this being their home. For example, there were no personal photos of people, artwork or items which demonstrated people's personalities. On the second day of our inspection a picture a person had made was pinned on a notice board in the dining room. One person's bedroom contained a fridge that was being used by staff to store food for the home. The person told us staff always knocked and asked if they could get an item from the fridge but we raised the location of this fridge with the registered provider as this did not demonstrate consideration for people's personal space. Prior to our second day of inspection the registered manager had removed the fridge from this person's room.

We observed instances of staff being caring towards people and treating them with dignity. For example, one member of staff brought a person a comb so they could tend to their hair. This member of staff then joked with this person who responded to them with warmth.

One staff member had brought in a bongo drum for a person from their home so they could enjoy playing it. This demonstrated a caring attitude towards some people in the home.

Staff spoke highly of some of the people in their care, although not all of them. Staff praised some people's personalities and spoke about them in respectful ways. For example, one staff said "He is a lovely, lovely person" about one person who lived in the home.

People's privacy was respected. For example, staff knocked on people's doors before entering and people received personal care in private.

Inadequate

Is the service responsive?

Our findings

We identified concerns relating to people not receiving person centred care which encouraged development and promoted recovery. We also identified concerns relating to people's care plans not reflecting their needs and people not having access to activities which promoted their wellbeing.

People who lived in St Andrews Lodge Care Home had not been fully involved in the planning of their care and risk management. People had signed their care plans to state they consented to them but these were very basic and did not contain detailed, personalised information about people's specific needs. Where people had specific needs relating to their behaviours, staff did not have information about what triggered these behaviours, how they presented, how they should best communicate with people and what actions to take to manage these behaviours. People's risk assessments were brief and it was clear people had not been involved in discussions around the best ways to minimise risks. People's risk assessments were not personalised and did not contain any information about how people themselves may wish to be supported. Staff told us they had a basic understanding of how to deescalate situations but did not have any specific knowledge or guidance in relation to each individual. When asked about how a member of staff supported one person to become more calm when they got anxious or agitated they said "I don't know I act on instinct, talk to him calmly. If it was serious, I would call the manager and call the police, however I've had no guidance".

People's support did not encourage development or recovery. People were not working towards becoming more independent with their medicines, their finances, their cooking or other household tasks. There were no plans for people to develop new skills relating to new activities or subjects they enjoyed and no personalised goals for people to work towards. We discussed this with the registered provider who told us they would look to review people's plans to introduce some development plans and personalised goals for people where they wanted these.

People's care plans did not reflect their needs and had not been updated when their needs changed. For example, one person's mental health had significantly declined following their admission to St Andrews Lodge Care Home; however their care plan did not reflect this. This person's care plan stated they had a history of being verbally aggressive towards others but did not state they had ever been physically aggressive towards others. In the weeks following their admission this person had demonstrated physical aggression towards others on numerous occasions. This person's care plan had not been amended to reflect this change and neither had their risk assessments. The registered provider had referred this person to the local mental health team in order to request a review of their needs and to the GP to conduct a review of their medicines. These reviews had not yet been completed and staff had not been provided with any updated guidance on how to meet this person's needs and protect them and others in the meantime.

Although some work had gone into improving activities for people, these were not sufficient to ensure people had access to sufficient activities to meet their needs and preferences. The majority of people at St Andrews Lodge Care Home spent the day in their bedrooms, with a few coming and going independently. People had not been individually assessed as to what they enjoyed and would like to do. Plans were not

devised for people as to how their preferences and interests could best be met. There was very limited information within people's care plans about their hobbies, interests, likes or dislikes. People who lived in the home ranged in ages from 27 to 72. Where people did not have interest in taking part in quizzes or going on a trip for a coffee, there were few alternative options. Staff had not organised for people to take part in organised exercise activities, organised music or art sessions for example. People did not own mobile phones or portable computer equipment to access the internet or make contact with their loved ones. People were able to access the home's laptop on occasion should they specifically ask to use it. The registered provider told us they had not considered this and would involve people in a discussion about internet access and communication following our inspection.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had purchased a mini bus in order to take people out of the house for trips. These trips were offered to everyone but only very few people took part. On the morning of our inspection three people went to Torquay and to Teignmouth for a trip out. Those people told us they highly enjoyed this. The registered provider had asked people during a 'residents meeting' what activities they would like to see take place in the afternoons but the suggestions had not been very forthcoming. This meant the regular activities which took place in the afternoons were quizzes. During the afternoon the same group of people who had been on the trip out, along with one other, took part in a quiz game with staff. Staff told us they regularly held quiz games in the afternoons with people but told us only a maximum of four people ever participated. Very limited numbers of people took part in individual activities, with one person going to a day centre, one going night fishing on their own and one taking part in cooking and baking. Those people were supported to take part in their preferred activities. The home had a garden at the rear of the house as well as an area outside the front people could use. People made use of this and spent time coming in and out as they pleased.

The home had a complaints policy in place which people could access. People were encouraged to make complaints if they wanted to and felt comfortable doing so. People confirmed the registered provider was approachable and would listen to their concerns if they had any. No complaints had been recorded for over a year. The last complaint had been investigated and action had been taken to the person's satisfaction.

Inadequate

Is the service well-led?

Our findings

During our inspection we identified concerns with the effectiveness of the systems in place to monitor the safety and quality of care at the home. We also identified concerns with the values embedded at the home, the lack of action taken to rectify these and concerns relating to the accuracy of records within the home. The provider had also failed to refer incidents and allegations of abuse to the Care Quality Commission as required.

The previous registered manager had left the service in April 2016, since that date the registered provider had taken on the day to day management duties at the home. At the time of our inspection the registered provider was not yet registered as the registered manager with. The Commission but was in the process of applying. The registered provider had completed their level five diploma in management for health and social care. They did not have any qualifications or specialised training in caring and supporting people who lived with mental health conditions or substance and alcohol misuse.

The systems and processes at the home to monitor the safety and quality of care had not been effective in identifying the concerns we found during our inspection. For example, the process in place for monitoring the incidents in the home consisted of the registered provider reviewing the accident and incident book once a year. We found, however, that staff were not recording significant incidents within this book and therefore the system in place to identify patterns, trends and risks to people's safety was not effective. Out of 10 incidents we found recorded within several people's daily notes (communication sheets), only one had been recorded in the accident and incident book. Some of the incidents not recorded within the accident and incident book related to people being kicked in the chest, people being punched in the face and people having cups of tea and buckets of water thrown over them. None of these incidents had been reported to safeguarding or had been identified by staff as being harm or abuse. The registered provider told us they did not have knowledge of a number of these incidents due to the lack of appropriate recording. This meant they did not have clear oversight of the safety of people in the home or oversight of their care needs.

The registered provider had recently admitted five new people to the home within a short space of time. The registered provider had been provided with very basic information about people's care needs which did not highlight potentially significant risks. The registered provider had requested further information be shared with them but had not pressed this or ensured their request was fulfilled. This meant the registered provider and staff knew very little about some of the people they were supporting. Following our inspection we, alongside the registered provider, discovered one person had a different diagnosis to what was recorded in their care plan and had significant risks the home was not aware of. This demonstrated the lack of oversight the registered provider had over the needs of the people in the home in order to meet these needs and ensure people's safety.

We found people's risk assessments and care plans did not contain up to date information about their care needs and risks. The quality assurance systems in place at the home had not identified this although a completed 'quality assurance checklist' showed risk assessments and care plans had been checked monthly and there were no actions to complete following those checks. This demonstrated the regular quality

assurance checks at the home had not been effective in identifying issues or acting on these.

The culture at the home did not promote people's dignity, independence, respect, equality or safety. We identified concerns relating to some behaviours and practices amongst the staff team. People were not always treated with respect and some comments used about people were degrading. Staff had also failed to highlight significant incidents of aggression and racial abuse to the registered provider or to other external agencies such as safeguarding or the police. This indicated a negative culture at the home where some poor practice was seen as normal. The registered provider did not have effective systems in place to keep the culture of the service under review and did not take action to challenge staff attitudes and behaviours. This put people at risk of being discriminated against, having their rights violated and being exposed to harm.

People's records were not always accurate or up to date and therefore the provider was unable to assure themselves people were receiving the care they required. For example, people's care plans, risk assessments and behavioural charts were not up to date. One person's care plan stated they required regular repositioning during the night in order to protect their skin integrity. We asked staff and the registered provider about this and they told us this was no longer required since the person was now sleeping in their bed instead of in their chair.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Incidents of abuse or allegations of abuse had not been notified to the Care Quality Commission in line with requirements.

This was a breach of regulation 18 of the Care Quality Commission (Registration) Regulations 2009

People spoke highly of the registered provider, with one person saying of the registered provider "He's lovely that man". Staff told us the registered provider was approachable and would listen to any concerns they had. People told us they were comfortable raising concerns with the registered provider and felt these would be taken seriously.

The registered provider sought feedback from people, staff and healthcare professionals in order to improve the service. 'Residents Meetings' and staff meetings were held every two months and during these meetings people and staff were asked for their feedback and their views. Staff told us the registered provider regularly asked them for their opinions and ideas on how to improve the service. People, staff and healthcare professionals were sent yearly questionnaires to complete. These questionnaires were reviewed by the registered provider who told us they took action to respond to concerns raised. During the previous questionnaires both staff and people had complained about staff spending too much time cleaning the home and not enough time with people. A number of months after these were analysed a housekeeping member of staff was recruited to work 16 hours a week.

Audits were undertaken to ensure the home was safe. For example, kitchen inspections, medicine audits and infection control audits had been completed. Where issues had been identified these had not always been recorded as being completed but staff confirmed they had been. For example, staff confirmed that although records showed no action had been taken to repair a leak in a pipe in the kitchen, this had in fact been repaired.

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 18 Registration Regulations 2009 Notifications of other incidents The provider failed to notify the commission of abuse or allegation of abuse in relation to a service user. Regulation 18 (1)(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People were not involved in the planning of their care, people's care was not designed with a view to meeting their preferences and ensuring their individual needs were met. Where people's hydration needs were met the provider did not have regard to their well-being. Regulation 9 (1)(a)(b) (c) (2)(3)(a)(b)(i) of the HSCA

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with respect. Regulation 10 (1)(2)(c) of the HSCA.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's consent was not always obtained in line

with legislation. Regulation 11 (1) of the HSCA.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected from risk of harm. Regulation 12 (1)(2)(a)(b) of the HSCA.

The enforcement action we took:

NOP to 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 People were not protected from abuse. Systems and processes were not effective to prevent abuse, incidents and allegations were not referred to relevant outside agencies. People were subject to discrimination. People were subject to acts of control and restraint which were not proportionate. Regulation 13 (1)(2)(3)(4)(a)(b) of the HSCA.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Processes in place to monitor the quality and safety of care were not effective and records were not kept accurately for each person. Regulation 17 (1)(2)(a)(b)(c) of the HSCA.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff to meet people's needs. Staff did not have the appropriate training necessary to enable them to meet people's needs. Regulation 18 (1)(2)(a) of the HSCA.

The enforcement action we took:

NOP to cancel registration