

# West Sussex County Council

# Stanhope Lodge

## Inspection report

Poplar Road  
Durrington  
West Sussex  
BN13 3EZ

Tel: 01903264560  
Website: [www.westsussex.gov.uk](http://www.westsussex.gov.uk)

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?	<b>Requires Improvement</b> 
Is the service effective?	<b>Good</b> 
Is the service caring?	<b>Good</b> 
Is the service responsive?	<b>Good</b> 
Is the service well-led?	<b>Requires Improvement</b> 

# Summary of findings

## Overall summary

This inspection took place on 20 August 2018 and was unannounced. We also returned on the 21 August 2018. The registered manager was given notice of the second date, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

The inspection was prompted in part by information of concern raised by partner agencies. This was following an investigation in August 2018 of an incident which a person using the service died in 2016. This incident is not currently subject to a criminal investigation. However, the information shared with the Care Quality Commission (CQC) about the incident indicated potential concerns about the management of risk of how epilepsy and other specific health conditions was assessed and planned for. This inspection examined those risks.

Stanhope Lodge is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Stanhope Lodge is registered to provide accommodation and care for up to 28 people with a learning disability and/or challenging behaviour and other complex needs. At the time of our visit 20 people were residing.

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 have access to gardens surrounding the home.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At the last inspection in December 2015 the service was rated Good. At this inspection we found that the provider had been unable to sustain the rating of Good as we identified two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have asked the provider to take at the end of the full version of this report.

At the last inspection in December 2015 we found the provider was meeting the regulations, but 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. We asked the provider to make improvements to these areas.

At this inspection we found the provider had taken steps to improve the two areas lacking quality

monitoring and oversight, which related to ensuring medicines were managed safely and checks made to ensure that areas were cleaned thoroughly and effectively. However, the provider continued to not have an effective system for monitoring how the quality of care was assessed, planned and delivered. At our last inspection we found this had not impacted people's safety. At this inspection we found risk assessments provided incomplete information about people's risks and insufficient information and guidance for staff on how to mitigate risks.

The provider had also not notified CQC of relevant incidents of notifiable events when necessary.

The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

Health and safety audits were completed as needed and checks made on the safety of equipment, electrical installations and gas safety. Staff had been trained to recognise the signs of potential abuse and knew what action to take. Safe recruitment practices were in place. Medicines were managed safely. People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Staff we spoke with understood the requirements of the Mental Capacity Act (MCA). Staff completed training in a range of areas including safeguarding, moving and handling, first aid, health and safety. New staff followed the Care Certificate, a nationally recognised qualification. Staff meetings took place monthly and records confirmed this. Staff received monthly supervision and annual appraisal and told us they felt supported in their roles. People's nutrition and hydration needs were catered for. People received support from a range of healthcare professionals and services. People had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

Staff had a good understanding of person-centred care. A range of activities was organised for people at the home. Complaints were managed in line with the provider's policy. People and their relatives knew who to talk with if they had any concerns or wished to make a complaint.

There was a range of quality audits in place completed by the management team. These were up-to-date and completed on a regular basis. Accidents and incidents were reported and monitored to identify any patterns or trends. People and their relatives were asked for their views about the service and actions taken where needed. Staff we spoke with felt supported by the management and leadership of the home.

At the time of our inspection the quality assurance manager and registered manager gave us a detailed list of actions that would be taken to address the issues and concerns we found at inspection.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** 

Some aspects of the service were not safe.

Risks to people were not always identified, assessed and managed safely. Risk assessments did not provide sufficient detail or guidance for staff on how to keep people safe.

Staff had been trained to recognise the signs of potential abuse and knew what action to take.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were employed to support people.

Medicines were safely managed.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

### Is the service effective?

**Good** 

The service was effective.

People were encouraged and supported to make their own choices and decisions. The service was meeting the requirements of the Mental Capacity Act 2005.

People enjoyed their meals and were helped to eat and drink enough to maintain a balanced diet.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

### Is the service caring?

**Good** 

The service was caring.

People were treated with kindness, respect and compassion and

they were given emotional support when needed.

People were supported to increase their independence and learn new skills.

People were supported to express their views and be actively involved in making decisions about their care

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

### Is the service responsive?

Good ●

The service was responsive.

People's support plans were personalised and contained information on how people liked to be supported and the activities in which they preferred to engage.

People's concerns and complaints were listened and responded to improve the quality of care.

The service was not supporting anyone at the end of their life. However, the provider was putting plans in place.

### Is the service well-led?

Requires Improvement ●

Some aspects of the service were not well led.

Systems were not in place to ensure robust monitoring and measuring of the care delivered.

There were seven occasions when the registered manager did not notify CQC of significant events as required.

People who used the service, their relatives and staff were engaged and involved in making improvements.

The registered manager promoted an open culture in the service. The provider's values were embedded in staff working practices.

The service worked in partnership with other relevant organisations.

# 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.

This inspection took place on 20 August 2018 and was unannounced. We also returned on the 21 August 2018 which was announced.

The inspection was prompted in part by information of concern raised by partner agencies. This was following an investigation of an incident which a person using the service died. This incident is not currently subject to a criminal investigation. However, the information shared with the Care Quality Commission (CQC) about the incident indicated potential concerns about the management of risk of how epilepsy and other specific health conditions was assessed and planned for. This inspection examined those risks.

One inspector, a nurse specialist 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.

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 the service does well and any improvements they plan to make. We reviewed the information that we held about the service and the service provider. This included previous inspection reports and 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.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the breakfast and lunchtime meal, medicines administration and activities.

We spoke with three people who lived in the service and with one relative. We spoke with the registered manager and deputy manager. We spoke with two senior support workers and five support workers. During our visit we spoke with a visiting advocate who gave us permission to share their views in this report.

We looked at the care plans and associated records for seven people, including medicine records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Following the inspection, we sought feedback from Health watch and staff from the local authority on their experience of the service. Health watch are an independent organisation who work to make local services better by listening to people's views and sharing them with people who can influence change. We received feedback from one commissioner who gave us permission to share their views in this report.

# Is the service safe?

## Our findings

When we asked people if they felt safe living at the service they confirmed that they did. A relative also told us that they felt that the service was safe. One relative said, "On a personal level the staff understand [person], the staff have effective systems and procedures. Belongings are locked into the cupboard [for security]. There is an alert bell if [person] leaves their bedroom, and walks out into the corridor [this alert's staff the person may need support.] There is enough staff that makes it safe."

Despite the positive feedback about the service we found that risks to people were not always anticipated, identified or managed safely. Risk assessments are documents used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to people. Risk assessments should include guidance for staff on how to support people safely. Risk assessments we looked at were incomplete and did not provide detailed guidance to ensure people's risks were managed safely.

For example, we read that that one person had low blood pressure. The risk assessment did not indicate what the persons "normal" range was, the risk assessment did not give details how to monitor this and at what point a referral to a GP would be required. The plan lacked detail how the person may present while suffering from low blood pressure and how to respond. The person's daily records indicated that the individual regularly experienced episodes of dizziness. We found no evidence of blood pressure monitoring. The same person had a stomach ulcer and hernia. The guidance to staff was to monitor this, but there were no details of how to monitor this. Staff were unable to explain what changes they were looking out for and at what point medical intervention would be sought. This was insufficient.

Another person had been identified as having epilepsy. The person had no risk assessment in place for the management of this condition. The individual was on regular medication as an anti-epilepsy treatment plan. The registered manager told us they felt this was sufficient as the person had not had any seizures for a long time. However, staff told us the person had a seizure within the last five years when the person had not taken their medication as prescribed. No consideration had been given if the medication either became less effective or not taken. The risk assessment did not describe the type of seizure the person could have and what signs to look for. The same person was also assessed as at risk from choking. The risk assessment did not give a clear management plan to ensure the persons safety.

Another person had also been identified as at risk from choking. The management plan for this was for staff to supervise the person while eating. The risk assessment identified the person may eat food in their bedroom when left unsupported, the plan stated this was the persons choice. The registered manager told us this food was available in the persons bedroom because the items were brought in by relatives. The registered manager confirmed no attempts had been made to inform the relatives that the person was at risk from choking and that their actions could cause injury. The registered manager told us, if they had been informed, they were likely to hand the food to staff for monitoring rather than leaving the food in the persons bedroom. This person also lived in a unit that was not continuously staffed. The unit was allocated one staff member who shared their time with the unit next door. Although the risk assessment had identified



the person may choke in their bedroom no consideration had been given on what would happen if this occurred when there were no staff in the unit to respond.

The above evidence shows that people did not always receive safe care and treatment. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We fed back our concerns to the registered manager on the first day of our visit. The registered manager spent time on the first and second day reviewing and updating people's health risk assessments to ensure risk's we had identified were more robustly planned for. However, at the end of our second day, we agreed with the registered manager, more work was needed to ensure they contained the detail needed to meet people's needs.

The registered manager provided assurances that a referral to the West Sussex's Community Team would be made the same day. This would mean a community nurse will visit Stanhope Lodge to review all people's health needs. Following our visit, the registered manager provided sufficient evidence that a community nurse did attend Stanhope Lodge to review the health care plans and risk assessments. The community nurse gave assurances they would continue to engage with the provider. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

Other risks had been effectively assessed and planned. For example, a person with a lung condition had been identified as at risk of aspiration (this is when a person is at risk from inhaling contents from the stomach). A physiotherapist had recommended chest physio twice a day to mitigate the risk of choking or being sick. We found the physiotherapist's advice had been included in the risk assessment and records demonstrated the chest physio had been occurring as advised. The care plan contained images to guide staff on how to carry out the chest physio safely.

We reviewed management plans for people who displayed behaviour that could put them and others at risk. Their management plans included giving them reassurance and space when needed, talking to them about their concerns and engaging them in activities.

We looked at audits relating to the maintenance of the home in relation to health and safety. Records had been completed appropriately in relation to water, Legionella testing, gas safety, electrical installations and fire safety. Equipment was serviced as needed. Fire drills and testing of fire alarms were completed.

People were protected from abuse. There was an up to date safeguarding policy and procedure in place. Staff training was up to date and staff were able to demonstrate that they knew what the possible signs of abuse were such as unexplained bruises and a change in behaviour. Staff told us that they knew how to raise concerns about abuse and were confident that the provider would deal with any concerns. Staff were also aware of what to do if the concern was not addressed. Staff were able to demonstrate they were aware of whistle blowing procedures and how to report any poor practice identified at the service.

There was an equality and diversity policy in place and staff received training in this area. Staff demonstrated that they were aware of their responsibility to help protect people from any type of discrimination and ensure people's rights were protected. The registered manager gave us an example of this regarding one person's life choices which could lead them to be bullied by people outside the service. There were plans in place to ensure the person could enjoy their lifestyle in a way that protected them from harassment.

There continued to be enough staff to meet people's needs. Staffing numbers were based on a full

assessment of people's support needs and we observed that people were supported by a small team of staff who knew them well. There was enough staff available to support people to do what they wanted to do each day. For example, people benefited from one to one staffing input. The service did not regularly use agency staff and there was sufficient staff to cover absences. The provider was also available to provide support to people and regularly undertook shifts at the service working alongside staff to support people. There was three members of staff on shift overnight with a fourth staff member who slept on site in case additional support was needed. There was an out of hours system in place in the event of an emergency.

When new staff were recruited they completed a number of pre-employment checks. This included Disclosure and Barring Service (DBS) checks and supplying suitable references. This meant people were protected from the risk of being supported by staff who were not suitable to work in the care sector.

People received their medicine safely and on time. Staff had received training on how to give people their medicines and medicine administration records (MARs) were complete and up to date. There continued to be policies and procedures in place to ensure people received the medicine they were prescribed and on time. For example, staff competencies were checked on an on-going basis and recorded and medicines were in date. Medicines continued to be stored safely and at the right temperature in a locked cabinet and were disposed of safely. People had regular medicines reviews. Checks were carried out to ensure that medicines were administered appropriately and an external audit of medicines had been undertaken.

People were protected from the risk of infection. The service was clean and smelt fresh. Risks of infection were minimised by health and safety control measures based on an up to date infection control policy. There were schedules for staff to check and clean areas on a daily, weekly, monthly and quarterly basis and staff signed to confirm that these had been completed. People were also encouraged to take part in cleaning tasks. The provider undertook infection control checks, recorded any actions needed and then checked that those actions were complete. Fridge and freezer temperatures were checked daily to ensure that they were at the correct temperature to keep food safely. Food was labelled with the date of when it was opened to ensure that staff knew when it was to be used by.

Personal protective equipment such as aprons and gloves were available to staff when these were needed and we observed staff used these when appropriate. Staff understood the importance of regular hand washing and how infection was spread. Staff had completed infection control and food hygiene training.

The service maintained records of incidents and accidents. Staff knew how to report incidents and accidents. The registered manager reviewed these and considered ways to prevent them from happening again. We saw that a person's risk assessment and care plan had been updated following an incident. Handover and team meetings were used to discuss incidents and actions or lessons learned.

# Is the service effective?

## Our findings

At our last inspection in December 2015, the key question Effective was rated good. At this inspection we found Effective remained good.

People told us they thought staff had the skills and knowledge they needed to meet their needs. A professional connected to the location told us, 'All staff I have come into contact with have an appropriate understanding of key issues such as safeguarding, medication administration, risk assessment, health & safety, health issues and mental capacity.'

The registered manager maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the registered manager to monitor when this training needed to be updated. These courses included first aid, safeguarding, manual handling, fire safety, food hygiene, infection control and diversity and inclusion. Additional training was available to staff in specific conditions such as epilepsy. Staff also received on-going refresher training to keep their knowledge and skills up to date.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. 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. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures. Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. These 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.

Without exception all of the staff we spoke with, told us teamwork among the care staff was positive and that morale was good. Staff received monthly supervisions with the registered manager, deputy manager or senior support worker and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. We reviewed records of staff supervision which noted that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this.

People's nutritional needs were met. The service provided food, drinks, fresh fruits and snacks so people could help themselves as they wished. People told us they had enough to eat and drink. Staff supported people to prepare their meals. People were also encouraged and given the support they needed to cook for themselves as part of promoting their independence.

Staff told us they had monthly team meetings to discuss their roles, training, people's individual needs, recruitment and changes in policy. Staff told us this was also an opportunity to suggest improvements to the registered manager. Records showed the discussions that had taken place, together with a review of actions agreed from previous meetings. This provided an opportunity for the team to work together to deliver

effective care.

Some staff had a lead role within the service. This meant they had oversight of this area of practice and specific duties in relation to their lead role, including keeping up to date with any key changes of legislative practice. They also ensured staff were aware of their responsibilities and were complying with the company's policy and any other legislation. For example, we viewed documentation for the infection control champion. The folder included the auditing schedule they had developed and how they encouraged all staff to take responsibility for good infection control practices and use of personal protective equipment. In addition to an infection control lead, there were other champions for areas of health care and related regulated activity.

A professional connected to the location told us, 'In regard to the support planning Stanhope Lodge has received from me, staff have been very clear about what they can and cannot achieve in terms of their own skills set and training but also in regard to resources and manpower and their advice has always been appropriate on meeting required outcomes for the individual.'

People's records contained essential information about them which may be required in the event of an emergency, for instance if they required support from external health professionals or if someone needed to be admitted to hospital. These were referred to as 'hospital passports.' Information included people's means of communication, medicines, known allergies and the support they required. This ensured health professionals would have the required information in order to be able to support people in line with their needs and preferences.

People had access to health and social care professionals when they needed them. Records showed regular attendance at appointments that included GP, chiropodist, dentist and optician. Feedback from these appointments was clearly documented and any recommendations or guidance was included. We saw that staff were proactive in seeking input from advocacy services. Advocates help people to make decisions that are right for them and in line with their personal preferences and choices.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. There was sufficient communal space in the dining room and in the lounges. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs. Some of the units had been adapted so that kitchen work surfaces were the height of the individual so they were able to cook more easily.

The service had policies and procedures to support the principles of equality and human rights. This meant consideration was given to protected characteristics including: race, sexual orientation and religion or belief. Records also showed that the registered manager's assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the registered manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care. Another example we observed were gender neutral toilets which were available to people who did not identify as male or female.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The 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. We found DoLS applications had been made to the local authority and authorised where appropriate.

People's care records identified their capacity to make decisions. Staff had been trained in the MCA and DoLS and demonstrated they understood MCA and how this applied to the people they supported. Three people told us staff listened to them and respected their decisions.

# Is the service caring?

## Our findings

At our last inspection in December 2015, the key question Caring was rated good. At this inspection we found Caring remained good.

One person told us, "The staff talk to me politely, the staff are caring doing what they do." A relative told us, "[Person] is always given choices, however they are not always able to make a choice themselves, or they are not interested, however [person] will make it heard if they don't like something." The relative also told us, "The staff members I know are caring."

A healthcare professional told us, 'Every person I have worked for who stays at Stanhope Lodge, on either a short or long-term basis has indicated, communicated or told me that they love Stanhope Lodge, the staff and what they do when staying there. Several people in respite have wanted to become full time residents and I take this as good measure of the staff working in the service all round.' An advocate visited Stanhope Lodge during our visit and told us, "It's a nice home, the staff are very caring."

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. Care staff were informal, friendly and discreet when caring for people. We witnessed positive conversations that promoted people's wellbeing. Staff spoke with people as they went about their work and spent time with people who were cared for in their rooms.

Records demonstrated that care staff had sensitively asked people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night. People were asked if they would prefer a bath or shower. Whether people wanted to be supported with having a wet or electric shave. Records demonstrated that choices were being met and documented.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to see what was important to the person and how best to support them.

A relative told us, "Staff encourage [person] to make their own decisions [in regard to being involved in their care planning]." We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who

could support them to express their preferences. Care plans included people's preferences around clothes and gender of care staff they wished to be supported by.

There was an advocacy service available if people required this, providing advocates who were skilled in supporting people with mental health needs. An advocate is an independent person who can help someone express their views and wishes and help ensure their voice is heard. An advocate visited Stanhope Lodge during our visit and told us, "This service is always looking at how restrictions can be reduced. For example, the kitchen used to be locked, no access to people. Now it is open and only individual cupboards that do need locking are locked. They are constantly evaluating people's needs. For example, what a person is getting from an activity. One person who is unable to verbally indicate this, they monitor their reactions, is the person appearing to enjoy it? The staff communicate well with each other about the response and document it in the care plan. They document the films seen so that the person is not taken to the same movies."

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. People had the opportunity to attend church services within the service. A staff member told us, "We are trained to be open minded, not to influence an individual we support. For example, influencing an individual's belief like wanting to go to church, or other religious functions irrespective of my own beliefs."

Where possible the service provided access to local events to enhance social activities for people to access and get involved with, taking into account their individual interests and links with different communities. An example of this was supporting people to attend Worthing's recent first pride parade. Pride parades are events celebrating lesbian, gay, bisexual, transgender, and intersex culture and pride.

People's privacy, dignity and independence were respected and promoted. A person told us, "I do my own cooking, washing up, I do a little bit of house work." A staff member told us, "You have to treat people with respect, empathy, and obviously how you would like to be treated yourself, each person has their own individuality their needs, their rights, and try to work with them."

A professional connected to the location told us, 'I have found that all staff I have met are consistent and capable working with people with wide ranging and differing levels of independence and or dependence and that staff work in a positive way that allows people to maximise their potential in terms of learning, development and choice.' A relative told us, "When [person] gets stressed then they need space, a private space because [person] normally strips their clothes off. Staff members would pre-empt this [to maintain the persons privacy and dignity].

We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

We found that people could speak with relatives and meet with health and social care professionals in private if this was their wish. In addition, care staff were assisting people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of

staff. Records showed that care staff had been given training and guidance on the importance of maintaining confidentiality and we found that they understood their responsibilities in relation to this matter.



# Is the service responsive?

## Our findings

At our last inspection in December 2015, the key question Responsive was rated good. At this inspection we found Responsive remained good.

People told us their choices were respected and acted on in line with their wishes. A relative told us, "I don't think [person] could get better support and care that they receive, or better and above than what Stanhope delivers."

A professional connected to the location told us, 'In general all staff I have spoken to and in particular my working relationship with the manager and deputy manager I have seen a very professional and person-centred approach to the care of all the individuals who stay there both in respite and as full-time residents. Stanhope act as our emergency respite service and when I have needed a quick and firm decision on what is available and can be done to support individuals in crisis I have had my answers within the hour and am able to work more efficiently as a consequence. Staff have been very good at identifying possible areas of need and or concern for individuals that stay with.'

Without exception the staff we spoke to were able to describe the importance of person centred care. A staff member told us, "Its individual based caring, to encourage independence, in a safe environment, what works for one individual doesn't mean the same works for other individuals."

For people who were regularly came for respite, staff were aware of which bedrooms people liked when they stayed and what they liked to be in their rooms. For example, one person liked three pillows and a lamp above their head. We viewed the bedroom and it was prepared for their coming stay. Where possible we saw staff had been able to provide people with the room they wanted. We also saw staff were aware of relationships between the different people who use the service. People who had stayed at the same time knew each other from the past and were able to re-kindle their friendship.

There was information around the service showing what was planned including activities, forthcoming events, planned meetings and photographs of different things people had participated in. There was information about people's birthdays. Relatives when coming in could see what had been happening or was planned to help to keep them informed.

Staff maintained daily handover records. These commented on people's wellbeing and any significant events which had occurred during the shift. Including health appointments, incidences and accidents.

People had detailed social histories which staff were aware of and helped them to provide greater personalisation around people's individual needs. The profiles gave staff an insight in to the person's life experiences and what was important to them. We saw photographs and emphasis on what people had achieved in their lives. The service continued to support people to achieve and pursue their own interests.

Care plans included a detailed assessment of people's needs and included people's preferences and

routines. However, where a person had a specific healthcare need, the risk assessment of the health need was not personalised, which we have reported on in the key question, is the service safe? Care plans had been completed with each person and their relatives where appropriate. Staff were able to provide examples of how they provided personalised care and support to people, which responded to people's needs.

People's care plans were detailed and informative, outlining their background, preferences and communication needs. People were being supported in line with what was recorded in the care plan. Where particular routines were important to people these were clearly recorded and described, so staff were able to support the person to complete the routine in the way they wanted. For example, when the person preferred to go out, what time and what support would be required. Care plans were reviewed on a monthly basis or as required in response to any changes in people's needs.

There was an easy read complaints policy in place. Staff had explained the complaints policy to people so that people understood how to complain if they wished to do so. People told us they had not needed to make a complaint. However, they were confident that if there was a problem it would be addressed quickly. Formal complaints were dealt with by the management team, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People had the opportunity to discuss with staff what it meant to be at the end of life. People had expressed their own preferences in how they wanted their care to be provided when they were at end of life, which were recorded in care plans.

## Is the service well-led?

### Our findings

We found the registered manager did not have an effective system to prompt them to send notifications to CQC of significant events in line with requirements, as we were not notified on seven occasions of issues related to allegations of safeguarding concerns.

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

At our last inspection in December 2015, for the key question, 'is the service well-led?' we found 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. We asked the provider to make improvements to these areas.

At this inspection we found the provider had taken steps to improve the two areas lacking quality monitoring and oversight, which related to ensuring medicines were managed safely and checks made to ensure that areas were cleaned thoroughly and effectively. However, the provider continued not to have an effective system for monitoring how the quality of care was assessed, planned and delivered. At our last inspection we found this had not impacted people's safety.

At this inspection we found risk assessments provided incomplete information about people's risks and insufficient information and guidance for staff on how to mitigate risks. These risks included but are not limited to, people who had low blood pressure, epilepsy, a hernia, a stomach ulcer and two people identified as at risk from choking.

Other risks we found that had been identified and not adequately planned for was a vulnerable person at risk of being manipulated to leave the grounds of the location from a visiting person on respite. The same person's hospital passport did not include essential information for the hospital staff to know about the person's diet. Another person was at risk of demonstrating challenging behaviours in a vehicle, the management plan for this was not in the person's risk assessment. A person who required their bowel movement monitored to ensure PRN medication was offered at the right time to keep the person comfortable had no monitoring system in place to check this. Whilst the person had not suffered harm the practice left them at risk.

The above evidence shows that the quality and safety of the service were not always operated effectively. Records relating to risks were not always managed safely and there were gaps in recording information relating to risks. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each time we informed the registered manager of our findings, she immediately responded by ensuring shortfalls were addressed. This included developing a new audit tool to ensure the areas we identified would be included. The registered manager also reviewed and updated all of the risk assessments we identified as not being robust to mitigate people's identified risk. As an additional measure the registered manager also gave assurances that a referral would be made to the West Sussex's Community Team, for a

community nurse to visit and review each person's health care needs to ensure the risk assessments and care planning for each person was comprehensive and robust in meeting their needs. Following our visit, the registered manager provided sufficient evidence that this visit did occur. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

There was a regular programme of other audits. Systems included: finances, medicines management, accidents, activities, housekeeping, health and safety and infection prevention and control. We noted examples where shortfalls had been identified and addressed. The provider carried out compliance visits; this involved ensuring the audits were completed and actioned. We saw that these identified shortfalls which needed to be addressed and where shortfalls were identified, records demonstrated that these were acted upon promptly. The monitoring of accidents and incidents were recorded and audits were in place to identify any emerging patterns or trends.

Staff gave us their views about the management and leadership of the home. One staff member said, "The manager is very good and approachable. Their door is always open to us." Staff told us that they frequently observed the registered manager chatting with people, their relatives and staff and that they had a visible presence at the home. Staff felt supported by management in their roles.

Relatives were complimentary about the management. A relative told us, "The manager is there when she needs to be there, she doesn't micro manage, there is a chain of staff over here which seems to be very organised. I feel that the manager is very competent." We looked at seven compliments from relatives that had been received in 2018. All of which complimented the management of the service.

There was a welcoming and friendly atmosphere at the service. We observed numerous positive interactions between people who used the service, staff and managers. Staff spoken with expressed an understanding of their role and responsibilities. They were aware of the management structure and lines of accountability at the service. Staff had been provided with job descriptions and a code of conduct, which outlined their roles, responsibilities and duty of care. They had access to the service's policies, procedures and any updates.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people and their relatives annually with the last being in May 2018. We noted all expressed a degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.

The manager collated information relating to the running of the service which they shared with the provider through regular reporting. This covered everything from admissions, safeguarding, maintenance of the building, to incidents and accidents and care reviews. This information provided oversight of what was happening within the service and contributed towards plans for the continual improvement of the service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had clearly displayed their rating at the service.

The service worked well with other organisations to ensure people received a consistent service. This included those who commissioned the service, safeguarding and other professionals involved in people's care.

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 18 Registration Regulations 2009 Notifications of other incidents  The registered person had not notified the CQC of seven incidents where a service user suffered abuse or an allegation of abuse had occurred.  Regulation 18 (1)(2)(e)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Risks to peoples health and safety had not always been effectively assessed. The registered manager had not done all that was reasonably possible to mitigate any such risk.  Regulation 12 (1)(2)(a)(b)
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  Systems and processes had not been established or operated effectively to assess and monitor the service. Systems were not effective in monitoring and managing risks.  Regulation 17 (1)(2)(a)(b)(c)