Ms Kim Sanders

Stanbridge House

Inspection report

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Date of inspection visit:
07 June 2018

Date of publication:
24 August 2018

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

Summary of findings

Overall summary

The inspection took place on 7 June 2018, and was unannounced.

Stanbridge House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The care home can provide accommodation and personal care for 27 people in one detached building that is adapted for the current use. The home provides support for people living with a range of physical, sensory and mental health needs, including people living with dementia. There were 22 people living at the home at the time of our inspection. One person who had been staying at the service for respite left the home during the morning of the inspection.

The service had a registered provider. A registered provider is a person who has registered with the Care Quality Commission to manage the service. Like registered managers, 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.

At the last inspection on 19 January 2016, the service was rated Good. At this inspection we found the service remained Good overall.

The provider's quality assurance systems and processes were not consistently robust in relation to the recording of medicines guidance to inform staff practice. For example, staff did not always have access to detailed records or guidance to support the safe administration of people's prescribed or 'as required' medicines. However, this did not impact on people's wellbeing.

People's capacity was considered in line with the Mental Capacity Act 2005 (MCA) guidance. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies in the service supported this. However, the provider's quality assurance systems did not consistently ensure people's capacity to make specific decisions had been fully recorded including; for example, where their capacity may fluctuate. People were supported to have choice and control in their lives by staff that aimed to support them in the least restrictive way. The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People and relatives told us they felt the service was safe. One person told us, "Since I've been here, I've never seen any abuse" and "I'm not frightened living here. My family know I'm safe and can come as much as they can and want to." People remained protected from the risk of abuse because staff understood how to identify and report it.

Staff felt well supported to carry out their roles, and were appropriately trained. The registered provider was open to staff developing their skills and the home further through additional training and discussions in staff meetings.

Staff supported people to eat and drink and their nutritional needs, food preferences and ethical choices were met. One person told us, "The food's pretty good, and when there is something on the menu I don't like, they will do something else." Where special dietary needs were required in relation to people being at risk of malnutrition staff followed guidance given by care plans and the health professionals.

People's relatives told us and we saw that the staff were attentive, kind and respectful. One person told us, "They are a happy lot of girls here and are very caring." Care and support provided was personalised and met peoples' diverse needs. People and their relatives were included in the assessment of their needs and development of care plans that promoted their independence. One person told us, "Staff do sometimes ask about things in my care plan," and "Yes, I do feel involved in decisions."

A range of meaningful social activities were offered to people daily. One person told us, "There seems to be enough to do and I enjoy what they put on." People were also supported to have access to activities with and in their local communities.

Care plans provided information about people and were personalised to reflect how they wanted to be cared for. Daily records showed how people had been cared for and what assistance had been given with their personal care. Health professionals told us that they were very proactive in ensuring people's health needs were addressed and that treatment plans were followed to ensure their health and wellbeing was maintained.

People when needed received 'end of life care' that was responsive to their individual health care needs and respected their wishes. People's individuality and important relationships were respected.

Feedback received showed people and their relatives were satisfied, and felt that the home was well led and that staff provided good care. People and relatives felt listened to and any concerns or issues they raised were addressed suitably and dealt with in a timely way.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

People's medicines were administered safely.

People were supported by staff who had received training and recognised the potential signs of abuse and knew what action to take. People and staff were confident that the provider would take concerns seriously and act on them.

Accidents and incidents were recorded, investigated and actions taken to reduce risks. Risk assessments were developed to support staff

There were sufficient staff to meet people's needs and safe recruitment processes were followed.

Is the service effective?

Good

The service was effective

Staff understood and worked towards the principles of the Mental Capacity Act 2005.

People and their relatives told us that their preferences and choices for care and were respected.

People were supported to maintain their health and wellbeing and had access to healthcare services.

People were cared for by staff that knew them well, had received training and had the skills to meet their needs.

Is the service caring?

Good

The service was caring.

People were cared for by staff that were attentive, caring and knew them well.

People's diversity and rights to maintain important relationships

were respected by staff that would adjust their approach to meet their needs.

People were listened to and involved in the planning of their care. People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive

Care records and plans gave guidance to staff to ensure people's preferences were known and that they received consistently personalised care

People and their relatives received information about the service in a way that they understood. Complaints and concerns were listened to and responded to effectively.

Staff were sensitive to the needs of people living in the home and gave people time to make the decisions about how they wanted to spend their time. People had access to meaningful activities.

Is the service well-led?

Requires Improvement

The service was not always well led

Quality assurance systems and processes did not always ensure people's records were complete. Medicines and capacity records did not always provide staff with enough detail and guidance.

Staff communicated effectively and in a timely way with relatives and health professionals in relation to the health and wellbeing of people

The provider was committed to improving the quality of the home and worked with partners to inform best practice.

Stanbridge House

Detailed findings

Background to this inspection

We carried out this comprehensive 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 7 June 2018 and was unannounced. The inspection team consisted of two inspectors 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.

Before the inspection 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 they do well and improvements they plan to make. We looked at this and other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We contacted stakeholders, including the local authority contracts team involved in the service for their feedback. One local authority professional gave feedback regarding the service.

During the inspection we observed the support that people received in the communal areas. We were also invited in to people's individual rooms. We spoke to seven people, six relatives, two visiting health professionals, two health professionals by telephone, four care staff, the assistant manager and the registered provider. We spent time throughout the day observing how people were cared for and their interactions with staff and visitors in order to understand their experience.

We reviewed three staff files, medication records, staff rotas, policies and procedures, health and safety files, compliments and complaints recording, incident and accident records, meeting minutes, training records and surveys undertaken by the service. We also looked at the menus and activity plans. We looked at eight people's individual records, these included care plans, risk assessments and daily notes. We pathway tracked some of these individual records to check that care planned was consistent with care delivered.

At the last inspection on 19 January 2016, the service was rated Good. At this inspection we found remained Good

Good

Is the service safe?

Our findings

People and their relatives told us they felt people were safe living at the home and with the staff that supported them. One person told us, "Oh yes, I feel safe here, I don't want to be anywhere else." Another told us, "Since I've been here, I've never seen any abuse" and "I'm not frightened living here. My family know I'm safe and can come as much as they can and want to." Relatives told us they felt people were safe and that staff cared for them. One relative told us, "We've peace of mind because our relative is safe here."

People told us their medicines were administered safely. One person told us, "They do give me my medication and watch me take it." Medicine administration records (MAR) noted that daily medicines were being given and signed for. The medicines policies and systems gave guidance to staff on how to safely store, audit, record, administer and dispose of medicines including 'as required' medicines that were not for daily use. Staff were trained and assessed as competent to administer medicines and we observed medicines were offered respectfully and administered safely. Staff gave medicines conscientiously having gained consent. The medicines administration records were complete without gaps which demonstrated that people were receiving their medicines.

Accident and incident records and care plans demonstrated that staff and the registered provider took appropriate action following incidents. We noted that actions detailed on the formal records sometimes noted 'all procedures followed' without detail being added. However, where the incident involved people, they were investigated and actions recorded in people's care notes and care plan. For example, one person had experienced a fall, after they were initially checked by the ambulance service, they were then supported to have their medicines reviewed and their eye's tested. This demonstrated that, lessons could be learned and care plans adjusted to reduce the likelihood of reoccurrence.

People remained protected from the potential risk of abuse because staff understood people's needs and the types of abuse people living with dementia experienced. Staff received training and guidance on how to recognise and report abuse and were confident that if they raised a concern with their manager it would be taken seriously and acted on. Staff demonstrated an awareness in equalities and diversity issues and understood the importance of protecting people from all types of discrimination.

Risks to people were managed safely. Each person had an individual care plan that was supported by risk assessments that covered a range of needs, including, falls assessments, moving and handling, nutrition and personal hygiene. These in combination with daily needs and tasks sheets gave guidance to staff on the level of risk, how it may occur, and how to minimise the risk and restrictions. For example, one person was at risk of malnutrition, they had an eating and drinking checklist, their weight was monitored monthly and there was nutritional support guidance provided for staff so they could ensure the person ate a suitable diet and maintained a healthy weight.

Environmental risk assessments, audits, and a programme of regular health and safety checks ensured measures were identified to minimise environmental risk. The registered provider had oversight of health and safety through audits and checks of fire safety, LOLER, COSHH, Legionella, gas safety checks and

emergency plans. Personal Emergency Evacuation Plans (PEEPs) were in place for people and reflected their individual needs including their sensory needs. For example, one person's PEEP noted that they could understand instructions, that their sight was limited, they needed to mobilise slowly and what support they would need when outside the building." PEEPs provide information to staff on what action should be taken with people should the home be required to be evacuated in the event of an emergency.

People were protected by the prevention of infection. Staff had good knowledge in this area and all wore PPE (personal protective equipment) when required including aprons and gloves. The provider had detailed policies and procedures in infection control. The environment remained clean and free from malodours and the provider had recently redecorated the communal spaces and people's bedrooms. Staff told us that the registered provider always kept the property well maintained and one person told us, "Cleaning happens every day."

People told us and our observations confirmed there were sufficient numbers of suitably experienced staff to keep people safe and ensure their needs were met. Throughout the inspection, people's emotional and physical needs were met. Requests for support made verbally or using call bells were responded to promptly. One person told us "Mostly there are enough staff. When I call for help the response is pretty good." Staff told us they had sufficient time to meet people's needs and spend time with them to talk about their day or interests.

Staff recruitment processes ensured that staff were safe to work with people. Staff files included previous work history, application forms, proof of identity and suitable references. Records demonstrated that checks had been made with the Disclosure and Barring Service (DBS) to ensure staff were suitable to work with people.

Good

Is the service effective?

Our findings

People and relatives told us that staff had skills, knowledge and competencies to ensure people's preferences, choices and care needs were consistently met. One person told us, "I think the staff are good and well trained." Another told us, "Most staff are very good. I am well looked after." A relative told us, "Staff seem good at their jobs." Another relative told us that the staff made their relative laugh and that Stanbridge House was "The best place for my relative." Relatives told us that the care given was good and suitable for people living with dementia and that they were always kept informed in relation to people's health needs.

The Mental Capacity Act 2005 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 capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA.

At the last inspection in January 2016 staff demonstrated they had an understanding of and acted in line with the principles of the Mental Capacity Act 2005 (MCA). People's capacity to make day to day decisions had been considered, and staff gained consent and checked with people that they were happy for them to provide care tasks before proceeding with them. However, there was no specific formal recording where people may lack capacity to make these decisions regarding their care and support and staff had not consistently received training in relation to the Mental Capacity Act.

At this inspection improvements had been made. All staff had received Mental Capacity Act training and the home recognised that a number of people had relatives acting as the legal representatives in relation to finances. They also recognised that the needs and capacity of people living with dementia and health conditions could fluctuate. For example, their dementia progressing or a temporary urinary infection leading to confusion.

People who lacked mental capacity to make particular decisions were therefore protected by staff that understood and were working in line with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff and the registered provider had received Mental Capacity Act (MCA) training, and continued to demonstrate through their feedback and practice that they understood and acted in line with the principles of the Mental Capacity Act. To ensure people could be offered choice in an accessible and meaningful way staff used a range of communication approaches that were guided by their knowledge of the person and care plans. For example, one person who did not have the dexterity in their hand to use a call bell, was provided with a traditional bell that they could use, so they could remain within their room, with staff close at hand. Within people's care and support plans there was a 'consent to care' statement and the provider confirmed in their Provider Information Return (PIR) that, 'capacity assessment forms are completed for all clients that require them."

CQC is required by law to monitor the operation of the Deprivation of Liberty Standards (DoLS). DoLS are the

process to follow if a person has to be deprived of their liberty in order for them to receive the care and treatment they need. Individual mobility assessments gave clear information about how people should have access to their mobility aids and sensor mats to ensure they could be supported in the least restrictive way. The registered provider told us that they were aware of when and how to make an application for a DoLS authorisation and had oversight of current applications they had made with the local authority.

Staff told us they felt effectively trained and supported to carry out their roles. Staff received and refreshed mandatory training, and had inductions that included, shadowing experienced staff who could demonstrate how to work with people with complex needs. Staff also had access to training that was specific to the needs of the people using the service, including dementia, catheter care and end of life care training. The registered provider arranged for some staff to become infection control and safeguarding champions through training with the local authority so they could feedback to the wider team and update their knowledge and practice. In response to safeguarding awareness training staff told us they had found focussing on potential scenarios that could happen while in contact with people, very useful.

Staff told us and records demonstrated they had regular supervisions and appraisals. The registered provider recognised the importance of continual professional development to inform best practice. Staff told us that supervisions and appraisals were used to focus on staff development, staff wellbeing as well as addressing people's needs. One staff member told us, "Further training is encouraged in appraisals." As an established team no staff had completed the Skills for care certificate. The certificate is a set of standards for health and social care professionals that ensure workers have safe introductory skills and knowledge. However, they had completed a Diploma in health and social care or the equivalent.

Staff encouraged the use of technology to promote their communication and wellbeing. For example, staff told us they had supported one person to remain in regular contact with their relatives through an electronic tablet. The home also used a tele healthcare system to promote people's health and wellbeing. Tele healthcare systems are a remote exchange of health data, between the patient in their own home and their health clinician. This assists the clinician to regularly monitor the people with long term health conditions.

The premises had been refurbished as detailed in the Providers Information Return (PIR). All communal areas had been decorated, re-carpeted and a number of windows, soft furnishings and lighting fixtures replaced. This ensured the premises remained safe, mobility friendly and well maintained. The provider also was actively promoting improved dementia awareness through training staff and introducing the use of memory boxes. Memory boxes can be added to by the person and families and staff told us these memories can stimulate the person, prompting conversation linked to people's life time experiences. This had been promoted through meetings and newsletters. The environment was spacious which allowed people to move around freely without risk of harm. Where people had found the corridors leading from their room to the communal spaces, too far away, the registered provider had ensured they were given an opportunity to have a closer room. The home had a large sitting room and dining room that people used throughout the day. Bathrooms were accessible and equipped for people with limited mobility. Some bedrooms had ensuite facilities. The grounds were well maintained with access ramps so that all people could access the outside space.

People and their relatives told us they enjoyed the food at the service, and that their choices in relation to what and where they ate were respected. One person told us, "The food's pretty good, and when there is something on the menu I don't like, they will do something else." Another person told us, "They do accept that I like to eat in my room, which is a good thing." We observed people's lunchtime experiences to be sociable and relaxed. Menus were varied and offered at least two options each mealtime including fresh fruit and vegetables to encourage healthy eating. When required people had access to adapted cutlery so that

they could eat independently. If people required specialist diets for health or ethical reasons this was respected. For example, one person chose to have a diet that was mostly vegetarian and ate fish. Another person had diabetes and required a low sugar diet. The chef and records demonstrated, that people's likes and dislikes were known, reviewed and considered in menu planning.

People's nutritional needs were met. People had assessments of their nutritional needs and preferences recorded in their care records. One person was at risk of malnutrition and had also been referred to a dietician. There was detailed guidance available to staff that identified the types of calorific foods the person required and other actions to minimise the risk of weight loss including a nutritional screening tool and weight monitoring sheets. Staff were knowledgeable of people's dietary needs and we saw guidelines were followed at lunch-time.

People received care that remained responsive to their needs. Initial assessments were undertaken prior to a person moving to the home and then a care plan was designed around the needs of the person. The records were accessible, and gave descriptions of people's needs and the support staff should provide to meet them. Staff told us that the team worked well together and had good communication systems in place to ensure information about people's wellbeing and needs remained current. For example, people's needs would be discussed at daily handover's, staff meetings, during resident's meetings and when required contact would be made with specialist teams including the falls risk and memory assessors. All those we looked at detailed task based activities such as assistance with personal care, mealtimes and moving and handling. The records of care delivered were in line with people's assessed needs and demonstrated that people regularly had appointments with health professionals to ensure their wellbeing was maintained.

The home supported people to maintain good health with input from health professionals including; chiropodists and physiotherapists on a regular basis. The registered provider and staff told us that they worked closely with health professionals and GPs to monitor health and seek further guidance when required. A chiropodist visited the home six weekly to review care and treatment plans with the assistant manager. They told us that the staff had a good knowledge of people, were aware when to make referrals and always followed treatment plans. Another health professional told us that staff were good at leaving as much detail as the surgery needed to make an informed decision and that they always let them know if treatment plans were not being effective.

Good

Is the service caring?

Our findings

People were cared for by kind, attentive and caring staff. Throughout the inspection, people, their relatives and visiting health care professionals were positive about the care provided. Comments from people included; "They are a happy lot of girls here and are very caring." "I love all the girls, they are good to me, and they are never rude to me." A relative told us, "I'm very pleased with the care my relative is getting, and staff seem very understanding."

People were comfortable in the company of staff and we observed that staff interacted with people in a warm, friendly and respectful manner. The atmosphere in the communal areas was relaxed and staff made time to sit with people and talk with them about their interests. Staff listened carefully to people and gave good eye contact and adjusted their height when speaking to people. One staff member told us that when supporting one person with hearing loss, they spoke louder and ensured they were facing them as they were aware they could lip read and this promoted their understanding.

People's dignity and wellbeing was considered and promoted throughout the day. Staff used people's preferred names and were able to describe how they ensured people's dignity during personal care by; speaking calmly, gaining consent, ensuring curtains and doors were closed and approaching people gently. Staff knocked on doors and always waited for consent before providing support. People felt their right to privacy and dignity was respected. One person told us, "I feel I am able to get privacy, if needed." Another person told us, "Most staff are very respectful, especially when they give me a wash in my room." Staff understood their responsibilities in relation to confidential information. Care plans and electronic records were kept secure and access limited to people who needed to know.

Staff were genuine in their concern for people's wellbeing and independence. For example, when people required assistance from staff they did this in a timely and discreet way, ensuring that they were reassured, not rushed and that their clothing remained in place as they were supported to move. Staff supported people to make choices. One staff member told us that one person would communicate their choices by writing them on a piece of paper. Staff told us they encouraged people to take positive risks and to do as much as they could for themselves. A relative confirmed that, their relative had initially been unhappy with the distance they needed to travel from their room to the communal spaces. However, with encouragement from staff, and them always ensuring someone was behind their relative as they walked their mobility and greatly improved, and their relative now viewed the distance as good exercise.

Personal spaces had photographs, pictures and furniture that reflected individual needs and taste preferences. One person told us, "I entertain myself in my room, I do a lot of artwork and am able to decorate my room". Staff told us and demonstrated that they had a good knowledge of people's needs, backgrounds and likes and dislikes. People and their relatives, when they had the legal authorisation to do so, were involved in the review and planning of people's care. One person told us, "Staff do sometimes ask about things in my care plan," and "Yes, I do feel involved in decisions." A relative told us, "The home does get in touch when it's needed, they are very good at that, and they responded straightaway to a request for her to have her meals in her room." Relatives told us they could visit whenever they wanted to and were

always welcomed and informed of any issues relating to the health and wellbeing of their loved one.

People's diversity and right to maintain important relationships was respected and promoted within their day to day experience and care planning. Staff demonstrated an awareness of equalities and diversity needs, and recognised both the people they supported and their colleagues may have experienced discrimination due to their age, ethnicity, religious beliefs, gender, gender identity or sexuality. People's religious beliefs and how these were expressed were detailed in care plans. For example, one person's care plan detailed they had an identified religion but chose to be 'non- practicing'. Where people practiced their faith, they had access to places of worship or visiting religious preachers. People's important relationships were recognised and maintained. For example, when relatives visited they joined people for mealtimes and people were supported to contact their loved ones. One person was also supported to keep their pet budgerigar.

When required people had access to relevant advocacy services so that they could be actively involved when making decisions about their care. Advocates may be required when people do not have relatives or other significant people in their lives to support decision making. Statutory advocates include; Independent Mental Capacity Advocate (IMCAs) and Relevant Person's Representative (RPR). An IMCA provides a legal safeguard for people who lack capacity to make specific important decisions; these can include making decision about where they live and about serious medical treatment options.

Good

Is the service responsive?

Our findings

People and their relatives told us that staff were responsive to their needs and that their care was personalised. One person told us, "Yes, I do feel I get the care I should be getting." Another person told us, "This place is right for us, we get well cared for and we don't feel cooped up." People felt staff listened to them and that they were involved in making decisions about their care and support needs. One relative who's loved one chose to spend time away from groups of people told us, "The care and attention my relative gets suits them and is in their best interest."

People, relatives and staff told us that people were involved as much as they could be in developing care plans. One person told us, "I am aware of my care plan, I am given independence, and they always acknowledge what I want do." Another person told us, "I feel I am able to get up when I want, and I have some independence." Relative's confirmed that they were involved with any decisions. One relative told us, "They are always letting me know how my relative is getting on, and the communication with me is good." Staff told us that care plans and guidelines were clear and that they built on this knowledge through the contact they had with people and the choices they made. One staff member felt that the home could focus more on person centred care planning, however they acknowledged that improvements were being made, for example, through access to training from health professionals.

Care plans were personalised and contained basic details of social interests, communication needs, emotional needs, mobility, personal care and health needs to guide staff on how to provide personalised care and support. Care records and daily 'round' sheets detailed people's care needs and these needs were regularly reviewed with people. For example, one person's care plan detailed that they needed assistance with removing some articles of clothing and washing their back. However, they were independent in washing their face and upper body. Pre-admission assessments were completed for new people to ensure the home could meet their needs and fully understand how to support them. A local authority contracts professional, fedback that they had visited the home recently and observed some very person-centred activities including; one person who was being supported to engage with their local community."

Personal backgrounds and life histories were used effectively to assist staff to empathise with people and improve personalised care. For example, people's established relationships and life events including significant bereavements were detailed in a section called 'About Me'. One person's likes included; watching boxing and horse racing at the pub, and that they attended an ex-military club where they met friends regularly. There was also guidance noting that their television should always switched on, so they could independently use the remote to change channels. Relative's also fedback examples of how planned approaches in care had supported their loved ones. For example, one relative whose relative had initially spent a lot of time in their room and was at risk of social isolation, told us, "What they have done for her has been the right thing, they encourage her to mix with others as she was isolating herself." Staff told us, how they had supported one person with exercises designed by a physiotherapists assessment to improve their walking. They told us, "We do a bit day by day, a little bit more each day, we've got them back on their feet."

People told us that they could make choices about activities and how they spent their days in the home.

One person told us, "There seems to be enough to do and I enjoy what they put on." There were planned group and individual activities for each day including yoga, musical items, exercises, entertainers, cards, bingo and bus outings. Staff demonstrated that they promoted some positive outcomes for people living with dementia. People were kept informed about what would be happening next during the day, and given choices about whether they took part in joint activities or spent time in quieter spaces. Staff took time to explain options to people and gave them sufficient time to consider what they wanted to do as well as supported them to achieve this. We observed a music and movement session led by the external therapist who knew people well and engaged well with people. People joined in with the activity by singing along." One relative told us, "They seem to have nice activities and the residents do seem to enjoy entertainers when they come in". The registered provider also told us, there were also more personalised activities available including; hand and foot massages, and visits from well behaved dogs, that people who liked dogs could stroke and enjoy some companion time with.

Information for people and their relatives if required could be created in an accessible format to meet their needs and to help them understand the care available to them. For example, there were pictures available showing activities people had taken part in. Staff received guidance and information in relation to people's needs. Care plans included information about people's communication needs and specialist health needs, including sight loss, hearing and diabetes. For example, one person's daily care sheet stated, that staff should ensure their glasses were clean and that they were assisted with their hearing aid. The Stanbridge House website included clear information informing people and their relatives of the service's history, ethos and values and the support they provided.

When needed, the home provided considered end of life care for people. Staff told us that good end of life care involved, ensuring people were comfortable, without pain and that their relatives and suitable health professionals were involved. One relative who's loved one had received 'end of life care' at the service, wrote in a thank you letter to staff, "That bond of trust and kindness has been invaluable." People and their care plans described their preferences including who they wanted to be with them during their end of life care, and their religious and cultural needs. One person told us, "They do know that if I become very ill, I don't want to be revived. I have agreed this with them."

People and relatives were confident that complaints would be taken seriously and were happy to raise concerns they had with the registered provider. One person told us, "I did complain about the cleanliness of the toilet and things have improved and it's ok now." Another told us, "No complaints at all but I would ring my bell and ask for the lady in charge if necessary." We looked at the complaints policy and records and saw that complaints were taken seriously, investigated fully and actions taken to resolve concerns in a timely manner.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and health professionals spoke positively of how the home was managed. One person told us, "The manager is a very nice person and does a good job." Another person told us, "I think the management is very good." A relative told us, "The registered provider is very approachable, and there is a good atmosphere here." Another relative told us, "I would definitely recommend the home to anybody, it's a lovely place." A health care professional told us, "The staff are very helpful, and the registered provider co-ordinates care quite well." However, despite the positive feedback we found some areas of practice that needed to improve.

Quality assurance systems were in place to monitor the overall quality of the service. However, in relation to medicines administration and Mental Capacity Act records they did not always identify if staff had enough detail or guidance to inform their roles and ensure people's care needs were consistently met.

Medicines administration records (MARs) were complete without gaps which demonstrated that people were receiving their medicines. However, in relation to one person's 'as required' medicine for pain management we noted there was no specific protocol available that detailed the full purpose of the treatment, the type of pain, the desired effects or when to contact a health professional if the symptoms persisted. Further to this, the MARs sheets did not, as it is stated in the provider's medicines policy, have specific time ranges that medicines were administered.

The MARs sheet of another person who received warfarin did not have the most recent written instructions confirming the time and dose currently to be administered by staff. Warfarin is a medicine that helps prevent clots forming in the blood and to ensure it is provided in suitable doses, health professionals complete blood tests to review the levels are correct, and to assess any adjustments that may be required. The registered provider was able to access the confirmation of the doses and times provided by the lead health professional from an archived file. There was no indication that the person had received inaccurate doses. However, their quality assurance systems had not identified this gap in recording. This gap could have placed the person at risk of not receiving their medicines safely or suitable information being available to other health professionals. The records available to staff would benefit from more detailed guidance to ensure staff are informed about people's current medicines, for example in the event of a medical emergency when the emergency services are called. This is an area of practice that needs to improve.

The Mental Capacity Act 2005 was understood by staff and the service worked in line with the principles of assuming people have capacity and ensuring consent was given on a day to day basis. However, the quality assurances systems in place had not identified if mental capacity assessments had taken place, or that decisions had been recorded and documented where people had Lasting Power of Attorney Arrangements in place or could experience potential fluctuations in their capacity. For example, in relation to temporary illness. This placed people whose capacity could fluctuate at risk of their rights in relation to making decisions not being fully protected. This is an area that needs improving.

The registered provider and assistant manager were committed to improving the home and demonstrated

some areas of good practice in relation to assuring quality. Regular audits and checks were completed. Monthly audits were completed including; medicines incident, maintenance, falls and infection control. This demonstrated the home analysed trends and themes and designed action plans in response. For example, medicines incident reports were completed in relation to medicines errors or near misses. These detailed the causes of the incidents and actions taken in relation to individual staff and wider team feedback was provided in team meetings. This demonstrated that the home monitored and made improvements to the systems when required.

The registered provider was supported by an established team including an assistant manager, a new administrator and senior care staff. The Provider Information Return (PIR) stated, 'we pride ourselves on not having to use agency staff giving continuity of care to all our clients so they know who will be caring for them.' The provider was available to support the staff team and was very present at the service. One staff member told us, "I am happy working here, the management is good." Staff told us they were well supported and there were clear lines of accountability and responsibility through their roles and embedded practices. This was demonstrated on the day of the inspection through observations of staff interacting with the registered provider and assistant manager. Daily care sheets, handovers, team meetings and management schedules underpinned their day to day home delivery tasks, ensuring individual support needs were met.

The provider manager encouraged an open and transparent culture. People, relatives and staff told us that the registered provider was approachable and they would go to them with any queries or concerns. One relative told us, "It's an open-door policy here" and "We can always go to the office to talk about any concerns." Staff were encouraged to provide feedback and to make suggestions for improvements in the service. For example, in relation to activities one staff member told us, "The registered provider is always trying to maintain good activities, and they listen to suggestions on making improvements. This demonstrated that improvements were made to the home in response to comments.

The provider's value base was described on their website that stated, "We believe our home provides the independence you deserve, the assistance you desire with the privacy and ambience of your own home." The registered provider and staff demonstrated their understanding of this ethos through their interactions with people and each other. The assistant manager told us, "We look after people the way we would like to be looked after." Staff spoke with consideration and respect for the people living at Stanbridge House. One staff member told us, "We aim to provide people with friendly and very homely care." In relation to their team culture they told us, "We communicate well and have a good team culture, we don't moan about each other. The management are really nice and approachable."

The registered provider was continually looking to improve the culture of the service. For example, the registered provider was very mindful of developing approaches to ensure staff wellbeing and had recently introduced staff yoga sessions. They had also recognised that their documentation, did not always fully evidence some areas of practice and had employed a team administrator to support the further development of these systems and processes. The Provider Information Return (PIR) described that the home worked at building good working relationships with relatives and representatives. Community engagement was also promoted through local school children visiting the home and the arranging of visits to local churches and using community buses for planned days out. The home also worked in partnership with GPs, the local authority contracts and business development teams. The local authority fedback that the home had engaged with them in relation to training and general advice including; completing the 'Safe as Houses' training delivered by the fire service. One GP told us that they had a good relationship with the service, that staff were responsive to timescales and actions needed.

The registered provider understood their responsibilities in relation to their registration with the Care Quality Commission (CQC). The registered provider had submitted notifications to us, in a timely way. This meant we could confirm that appropriate action had been taken. There was a policy in place in relation to the Duty of Candour and the registered provider was aware of their responsibilities under the Duty of Candour. This is where a registered person must act in an open and transparent way in relation to the care and treatment of people.

Satisfaction and quality surveys were regularly completed, which provided people and relatives with the opportunity to feedback about the quality of the service provision. The survey outcomes were consistently positive and staff were very proactive in providing people and their relatives with opportunities to feedback. One relative wrote in their survey response, "I visit nearly every week and am always impressed by the homely, friendly atmosphere as well the cleanliness and efficiency."