West Sussex County Council

Stanhope Lodge

Inspection report

Poplar Road, Durrington,
Worthing, West Sussex BN13 3EZ
Tel: 01903 264560
Website: www.westsussexcountycouncil.gov.uk

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 1 December 2015 and was unannounced.

Stanhope Lodge is situated on the edge of a residential housing estate on the outskirts of Worthing. It is registered to provide accommodation and care for up to 28 people with a learning disability and/or challenging behaviour and other complex needs. The provider refers to people using the service as 'customers'. The service comprises a number of units providing accommodation for between one and eight people in each unit. One unit provides short breaks for people and includes two emergency beds for people requiring immediate care and support. Rowan and Beech units form an area known as 'The Hostel'. The other units: Peartree, Sycamore, Holly Cottage, Cherry Cottage, Ash and Willow are part of an 'Intensive Support Unit' (ISU). People living in the ISU require a minimum of 1:1 support by staff. There is a mixture of communal areas, such as living rooms and kitchens, whilst other units are self-contained and offer individual accommodation with sitting rooms, kitchens and bathrooms for people living there. People have access to a range of garden and courtyard areas.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People were supported by staff who understood how to identify, assess and manage their risks safely. Staff were trained in safeguarding adults at risk and knew what action to take in the event of abuse taking place. Effective reporting systems were in place in relation to the management of incidents and accidents and measures were in place to prevent reoccurrence. Generally, premises were managed safely, although a lack of investment by the provider meant that some areas of the service were in need of redecoration or refurbishment. There were sufficient numbers of staff on duty at all times to support people safely and the provider followed safe recruitment practices. People's medicines were managed safely by trained staff.

Staff received care from staff who had been trained in a wide range of areas and new staff followed an induction which included the Care Certificate, a universally recognised qualification. There were a number of training opportunities on offer to staff who had access to the local authority's learning gateway on line. Team meetings were held and people's care was reviewed. Staff had a good understanding of the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards and put this into practice. People were supported to have sufficient to eat and drink and to maintain a healthy lifestyle. They had access to a range of health and social care professionals. People were encouraged to personalise their rooms and to choose how they wanted their rooms furnished.

People were cared for by kind and caring staff who understood them well. People's likes and dislikes, choices and preferences were taken account of and staff demonstrated they met people's needs in line with these. As much as they were able, people were able to express their views and to be involved in decisions about their care. Relatives were also involved and attended annual care reviews. People were treated with dignity and respect.

People received personalised care that responded to their needs. Many people were out during the day, either attending a day centre or pursuing an activity in the community. A wide range of activities was available to people. Care plans provided comprehensive information about people's care needs. Where people exhibited challenging behaviour, support plans provided advice and guidance to staff on how this should be managed. The provider had a complaints policy in place and complaints were responded to in line with this policy and to the satisfaction of the complainant.

People and their relatives were asked for their views about the service through an annual questionnaire and were positive about Stanhope Lodge overall. People received person-centred care and staff responded to people's needs in a personalised way. Staff understood the importance of being open and honest with people and their relatives and had a good understanding of the vision and values of the home. The registered manager was involved in all aspects of the service and supported staff effectively. There was a range of audit systems in place for kitchen management and analysis of accidents and incidents, but there was a lack of audits in cleaning, medicines and quality of care.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Risks to people were managed safely and staff were trained in safeguarding adults at risk.

There were sufficient numbers of staff on duty to support people safely and safe recruitment practices were followed.

People's medicines were managed safely.

Good

Is the service effective?
The service was effective.

People were supported to have a healthy diet and had access to a range of health and social care professionals.

People were encouraged to personalise their rooms.

Staff were trained in a wide range of areas and had a good understanding of the Mental Capacity Act 2005 and associated legislation.

Staff received monthly supervision meetings and annual appraisals.

Good

Is the service caring?
The service was caring.

People were supported by kind and caring staff who had a good understanding of their needs and knew them well.

People were encouraged to express their views and to be involved in making decisions about their care, as were their relatives.

Privacy and dignity for people were maintained by staff.

Good

Is the service responsive?
The service was responsive.

Care plans provided comprehensive, detailed information and guidance to staff on how to care for people in a personalised way.

There was a range of activities organised for people and many attended day centres or the community on a daily basis.

Complaints were listened and responded to and managed by the provider in an effective way.

Good

Is the service well-led?
One aspect of the service was not well led.

Requires improvement

Summary of findings

There was a lack of robust and rigorous systems in place to measure the quality of care delivered in some areas.

People and their relatives were involved in the service, their views listened to and taken account of.

The service demonstrated good management and leadership and staff felt supported.

Stanhope Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service and to provide a rating for the service under the Care Act 2014.

The inspection took place on 1 December 2015 and was unannounced. Two inspectors and an expert by experience undertook this inspection. 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 in challenging behaviour.

Before the inspection, we examined the previous inspection reports and notifications we had received. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with four people living at the service. Due to the nature of people's complex needs, we did not ask direct questions. For some people, being asked questions by an inspector would have proved too distressing. We did, however, chat with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the registered manager, the duty officer, two senior support workers and two support workers.

The service was last inspected in November 2013 and there were no concerns.

Good

Is the service safe?

Our findings

Risks to people and the service were managed so that people were protected and their freedom was supported and respected. Stanhope Lodge comprises seven self-contained houses, all on one site. People could leave their houses without difficulty and move freely around the site. Exits from the home to the road were protected by key codes and people were accompanied by staff, or relatives, when accessing the community. Relatives felt their family members were safe. One relative told us, "They [referring to staff] make sure he is safe and they take necessary precautions so that he is always safe".

Staff members had undertaken adult safeguarding training within the last year. They were able to identify the correct safeguarding procedures should they suspect abuse was taking place. Staff were aware that a referral to the local adult services safeguarding team should be made, in line with the provider's policy. One staff member said, "I would contact Safeguarding if I had to". Another stated, "I would make sure the person was safe if I saw something, then I would tell the manager". Staff confirmed to us that the registered manager operated an 'open door' policy and that they felt able to share any concerns they might have in confidence.

We asked staff about their understanding of risk management and keeping people safe, whilst not restricting their freedom unnecessarily. One staff member said, "Customers choose how they want to live here". Another member of staff told us, "We have to keep customers and staff safe, but the rest is up to them". We observed that one person wanted to know which staff were on duty at weekends as they could display challenging behaviour if they were not informed. The provider had introduced a system of regularly informing the person of the weekend duty rota without being asked and arranged trips out on Fridays. As a result of this, incidents of challenging behaviour had reduced significantly.

Risks to people and environmental risks had been identified and assessed appropriately. Risk assessments had been drawn up and included six stages: Stage 1 – Identify who may be harmed, Stage 2 – Identify all the hazards that are foreseeable, Stage 3 – Identify what control measures are already in place to prevent harm being realised, Stage 4 – Evaluate the risk, Stage 5 – Put into place pragmatic measures that reduce the risk and Stage 6 – Evaluate the residual risk factor. Comprehensive risk assessments for people included advice and guidance to staff on how to manage and mitigate risks. One care record contained risk assessments relating to accessing the community, use of transport, going swimming, epilepsy, eating and drinking, visiting parents, physical intervention and other risk assessments relating to their hobbies and interests. Risk assessments were reviewed monthly to ensure they were accurate and care plans updated if required. A relative said, "[Named family member] can't have access to the kitchen because he breaks things".

The provider had two reporting systems in place relating to incidents and accidents. One system was used in the ISU and the other system for the 'hostel'. Thirteen incidents or accidents had been recorded since April 2015 in the hostel and 80 this year in the ISU. Reports contained a clear description of the incident and indicated whether it should be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. Each completed report explained the outcome of the incident and included details of action taken to avoid a reoccurrence. For example, one person had used an item in a violent incident which should not have been available to them. Measures were subsequently taken to prevent a reoccurrence of this.

Generally, premises and equipment were managed to keep people safe. We observed that a bath panel had come loose in one of the houses (Beech) and brought this to the attention of a staff member; they said they would contact the local authority's facilities department and arrange for this to be repaired. Some redecoration had been completed in communal areas. In one corridor we observed that the walls had been newly painted, but the ceiling had been left undecorated. In another house (Ash), dirt had accumulated around the toilet pan downstairs. In the kitchen at Ash, there was a rim of dirt around the edges of the floor and black mould was growing in the sealant at the back of the sink. We discussed these issues with the registered manager. Whilst robust cleaning systems might resolve some of these issues, lack of ongoing maintenance and financial investment to premises by the provider has resulted in an inability by staff to clean areas to a high standard.

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs and relatives confirmed this. We asked staff, "Do you think there are enough staff on duty to consistently care for people safely?"

Good

Is the service safe?

One staff member said, “Yes, without doubt. Sometimes there are enough staff so that I’m not allocated anyone specifically to look after. It means I can catch up on other things or do preparation work”. Another staff member told us, “I haven’t yet come across a situation where we are short of staff”. A third staff member said, “We have loads of staff because quite a few people need one-to-one care”. The staff duty rota for the previous four weeks showed that staff worked in either the ISU or the hostel units. In total, these consisted of eight separate units and cottages. The ISU had a large number of people requiring one-to-one support and there were always enough staff to provide this cover. The provider used existing staff, where possible, to cover vacant shifts left when staff were on annual leave or absent through sickness. Agency staff were also used from time to time, particularly at weekends.

Safe recruitment practices were followed. Appropriate checks were undertaken before staff commenced employment. Staff files contained recruitment information and criminal records checks had been undertaken with the Disclosure and Barring Service (DBS). This meant that new staff were of suitable character to work with vulnerable people. There were copies within staff files of other relevant documentation, including character references and job descriptions.

People’s medicines were managed so that they received them safely. Medicines were ordered on a 28-day cycle so people had sufficient stocks in hand. Care staff were trained to administer medicines and senior staff undertook regular competency checks. Medicines were administered through a Monitored Dosage System and when people were away from Stanhope Lodge, their medicines went with them. People’s relatives would then be responsible for the administration of their medicines. Medication Administration Records (MAR) had been completed appropriately by staff to show that people received their medicines as prescribed. Controlled drugs were managed safely. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated regulations.

Good

Is the service effective?

Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. A relative said, "I have no complaints about current staff; they're all very well trained". Another relative told us, "Staff are very well trained. They're very patient and then try to please everyone that lives there". Staff we spoke with had worked at the home for several years, so it was not appropriate to talk with them about their experiences of induction. However, new staff followed the Care Certificate, covering 15 standards of health and social care, which the provider had introduced. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

We spoke with staff about the training opportunities on offer. One staff member said, "We have access to the 'Gateway' so there is plenty on offer there". (West Sussex Learning and Development Gateway is an online learning resource provided by West Sussex County Council.) Another staff member confirmed, "Yes, there is plenty of training". We observed a positive behaviour support training session during our visit to the home which was led by the registered manager. The 2015 training matrix and staff files showed that all staff were able to access training in subjects relevant to the care needs of people they supported. The provider had made training and updates mandatory for all staff in the following areas: infection control, health and safety, medication management, moving and handling, fire awareness, safeguarding vulnerable adults, first aid, food hygiene, food allergies, Mental Capacity Act 2005 (MCA) and PROACT SCIP (positive behaviour management for people with a learning disability). Other training undertaken by staff included: Challenging Needs – A Non-Confrontational Approach, Adults at Risk and Management of People with Epilepsy.

Team meetings were held for staff and people's care plans were reviewed at these meetings. Staff were able to contribute to meetings and to make suggestions of importance to them. However, the minutes did not contain a review of the minutes of the previous meeting. We recommend that, following a staff meeting, a plan is drawn up to decide what action should be taken as a result of the meeting, by when and by whom. This would provide an opportunity for management to ensure that any ongoing issues are monitored and resolved. We asked staff how they were formally supervised and appraised by the provider. Staff said they had met with senior staff and had a recent supervision meeting; also a yearly appraisal. One staff member said, "I find it helpful; it's open and honest". Another staff member told us, "I wonder sometimes if every month is too much. Sometimes there's not much to say". The staff supervision planner and other staff records showed that all supervision sessions and yearly staff appraisals for all staff had been undertaken or was planned, in line with the provider's policy.

We asked staff about issues of consent and about their understanding 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. Most of the staff had undertaken recent training in this area. They had a good understanding of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. Some staff explained the implications of Deprivation of Liberty Safeguards (DoLS) for the people they were supporting. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. Where required, authorisations had been agreed by the local authority. One staff member told us, "We are particularly aware of that here as you can imagine". Another staff member said, "We do try to do things with customers in the least restrictive way we can". The provider had completed mental capacity assessments for each person living at the service. The assessment included a determination of capacity, advance decisions to refuse treatment, determination of best interest and an assessment summary.

People were supported to have sufficient to eat, drink and maintain a balanced diet. The main meal was served in the evening as the majority of people were out during the day. The menu was changed every two weeks. On the day of our

Good

Is the service effective?

inspection, people had a main meal choice of either sausages or fishcakes, with vegetables or salad. Other options were available to people if they did not like the main meal choice on offer. People's weight was recorded on a monthly basis. However, it was difficult to see over time whether people had gained or lost weight. In addition, people's height was not recorded, which would have provided a gauge within which to ascertain healthy weight limits. We discussed this with the registered manager and whether a graph might provide a clearer visual aid for monitoring people's weight.

People were supported to maintain good health and had access to healthcare services and professionals. Relatives told us that staff at the service supported people to attend medical appointments. Care plans confirmed that the provider involved a wide range of external health and social care professionals in the care of people. Advice and guidance given by health and social care professionals was followed and included in care plans. People had hospital passports in place. The aim of the hospital passport is to assist people a learning disability to provide hospital staff with important information about them and their health when they are admitted to hospital.

The majority of people's rooms were personalised and homely; some people preferred their rooms to be more minimalist with little furniture or personal effects on display. People were encouraged to choose how they wanted their rooms furnished and to keep their rooms clean and tidy. In the Beech unit, people stayed for short breaks, so rooms were not personalised. However, people were encouraged to bring small items or mementoes with them during the course of their stay.

Good

Is the service caring?

Our findings

At the time of our inspection, the majority of people living at the service were out for the day. However, we observed that positive, caring relationships had been developed between people and staff. Staff were genuinely caring of people. One person had difficulties with anxiety and we observed the member of staff was very responsive to them, without being overwhelming. They seemed to know the person well and were gentle in their interaction. Another member of staff referred to one person living at the service and said, "Years ago he used to dress, he used to read his magazines, he's such a different character now. If you do something for him, he can show you he is happy. He will come and shake your hand". We observed one person in the living room, quietly knitting two rows, then dismantling and starting again. Staff said she did not like knitting more than two rows, but she was gently encouraged and praised by staff in her project. We spoke with one person who chatted about their father. They said the care staff were nice and that they went to Costas for coffee together. We spoke with another person in their flat and they confirmed they were very happy with everything. They had their own phone and an alarm to use if they needed to call staff. They were encouraged to be as independent as possible and said that staff were very nice. Relatives confirmed they were very happy with the care provided to their family members. They spoke about the staff being patient and that their family members were well looked after. One relative said, "I've seen the carers interact with him and they're very caring and kind". Another relative said, "He is well looked after. His home is cosy and comfortable".

People were supported to express their views and to be involved in making decisions about their care. We asked how staff sought to involve people and their families with their care as much as possible. Care plans provided information to staff about how best to communicate with people. One care plan stated that the person could communicate verbally and through signing and that staff should give them time to communicate. One relative said, "We're always invited to the care reviews. They do take our views into account and they send us the care plan afterwards". Another relative said, "Their communication with me is very good. I am reassured. I always have the opportunity to discuss anything". A third relative said, "We have a care review once a year and we're always invited and listened to". Consequently, there were opportunities to amend people's care plans if it was felt their care needs were not reflected accurately. Notices on display in communal areas showed photos of which staff were on duty at particular times of the day so people were aware.

We asked staff how they supported people to maintain their dignity and privacy. One staff member told us, "We let customers live their lives as they want to". Another staff member said, "I think it's more than just making sure they have privacy. It's about giving people choices". Some people had keys to their rooms to maintain their privacy and promote their independence.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Many people attended a day centre during the week or were involved in other community activities which they had planned with support from staff. People were encouraged to follow their interests and hobbies. One person told us that they were going shopping that day to buy slippers. They added that they liked cups of tea with sugar and toast and marmalade for breakfast. They said they liked music and that someone came to play music every week. One care plan stated that the person enjoyed music and performing and that they attended church on Sundays. Relatives said they were happy that there were enough activities provided for people and that the choices of their family members were supported by staff. One relative made reference to social activities at the service and said, "They often have parties and [named family member] likes getting dressed up, so this is really lovely for him". Another relative said, "There are enough activities going on all the time. He likes ten pin bowling and he goes every week". A third relative said, "He comes home every weekend and staff help him". People were supported in their independence and a care plan had information and aims for one person on their personal care. It read, 'To maintain independence with personal hygiene needs, to ensure safety in shower, to have a daily shower. Objectives – to enable him to achieve his personal hygiene needs in shower, to ensure support needs are met am and pm, to achieve his shave each morning'. Additional information was provided for staff about this person's mobility, health and well-being and that they, 'like praise and responds well to this'.

Care plans and daily records contained detailed information about people's care needs, for example, in the management of challenging behaviours and nutritional needs. Care plans also contained information about people's personal histories and likes and dislikes. Their choices and preferences were documented. Daily records showed that these were taken into account when people received care, for example, in their choices of food and drink. Care planning and individual risk assessments were reviewed monthly and showed that people or their representatives were involved in this.

People's needs were assessed appropriately and care and treatment was planned and delivered to reflect their individual care plan. One person's care plan provided detailed advice and guidance to staff about how to manage possible challenging behaviours. The behaviour support plan included 'setting events', 'trigger events' and 'crisis phases'. This helped staff to anticipate possible risks and dangers and prevent them escalating to a hazardous level. There was also an 'Overview Support Plan' in place which contained details of the person's day-to-day life and the management of risk associated with it. The risk assessments were detailed and included a six stage process, from identification of risk to evaluation of the measures put in place. These were varied and relevant to the care needs of individuals and included risks associated with the use of a scooter and the dangers posed by hot radiators.

We asked staff what they understood by the term 'person centred care'. (A person-centred approach focuses on the individual's personal needs, wants, desires and goals so that they become central to the care process.) One staff member told us, "Well, it's letting people live their own lives". Another staff member said, "It means we give care that is for that person. We fit round them".

We looked at the provider's complaints policy and procedures. The complaints procedure was also displayed in communal areas for people and their representatives to view and in an easy read format. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. Relatives felt that any concerns they had were heard and addressed promptly. One relative said, "I have no qualms. On extremely rare occasions where I have had a problem, they have listened to me and done something about it pretty sharpish",. Another relative said, "Once he lost his watch and it was a good watch. They eventually found it in the toilet, another resident had taken it". The provider's complaints log showed that one complaint had been received in 2015. The complaint was managed in a timely and effective way, to the satisfaction of all parties, in line with the provider's policy.

Requires improvement

Is the service well-led?

Our findings

The service promoted a positive culture that was person-centred, open, inclusive and empowering. People were involved in developing the service to the extent that they met with staff regularly to discuss matters that affected them and in day-to-day planning of their lives. We asked staff about 'duty of candour' and its relevant to the care and support of people living at the service. Duty of candour is about providers being open and honest with people and other 'relevant persons' when things go wrong with their care and treatment, giving them reasonable support, truthful information and a written apology. Providers must have an open and honest culture at all levels within their organisation and have systems in place for knowing about notifiable safety incidents. The provider must also keep written records and offer reasonable support to the person in relation to the incident. Some care staff were aware of this regulation and were able to describe its relevance and application.

We asked staff about the vision and values of the home. We asked the question, "What is the purpose of the home and what does it offer to people?" One staff member said, "It's to broaden people's horizons I think". Another staff member told us, "I think we're here to provide a positive environment so we can build up people's confidence". The registered manager said, "The most important thing is the customers. We've worked really hard as a team to reduce behaviours". We observed the registered manager positively engaging with people and supporting staff during our inspection. The registered manager referred to challenges and said that it was, "Increasingly difficult to provide a higher level of support with fewer resources".

The service demonstrated good management and leadership. A relative referred to the service and said, "It's very well run and you can always get hold of them if you need to". We asked staff if they thought the home was well led. One staff member told us, "It's really well led. The manager is very organised". Another staff member said, "The senior [support worker] system works really well. I do feel well supported".

A report had been compiled by the provider in light of the findings of the 2015 satisfaction survey. These included the views of people, their representatives, external professionals and staff. The questionnaires contained relevant questions concerning people's experiences of the service such as staff attitudes, safety and the quality of care. There was a high degree of satisfaction across all areas expressed by all those asked. One relative said that the service now had, 'The best management team in the 19 years I've known the home'. An external professional said, "I use Stanhope as an example when it comes to organisational management'. Another relative told us, "The manager is very 'hands-on'".

There was a lack of quality audit systems in place in two areas and no specific system in place to monitor the quality of care delivered. The registered manager or other senior staff member would undertake informal checks to ensure that medicines were managed safely. However, there were no formal audits in place to corroborate this and therefore no system in place to ensure that people received their medicines as prescribed and that staff had recorded this accurately. There was no system in place to audit cleaning around the service or checks made to ensure that areas were cleaned thoroughly and effectively. Although at this inspection we found that this had not impacted upon people's care and safety, we have identified this as an area for further improvement.

Environmental checks were undertaken on health and safety issues and a comprehensive audit had been undertaken in the kitchen relating to areas such as hygiene, premises, food safety management, food delivery and storage and nutrition and hydration. This audit, undertaken in November 2015, showed an overall average audit score of over 90%. Where areas had been assessed as requiring attention, there were action points in place and a date for completion. Accidents and incidents were analysed together with people's behaviours that might contribute to any incidents at particular times of day and preventative strategies were put in place.