Mrs P Sewpaul

Aldwick Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 4, 5 and 6 July 2016.

Aldwick Residential Care Home, provides care and support for up to 27 people with a variety of mental health needs. At the time of our inspection there were 15 people living at the home.

The facilities consisted of two terraced houses, which had been knocked through to form one house. There was one communal dining area, one lounge, three toilets, one shower room and two bathrooms. However, there was only a hot water supply to one bathroom. The garden was unkempt and had a designated smoking area for people to use.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered provider visited the service on the second day of our visit at the request of the inspector.

The service did not have appropriate systems in place to protect people from harm. The registered manager had not ensured all staff working at the service received safeguarding training and staff were unsure of how to report issues of concern. Staff recruitment processes were not robust and the necessary checks had not been undertaken to ensure staff had been recruited safely.

Building works started at the service were incomplete. The provider had run out of funds and was unable to pay the contractor to complete the works. The building was unsafe and some rooms did not have fire detectors. There was inadequate compartmentation between rooms that would result in a fire spreading. Fire equipment had not been checked, the fire risk assessment was out of date and not all staff had been trained in what to do in the event of a fire. We contacted the West Sussex Fire and Rescue Service to report our concerns. A Fire and Rescue Inspector carried out an inspection on the third day of our visit, which resulted in two prohibition notices being served on the provider. This resulted in people needing to move to alternative accommodation within 7 days of the notice being issued unless the provider was able to make the building safe.

We also shared our concerns with West Sussex Adults Team, The Health and Safety Executive, Environmental Health and Building Control.

Staffing levels were insufficient to support people's needs and people did not always receive care and support when required.

Risks to people's health and wellbeing were not appropriately assessed and reviewed. Care plans were not sufficiently detailed to provide an accurate description of people's care and support needs.

Medicines were not managed safely. There was no system for checking the stock of medicines or to monitor the competency of staff responsible for administering medicines. Changes had been made to the prescribing instructions without evidence this was supported by an appropriate healthcare practitioner. The dates of when creams had been opened were not being recorded, this presented a risk because after the expiry date, prescription creams may not be safe or they may lose their effectiveness.

Staff were not knowledgeable about the people they supported. Staff had inappropriate experience and qualifications. In spite of their best efforts and hard work to provide care in a supportive and friendly way, they lacked experience and training. Staff had received induction training that did not provide them with the skills and knowledge to deal with the complex needs of people using the service and they were reliant on the guidance of the registered manager, who was completing a mental health awareness training. This training had not been completed and the registered manager was not certified as competent. As part of their induction training, staff had not received training in behaviour that may challenge, de-escalation techniques or mental health. This meant that they were not appropriately skilled to deal with potentially challenging and stressful situations for people as well as themselves.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care services. Members of staff we spoke with did not have a full and up to date understanding of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of adults by ensuring that if there are restrictions on their freedom and liberty these are assessed by appropriately trained professionals. We found that appropriate DoLS applications had been made, and staff were acting in accordance with DoLS authorisations. However, we found the registered manager had made decisions for people who had capacity, in their best interest without involving relevant external professionals, such as a social worker and / or advocate.

As support plans and risks assessments were not up to date potentially, people were not protected from taking unacceptable risks, including those associated with nutrition and hydration.

Although people were treated in a caring and respectful manner, staff did not always engage with people when given the opportunity. People, who used the service, or their representatives, were not always encouraged to contribute to the planning of their care.

People did not receive person centred care as the care records did not give adequate information required for individualised care.

People told us that they were not given the opportunity to choose the way that their individual and group activities would be delivered.

Key documents were missing and records not kept up to date. The support plans for people using the service were missing, incomplete or did not contain up to date and regularly reviewed information. This meant staff was not able to perform their duties efficiently.

People's views were not taken into account and used to make improvements to the service. Processes were not in place to deal with people's complaints and concerns. When complaints had been raised and reported to the registered manager, the issues raised were not responded to and acted upon.

There was no overall leadership of the service in place. The service lacked an open culture; serious incidents, which had occurred, had not been reported to the appropriate authorities in a timely way.

Systems in the service that were meant to monitor and identify improvements were not effective and records were not always maintained and completed in full. This lack of effective governance led to all people not receiving safe and consistent care.

At the time of our visit, the registered manager and provider acknowledged the shortfalls. The provider informed us they did not have the funds to make the building safe and meet the Regulatory Reform (Fire Safety) Order 2005 – Prohibition Notices, which had been served. Consequently, all 15 individuals residing at Aldwick Residential Care Home, vacated the building and were found alternative accommodation by West Sussex County Council.

Since our visit, the provider applied to voluntarily de-register their service with The Care Quality Commission to close.

The overall rating for this service is 'Inadequate' and had the provider not voluntarily applied to de-register their service, the service would have been put in 'Special measures'.

Services in special measures are kept under review and, if we had not taken immediate action to propose to cancel the provider's registration of the service, they would have been inspected again within six months.

The expectation is that providers found to be providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement had made within this timeframe so that there had of been a rating of inadequate for any key question or overall, we would have taken action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This would lead to cancelling their registration or to varying the terms of their registration within six months if they had not improved.

For adult social care services, the maximum time for being in special measures would usually be no more than 12 months. If the service had demonstrated improvements when we inspect it and it was no longer rated as inadequate for any of the five key questions it would have no longer be in special measures.

During this inspection, we found nine breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found three breaches of the Care Quality Commission (Registration) Regulations 2009.

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.

Whilst some people said that they felt safe, we found that the registered manager did not have effective arrangements to ensure risks were assessed, monitored and mitigated. This meant there were risks to people's safety, health and welfare.

Staff had not been recruited safely. Staffing levels were not sufficient and were not effective to maintain people's safety and meet their needs. People were at risk because there were insufficient qualified and skilled staff to meet their needs.

People did not always receive their medicines consistently or as prescribed. Medicine was not safely administered, or medicine records correctly completed, monitored or regularly audited.

Not all accidents and incidents had been properly recorded. The ones, that had been recorded were not analysed to identify any patterns or trends to help prevent them from happening again.

The registered manager and staff did not have an understanding of safeguarding procedures. Safeguarding referrals had not always been made to protect people.

Risks of harm had not always been managed. The environment had not been maintained to a safe standard.

Is the service effective?

Inadequate

The service was not effective.

Staff had not always received appropriate training and supervision to ensure they could perform their roles and responsibilities effectively.

Staff knowledge of the Mental Capacity Act (2005) was limited, which placed people at risk of not being appropriately supported if they lacked capacity to make their own decisions. People, were being restricted in their choices regardless of having capacity.

People were supported to access healthcare professionals.

Is the service caring?

Requires Improvement

The service was not always caring.

People's choices, likes and dislikes were respected however, staff did not engage socially with people when they had the opportunity. Staffing arrangements meant care was task focused and not focused on people.

People's preferences for the way in which they were supported were not suitably met or clearly recorded. Care was centred on people's immediate individual needs, in a re-active and unplanned way.

People were not always involved in making decisions about their care.

People's privacy and dignity was not always supported.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support was not responsive to people's individual needs. It was not evident people had been involved in planning their care.

People were not always supported to undertake social activities within the home and the broader community. Opportunities for people to follow their interests or be involved in social activities were limited.

There was no effective system in place for recording, monitoring or responding to complaints.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of managerial oversight of the service as a whole. There was a reactive rather than proactive approach by the management team, which meant that people did not receive a consistent safe and appropriate service.

The service lacked appropriate governance and risk management frameworks, which resulted in poor outcomes for people who used the service.

People were not able to provide feedback about the quality of the service and any feedback given was not acted upon.

Appropriate notifications had not been made to the CQC.

Records were not properly maintained to ensure that information was available to all staff in an up to date and appropriate format or to show that management of the service were governing effectively across the service.

Aldwick Residential 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 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 inspection took place on the 4, 5 and 6 July 2016 and was unannounced. On day one, one inspector undertook the inspection with a specialist professional advisor in mental health and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was mental health. On days, two and three, one inspector undertook the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This form asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service. This included previous inspection reports and statutory notifications. A notification is information about important events the provider and registered manager is required to send us this by law.

During the inspection, we spoke with 12 people who were living at the service. We spoke with two visiting mental health professionals, the chef, five members of care staff, a senior support worker and the registered manager. We also spent time observing people in the communal living areas.

We looked at the care plans and associated records for six people. We reviewed other records, including the registered manager's internal checks and audits, staff training records, staff rotas, accidents, incidents and complaints. Records for four staff were reviewed, which included checks on newly appointed staff and staff supervision records.

The service was last inspected on 6 January 2014 when no concerns were identified.

Inadequate

Is the service safe?

Our findings

Despite some people telling us they felt unsafe, other people told us they did feel safe. One person told us, "I feel safe because staff and residents are soft and nice". Another person told us, "Yes I do feel safe. We have staff round the clock and call buttons in our rooms".

People who lived in the service were not always protected from the risk of potential abuse or neglect. Seven of the eight staff we spoke with had not received safeguarding adults training. Staff we spoke with, although able to say they would raise concerns to their immediate line manager, were not aware of how to share their concerns with external agencies such as the local authority safeguarding team, the police or the Care Quality Commission. This meant there might be times when issues regarding people's safety would not be reported and acted upon robustly and in line with local safeguarding procedures.

The registered manager told us they understood their responsibilities to protect people and to report potential safeguarding concerns. However, we identified three safeguarding concerns, which had been reported to staff and the registered manager, but no action taken to report the concerns as potential criminal or safeguarding matters. This included allegations of financial abuse, theft of property and concerns of feeling bullied by other people using the service. These concerns had not been reported to ensure they were fully investigated in order to protect people. After day one of our visit, we notified the local authority to ensure risks to people's health and safety could be followed up. The registered manager did not have a system to prevent abuse or to investigate allegations of abuse.

The failure to protect people from abuse and improper treatment was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at the service were not always protected from risks to their safety. The risks to individuals were not always assessed when they were admitted to the home. In addition, the assessments in place did not give staff enough information on how to manage the risks to keep people safe. For example, body maps were not completed to record bruising and other injuries. Records completed each day which identified a bruise or bump did not always record how they had occurred. For example, one person was recorded as having a deep scratch on the bottom of their back, but there was no information about how it had occurred and what action should be taken as a result.

One person's assessment identified historical risk of falling. We read, 'Extreme anxiety affects mobility and balance, and loses confidence on the stairs and increased risk of falling'. The care plan stated 'Has tripped over footing in the lounge, fallen and caused injury'. There was however, no assessment of the risk of the person falling or information in their care plan to direct staff on how to support the person and minimise the risk of injury. A second person had started a fire on three occasions since moving to the home. The person's records indicated a history of fire setting in their previous placements, but there was no evidence of risk assessment or management/crisis plans to mitigate these issues. This put the person, other people living at the home and staff at risk of harm from future fires. A third person was diagnosed with type 2 diabetes but their records contained no evidence about on-going management or treatment for this condition. Although

their blood glucose readings were taken and recorded in a separate book, there was no guidance about what was considered to be normal limits, no indication about what to do if their levels were too high or low and what action staff should take to support them. Many of the people who used the service were assessed as at risk from social isolation and self-harming. They did not have risk assessments in place that provided staff with the appropriate guidance to support these risks. The registered manager had failed to thoroughly assess risks to people's health and safety and had not taken action to mitigate known risks.

Individual accidents and incidents that had been recorded had not been analysed to identify any patterns or trends to help prevent them from happening again. For example, on individual daily log records, staff had documented they had witnessed injuries from trips and falls. There was no system for recording falls. The registered manager acknowledged this practice was not safe.

The lack of risk assessment/action to mitigate risks was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment process for employing staff to work at the service. We found that the required checks were not in place to ensure that people employed were suitable and safe to work with people who used the service. Employment applications did not provide details of previous employment or education history. Gaps recorded in their employment had not been checked in any of the four recruitment files we looked at. Therefore, staff employed may not have had the relevant skills, experience and knowledge to provide the safe care and support to people and this had not be assessed through their recruitment checks. The references that we saw had not been fully completed and signed, which did not ensure they were authentic and accurate. References to ascertain proof of a person's identity and their conduct had not been checked and verified prior to employment being offered and work commencing. Therefore the registered manager could not be assured that the staff employed were of good character and had the necessary qualifications, competence and skills to provide care to people using the service.

This is a breach of Regulation 19 of the HSCA 2008 (Regulated Activities) Regulations 2014.

The registered manager had however, completed Disclosure and Barring Service (DBS) check on staff. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Staff told us that they needed more staff on duty to safely supervise and support people. They told us this particularly applied to the level of care required by a number of people who had higher dependency care needs in the morning, from the hours of 8am to 10am. They also told us this applied to peak times of the day, such as during the late afternoon and teatime. One staff member told us, "The staffing levels here are a problem; we need an additional staff member in the mornings". There were two staff who worked between 8am to 2pm and two staff who worked between 2pm to 8pm. At night time, two staff stayed awake between 8pm and 8am. The registered manager covered shifts where needed. Rotas indicated that on occasions, there was a third staff member on shift, however this was not consistent. Staff told us, this staff member had been off sick for some time, which meant there was more often than not two staff on shift. The registered manager told us, they had assessed that they knew they needed at least three staff on duty in the mornings. This further demonstrates the registered manager did not deploy the correct number of staff that they had assessed was required.

During our visit, we observed there was not enough staff to effectively meet the care and support needs of some of the people who lived at the home. We saw that staff were very busy and shifts were task orientated which meant staff had little time to interact with people and provide emotional support or social

engagement. Some people required close observation and supervision to keep them safe, for example, from the risk of falls. This level of supervision was not given due to the numbers of staff deployed. The provider told us, numbers of staff could not increase due to the financial position of the business.

We saw how insufficient staff numbers impacted negatively on people's experience of living in the home and how the risks associated with their care and support were managed. For example, at 10am people were still receiving personal care as part of their morning routine, there were two staff supporting 15 people. Due to limited hot water supply, staff had to carry buckets of hot water from others parts of the building to help people to wash. This had a detrimental impact on people wanting to start their day due to the time it took staff to obtain water on one side of the building and carry it to the other. This also meant people were unable to get up when they wanted to due to staff not being available at their preferred times.

The failure to appropriately cover peak times of the day, meant people were not kept safe from the risk of harm at this time. We saw that some people were in communal areas of the home and other people were in their bedrooms. Therefore, it was difficult for the remaining staff to observe the people who required supervision. This included a number of people who had been assessed as at a high risk of falls, incontinence, and risk of self-harming and risk of starting a fire. For example, at this time we observed a person sitting in their room, their bed was soaked through with urine. There was no staff available to assist this person to be washed and changed or to make the room clean and fresh. We observed one of the toilets had a large puddle of urine on the floor that people had to walk through to use the toilet. This was unpleasant and unhygienic but there were not enough staff deployed to address this in a timely way.

We discussed staffing with the registered manager. They told us, they knew they needed more staff but there was no a budget for this due to the provider's financial difficulty. On the second day of our visit, we spoke to the provider, who confirmed there were no finances to ensure the service worked within the safe levels needed to deliver a safe, personalised service.

The registered manager and provider had not ensured that there were sufficient numbers of suitably qualified, competent and experienced staff deployed to meet people's needs and keep them safe at all times. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected against environmental risks in the service and we identified extreme failings in the safety and suitability of the premises. The registered manager did not undertake regular audits of the environment and equipment to ensure that the premises were safe and the equipment fit for use. The building premises had incomplete building works, which had left missing parts of walls, ceilings and doors. This also left exposed flammable stud boards, lose wires and missing doorframes. The provider had run out of funds and was unable to pay the contractor to complete the works. The registered manager told us, "We have all been trying to make the best of a difficult situation, and it's the first time in over 20 years that the home has been refurbished."

People were despondent about the environment. One told us, "There is no bloody hot water, no showers, the garden is a state. It is ridiculous. If there were a fire here, it would be chaos. The stairs are dangerous, the house is crummy." Another said, "I'm [age] and I shouldn't be going through this. There are tiles missing, mould, cracked walls; I think they've (provider) left us in limbo." A third, "It's disgraceful; they've left us with no carpets, holes in walls and wires hanging out."

One mental health care professional told us they visited two people in the service. They said they had not been with the community team for long, but they felt concerned about the environment. They confirmed the

lighting in all the hallways was quite dim, the hallways were narrow and this was not good for the people living there, who are diagnosed with a mental health disorder / depression or people with mobility issues. They also confirmed that the washing facilities were not ideal for people who were already struggling with personal hygiene.

The building had been left in an extremely unsafe and unfit condition. Multiple rooms had been boarded up, some without fire detectors. There were areas where there was loose exposed wiring, holes in the walls and the carpets not secured, which were a trip hazard. There were boiler pipes exposed in some areas, within reach of people, without adequate control measures to reduce the risk of scalding. This could cause a severe burn if someone was to touch them purposely or trip or fall on them accidently. There were areas of the building with asbestos. However, there was no follow up plan to treat these areas, and the areas were accessible by people using the service because the rooms were not secured. Therefore, people were at risk of asbestos exposure if they entered one of these rooms and disturbed the asbestos. The provider had also begun to replace the carpeting throughout the home but this was also an unfinished project. This left many areas of the home, including people's bedrooms, without carpeting and unsuitable temporary flooring in its place. We observed that the lounge was very hot and had poor ventilation. When we attempted to open the window, we were told by a person living there that the windows were sealed shut for some reason and could not be opened. Multiple bedrooms had broken furniture, doors hanging off wardrobes, missing drawers and sinks that had inadequate sealing, causing damp and mould.

There had been no hot water throughout the building except to one bathroom since October 2015. The bathroom was shared between all 15 people and staff had to transport hot water from this bathroom to people's rooms to assist them with their personal hygiene. The bath was heavily stained, there were tiles missing, leaving areas of heavy mould. The seal around the toilet and floor had come away, as had the seal of the flooring to the walls. This meant staff were unable to sufficiently clean the area and as a result it was in an extremely unhygienic state and we experienced powerful malodours in this area.

There were four toilets on site - three of which were in use. The three toilets in use did not have running hot water for staff and people living there to wash hands effectively. The three toilets in use were in a very poor state of maintenance and hygiene and not fit for use. The wallpaper was peeling off. There was no seal between the toilet and the flooring. The flooring was coming away from the walls. There was no seal between the sink and the wall. The floors were heavily stained and there was a build-up of mould. Because of the poor state of sealing and repair in the bathrooms, any cleaning attempted was ineffective. There were strong offensive odours in the bathrooms.

There was inadequate compartmentation between rooms that would result in a fire spreading quickly. Fire fighting equipment, which, is advised to be checked monthly (in line with best practice guidelines), had not been checked since January 2016, the fire risk assessment was out of date and not all staff had been trained in what to do in the event of a fire. Therefore, people and staff were at risk in the event of a fire due to the safety of the premises as well as the preparedness of staff in recognising and responding to fire risks. There were also areas of the home that did not have appropriate fire detection equipment or fire doors to slow the spread of a fire. We contacted the West Sussex Fire and Rescue Service to report our concerns. A Fire and Rescue Inspector carried out an inspection on the third day of our visit, which resulted in two prohibition notices being served on the registered provider. A prohibition notice is issued by the Fire Service where the use of the premises may constitute an imminent risk of death or serious injury to the persons using them. The issue of a Prohibition Notice under the Regulatory Reform (Fire Safety) Order 2005 is the most serious enforcement option available to the Fire Service other than prosecution. As a result of this, all of the residents were moved from the premises to alternative accommodation within a week of the prohibition notice being served.

We also shared our concerns about the safety and suitability of the premises and structural integrity of the building with The Health and Safety Executive, Environmental Health and the local Building Control team.

The provider had not ensured that the premises and equipment used was clean, secure, suitable and properly maintained. The registered manager had not ensured that they had maintained standards of hygiene appropriate for the purposes they were used.
This was a breach of Regulation 15 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The medicine file had a front sheet that recorded specimen signatures and initials of staff that had responsibility for administering medicine. These sheets contained specimen signatures and initials of staff that had left and did not include those of all new staff. Because of this it was unclear who had administered medicines in the service and if they had been trained to do so.

The registered manager reported that all staff had received on the job training from the pharmacist who supplied blister pack medication to the home on how to administer medication. There was no evidence available to verify the date, time and or duration of the training.

People's medicines were not always recorded, stored and disposed of safely. There was a risk that people were not receiving the correct medicines. One person's Medicine Administration Record (MAR), recorded the person was prescribed a medication for their depression to be taken once per day. This information was crossed out, not signed dated or initialled. The dose was then hand written on the MAR by care staff as one tablet to be taken in the morning and one at night, which again was not signed, dated, or initialled by the pharmacy. The registered manager was unable to provide documentary evidence about who authorised the change to the dosage of this medicine and on what date. The medication had been signed for twice daily for over seven days without an appropriate prescription for this change in dosage. Another person's MAR recorded that they were prescribed medication for anxiety to be taken once daily. The MAR was hand written and unsigned by staff, as 'take 1 @ 9:00 and one @ 5:30pm', the registered manager showed care records as recording the medication increased by the GP on 23/4/16, this note was hand written by care staff. There was no evidence from the GP that this change had occurred, indicating a person was being given medication not as prescribed. The medicine was to help them control their mood swings.

The PRN (as required) protocols were not detailed around when people may need them and how often before guidance was sought from health care professionals around whether regular prescriptions were needed. For example, people who were prescribed a PRN anti-psychotic medication had no guidance for when the person should be offered the medication. In some examples, people were taking PRN medication on a daily basis. In that situation, there was no evidence this had been discussed with general practitioner or mental health specialist for advice on what impact this may have on someone's health, or whether this medication should become prescribed as a daily medication rather than a PRN.

Medicine was stored in a locked facility. The dates of when creams had been opened were not being recorded, and we saw one had expired in April 2016, however was still in use. This presented a risk because after the expiry date, prescription creams may not be safe or they may lose their effectiveness. There was no audit trail of what medicines had been returned to the pharmacy or when and the amount of medicines received into the service to give assurances to the staff that only the appropriate medicines were kept at the service. We observed multiple pots of medication, left in the medicines trolley and medicines cupboard, mostly with no name or note of what the medication. The registered manager informed us this medication needed to be returned to the pharmacy for disposal. Dates in one pot indicated it had been there since October 2015. There was no system in place for returning or disposing of medication routinely. The

medication had still not been returned by the end of the third day of our visit.

The registered manager had not ensured there were effective systems for the proper and safe management of medicines. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service effective?

Our findings

People we spoke with did not feel they received care from sufficiently skilled and competent staff. One person told us, "They try their best, but they don't understand me." Another person told us, "The staff treat you like bloody idiots; it's like being in a prison".

Staff told us and records stated that they had received induction training. The induction training was not based on the Care Certificate. The Care Certificate is a nationally recognised qualification from Skills for Care. This Certificate covers 15 standards of health and social care that all care staff should know as a minimum is achieved through assessment and training. The registered manager did not know it was best practice for registered managers to use the Care Certificate for induction training of staff. Therefore, the registered manager's induction training did not cover the same breadth of training as the Care Certificate requires.

The induction training provided was minimal. It included, managing medicines, fire procedures and Deprivation of Liberty Safeguards (DoLS), with little information about or focus on the individual people using the service and how their mental health needs should be met. The registered manager told us, that once the induction training is completed, staff should be supported to undertake refresher training in fire evacuation, however we identified this had not always been completed.

One member of staff told us that they did not have an understanding of the needs of people with mental health issues. Another member of staff had been working without completing all of the service's mandatory training. They also told us that they had no training or understanding of the needs of people with a mental health diagnosis and felt they could have had more training before they started work there.

Staff we spoke with who had worked at the home for a number of years told us, they had not received regular supervision. One member of staff told us they had received supervision in June 2016 but had none previously. Another told us they had been in post for two years and had received two support and supervisions. They told us they did not feel supported in their role. A lack of regular supervision for staff meant that the knowledge and skills of staff were not being reviewed regularly to ensure staff were supported and competent to provide care to people.

Staff training records showed a number of significant gaps in the training that had been undertaken by staff. For example, on all of the days of our inspection a number of staff working on supporting people living with complex mental health needs, had not received mental health awareness training and no staff had received training in dealing with challenging behaviour. This placed people and staff at risk as staff did not know how to respond safely and appropriately to incidents such as aggression/violence, self-harm or arson that people sometimes displayed as a result of their mental health conditions. The registered manager told us they were completing a mental health awareness course. This training had not been completed and the registered manager was suitably knowledgeable or competent to train, assess or supervise other staff in this area.

Staff had not been given training on safe and hygienic food handling but were assisting with the preparation

of meals. Staff had not been given training in how to support people who self-harm or who suffered psychotic episodes. This impacted on the quality of care given to people as staff had not been given support to develop a set of skills to assist them give appropriate care for people.

Staff were not suitably supported, competent and skilled in their role.
This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People could not be assured that staff followed the principles of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards. 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.

There were some mental capacity assessments and best interest decisions undertaken for people in relation to the administration of medicines. However, we saw that some best interest decisions did not clearly show why decisions had been made. For example, decisions had been made to restrict people's access to their lighters and cigarettes. Another person who had diabetes was not being allowed access to foods of their choice. The records did not explain why people were on time schedules to smoke or why foods of particular choice were being restricted. The rationale for the decision was not documented. In these examples, no capacity assessments had been completed to determine whether people had the mental capacity to consent to these restrictions. The registered manager was restricting people's choices and liberties because they felt they were unwise' decisions. However, people who have mental capacity to understand and weigh the risks should have the freedom and right to make these choices, even if they are unwise or unsafe. These restrictions had not been regularly reviewed to ensure the restrictions were the most proportionate solution or that the person had been consulted. The registered manager had not involved any external professionals such as a social worker or advocate in making these restrictions. One person told us, "I am diabetic, I like a large gin and tonic, I like to eat chocolate ice cream, I'm nearly 76, why can't I eat what I want to? I know the risks."

Some staff we spoke with did not show a good understanding of the MCA and their role in relation to this. The training matrix showed a large number of staff had received recent training on this subject. However, staff told us they had not received this training. The registered manager was unable to show certificates of attendance to verify which staff had received training in this area.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

There were a number of people who lived in the home who were deprived of their liberty, as there were some people unable to leave independently due to their safety. The registered manager told us, they had made applications to the local authority for a number of DoLS. We saw three application records. However, there were some people who required a DoLs in place, which had not been applied for. This meant the registered manager was not always working within the principles of the MCA.

The registered manager had not ensured that people were protected from acts intended to control or

restrict their liberties and choice that are not a proportionate response to the risks posed. They had not taken into account people's capacity to consent to such restrictions and their best interests.
This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they enjoyed the food served to them. One person told us, "Food is nice and hot." Another person said, "If I don't want what is served, I can choose something else". We discussed the menu and choices with the staff who told us people were asked what they wanted to eat each morning. They told they usually cooked a small number of extra portions of each option in case people forgot what they had ordered or changed their minds. However, people we spoke with told us they were not informed of what the meal is for each day. One person told us, "The chef takes care of it. Sometimes we get to choose what's on the menu, but then we don't always get served it". Another person told us, "We are told on a daily basis what we are having for dinner, but its normally near lunchtime and its normally told to me in general conversation, not for me to make a choice".

The six care plans sampled showed a lack of information in people nutritional assessment records, such as people's food preferences, this meant staff would not have the knowledge to meet the nutritional preferences of a large group of people they cared for.

People's nutrition needs were not always met. Two care records we examined showed both people had been gradually losing weight since their admission to the home. However, there was no clear information in the care plans regarding how the weight loss had been managed. One person's weight assessment record showed they had lost seven kilograms in weight during a six month period, however when staff had completed the person's risk assessment tool they did not record this weight loss. In the same person's care record a number of months later the service's assessment tool rated the person as high risk due to their weight loss. We found no indication on file whether a medical professional had investigated this, or whether this was a planned / recommended programme of weight loss.

The second person's care records showed the person had lost six kilograms in weight, in a two-month period April to May 2016. There had been no record of interventions from health professionals or changes in diet and the weight loss was not questioned or checked by staff. We highlighted the issue to the registered manager who accepted that such an anomaly should have been checked by staff. This lack of management of people's nutritional records and needs meant some people who lived at the home were at risk of receiving care that did not meet their needs

Some people, who appeared anxious, walked around the service in a circuit. We observed these people were not always present in the lounge area when drinks were offered during the day. A person told us, "We are given drinks in the lounge at certain times during the day. But if we aren't around to get one, we get missed." We saw that drinks were provided to people in this way.
Three members of staff we spoke with confirmed there was set drinks rounds throughout the day. Staff we spoke with told us they asked people if they wanted drinks and snacks throughout the day, however we saw very few examples of this throughout the inspection. This and the lack of visual prompts for people who had difficulties making their needs known meant that some people's hydration needs were not always being met.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did have some access to a health care professionals, such as the GP, Community Mental Health

team, dentist and opticians. On the day of the inspection, one person was being taken to a health care appointment. We also saw two mental health care professionals visiting the service on the second and third day of our inspection.

Requires Improvement

Is the service caring?

Our findings

People we spoke with told us the staff were kind to them and willing to assist them when required. However, the majority of the interactions we saw related to tasks being undertaken for people. These interactions were positive with people and staff talking easily to each other, showing people felt comfortable with staff. However, we also noted there were occasions when there were opportunities for staff to engage socially with people that were not acted upon. This was not solely due to demands placed on staff or staffing levels. We saw staff standing in the lounge area and dining area not engaging with the people in the room. This showed a lack of person centred care for the people who lived in the home.

We observed lunches being served in the dining room. The management of the meal was at times noisy and disorganised. Staff talked over people's heads loudly to each other. People's reactions to this implied they were not happy. This mealtime experience lacked the air of sociability for the people in the room and had a negative impact on their dining experience.

The people we spoke with told us they were able to express their views and make day-to-day decisions about their care. However, we could not find any further evidence that people or their relatives were involved with planning their care. None of the six care plans sampled recorded people's involvement or consent to their content. As a result, there was no evidence that people or those who knew them best had been involved in planning or reviewing people's care.

People were not involved in their care planning. One person told us "I do not feel included at all", another person told us, and "I have no idea what they write about me. I don't know what they [staff] are following." The six care plans we looked at lacked personalisation and there was no evidence that people or their representatives were asked what they wanted. People did not have an opportunity to comment on their care planning or whether their needs were accurately reflected. The registered manager told us they evaluated the care plans themselves monthly. There was no evidence of how people were asked to be involved or what steps the registered manager had taken to try different ways of involving people.

People we spoke with told us that staff respected their privacy and dignity. One person told us, "I get help with personal care and they are careful to keep my privacy, the staff do everything for me". Another person told us, "They always knock on the door and ask if they can enter, for example with my personal care or when they are doing a room clean". A person told us, "Yes, I'm given privacy to give myself a strip wash and they help me to get in and out of the bath and wash my back, there's no shower".

Staff we spoke with told us they closed the door and curtains when they provided personal care. However, we observed some bedrooms, which did not have curtains or curtain rails. Staff informed us the provider does not have the funds to purchase these. The person told us, "I haven't had curtains up in my room for months, it is what it is."

During our inspection whilst we saw a number of positive interactions where staff clearly maintained people's privacy and dignity, there were occasions when this was not the case. For example, we saw one

member of staff call across the room to a person about plans for their personal care. This showed that people's privacy and dignity was not always maintained.

People were not always supported to be independent. One person told us "I like to cook my own dinner, but I am not allowed to here. We used to do cooking, but we haven't done this in a while." We asked staff if they encouraged people to be more independent and involved in their recovery and staff said, "No, we don't encourage people to cook for themselves. However, those that are able to, do go out independently during the day".

There was institutionalised practice from staff in the service. People overall were accepting of the way they lived their lives at Aldwick Residential Care Home. However, when asked if they felt that Aldwick was their home one person told us "I don't like living here but it is better than nothing". Another person told us, "This has been my home over 20 years, I don't know anything else".

People's décor were not personalised and lacked a homely feel. People told us that they were not involved in how their rooms were decorated and did not have an opportunity to choose their curtains or furniture. One member of staff said, "The rooms are awful, the manager won't allow us a maintenance person due to finances, so if we don't fix the lights or curtains, they don't get done." Another staff member said, "I wouldn't wash here, I wouldn't like to live here".
Looking at the bathroom, the registered manager said that they would not wish to bathe using the facilities. Rooms had a mixture of furniture that looked worn and in need of repair. However, people did have their own personal belongings in their room.

The registered manager had not ensured that care and treatment was provided that met people's needs or reflected their preferences.
This is a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

Care plans lacked detail and did not provide sufficient guidance for staff on how best to support people with their mental health or other needs. Two people's mental health had deteriorated and as a result, they were having suicidal thoughts and were self-harming. Staff did not have a plan in place to deal with this decline.

Care plans were not always up date and therefore did not accurately reflect people's needs. There were multiple care plans that stated people were at risk of 'self-neglect' and that this would include their personal hygiene, eating and drinking. These care plans indicated that these people had been admitted to hospital previously due to their mental health and self-neglect. The advice from each health care professional involved in these people's care, was that the person required monitoring around their mental health and wellbeing, their dietary intake, their medicines and the risk of neglect. However, the guidance for staff was wholly inadequate and describe how to meet each of these individual needs effectively so the person could maintain good mental health and physical wellness.

The registered manager told us she knew the care records were not dated and not personalised. The registered manager stated she had intended to make the care records more personalised by December 2016, ensuring people were more involved in their care plans.

There was a lack of support for people to follow their interests and take part in social activities. The people we spoke with told us there was a lack of stimulation. There were multiple people identified as being at risk of social isolation, who did not have risk assessments or care plans to mitigate these risks.

One person told us, "I'm bored all of the time, there is nothing to do, the staff do their best and will speak to us when they can." Another person told us, "I watch TV, sometimes the staff will do a quiz, I'm one of the lucky ones, I can do out when I want to do, but I don't do much".

On the days of the inspection, there was no evidence of meaningful activities on offer specific to the needs of people and their interests. There were no organised activities for the week. There were long periods where people had no meaningful engagement with staff. By 2pm, multiple people had taken themselves to bed. One member of staff told us that when they had taken people out it was only for a walk to the shops. There were not enough activities taking place to meet the needs of people. A lack of routine and opportunities for social and occupational engagement could exacerbate people's mental health, low mood and motivation and this was evident by people's feedback and behaviour during the inspection.

The registered manager showed us a list of activities that had taken place since January 2016. These activities were not always age appropriate and had not changed since the last inspection in September 2014. The activities recorded included a word game, out for walks and playing a quiz. There was a wide age range of people at the service and there was no evidence that people were encouraged to pursue activities outside of the service. For one person it was recorded they had accessed the local community on four occasions in six months. We brought this to the attention of the registered manager who agreed this was not adequate.

People using the service were not having their needs met and their preferences were not being considered.

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

We looked at how the registered manager managed complaints. There was a policy in place for dealing with complaints and a procedure setting out how to make a complaint. However, this was not accessible to people living in the service. People that we spoke to about this did not always know how to access the policy. There was no evidence that people were spoken to about how they could make a complaint and multiple people confirmed that this was not discussed at residents meetings or on a one to one basis. The service did not have a system of recording complaints. We identified a number of concerns and complaints in people's daily notes completed by staff, but these complaints were not logged and there was no evidence that they were handled within a reasonable timeframe or that the complaint was resolved to the satisfaction of the complainant.

The registered manager had failed to ensure they had an effective and accessible system for identifying, receiving, recording, handling and responding to complaints.
This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

The provider informed us they did not have the funds to make the building safe and meet the requirements of the fire safety regulations to avoid the prohibition notice served by the Fire Service. Consequently, all 15 individuals residing at Aldwick Residential Care Home, vacated the building and were found alternative accommodation by West Sussex County Council.

Since our visit, the provider applied to voluntarily de-register their service with The Care Quality Commission to close Aldwick Residential Care Home.

There was a lack of leadership at the service, which impacted on the care and treatment people received. The registered manager had failed to ensure that effective management systems were in place to assess, monitor and improve the quality of service people received.

We asked the registered manager to show us what quality monitoring had been undertaken since the last inspection in 2014. The registered manager told us, no other quality checks were undertaken. The Registered manager told us they could see that improvements needed to be made but had not had the opportunity to address them due to working shifts. The registered manager stated they were expected to work the shifts due to the provider not having the finances to cover the staffing shortfall. The provider confirmed this was the case and there were no more funds to pay their staff.

Although people's views had been sought these had not been used to improve the quality of care. There had been two resident meetings held in 2016 for people in the service to be informed of and updated on the building works, the last one being in April 2016. However, information given was vague and people were not properly informed that the hot water was not going to be repaired anytime in the near future. People were not given the opportunity to complain about their environment. At these meetings, the menus were discussed, however suggestions made by people were not reflected on the current menus.

The culture of staff and registered manager of the service meant that people were living in an institutionalised environment. Multiple staff told us that they did not feel supported there and they were doing the best they could with the resources available.

Although the provider came to the service regularly, she did not provide effective oversight or quality monitoring. The provider did not undertake any audits related to maintaining the quality of the service. As a result, she was not aware of the issues that affected people's safety.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate, resulting in the multiple breaches of regulation identified during this inspection.

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

The provider must take all reasonable steps to carry out the regulated activity in such a manner as to ensure the financial viability of the carrying on of that activity for the purposes of achieving the aims and objectives set out in the provider's statement of purpose. The provider had not achieved this and had not informed the CQC of their financial position. The provider informed us, that she did not have the funds to continue the viability of the service and as a result of this financial shortfall has allowed the service to run with an unsafe staffing level, with staff who have not had access to essential training and had allowed the premises to become unfit for people to live in and staff to work in.
This is a breach of regulation 3 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager must notify the Commission without delay of the death of a person using their service. The registered manager had not informed the CQC of a recent death.

This is a breach of regulation 16 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager had not informed the CQC of significant events. For example, due to the building works, lack of hot water, fire safety, unsafe staffing levels and DoLs authorisations..

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 Registration Regulations 2009 Financial position except health service bodies and local authorities The provider failed to take all reasonable steps to carry on the regulated activity in such a manner as to ensure the financial viability of carrying on of that activity for the purposes of achieving the aims and objectives set out in the statement of purpose. (1) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services The registered manager had failed to notify the Commission without delay of the death of a service user. (1) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify the Commission (CQC) without delay of incidents that had occurred at the service, including contact with the police, allegations of abuse, the outcome of DoLS applications made to the local authority and events that prevented the registered manager carrying on the a regulated activity safely.

(1) (2) (e) (f) (g) (i) (ii) (iii) (iv)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager had failed to assess people's needs and plan their care with them, with a view to achieving peoples' preferences and ensuring their needs were met. (1) (a) (b) (c) (3) (a) (b) (c) (d) (f) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not assessed the risks to people who used the service or looked at how they could be mitigated. Medicines were not managed safely. (1) (2) (a) (b) (d) (g)

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 at risk of harm because the provider lacked systems and processes to prevent the abuse of service users. (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered manager had failed to meet people's nutritional and hydration needs. (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to make sure the premises are suitable for the purpose for which they are being used. (1) (a) (b) (c) (d) (e) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered manager had failed to establish a system to manage and act on complaints. (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager and provider had not established effective governance systems to assess monitor and mitigate the risks relating to the health, safety and welfare of service users. The registered manager had not maintained securely an accurate, complete and contemporaneous record in respect of each service user. (1) (2) (a) (b) (c) (d) (e) (f)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered manager had failed to ensure staff were recruited safely and in line with current requirements. (1) (a) (b) (2) (a) (3) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered manager and provider had failed to make sure there were sufficient numbers of suitably qualified, competent and skilled staff. The registered manager failed to ensure staff received appropriate support, training, professional development, supervision to enable them to carry out the duties they are required to perform. (1) (2) (a)