

# London Borough of Waltham Forest

## Alliston Road

### Inspection report

Alliston House  
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### Ratings

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

# Summary of findings

## Overall summary

We inspected Alliston Road on 23 & 24 May 2017. This was an unannounced inspection. Alliston Road provides accommodation for up to 43 older people who have dementia care needs. There were 38 people living at the home when we visited. At the last inspection on September 2015 the service was rated as Good.

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

The experiences of people who lived at the service were positive. People and their relatives told us they felt the service was safe, staff were kind and the care they received was good. We found staff had a good understanding of their responsibility with regard to safeguarding adults.

People's needs were assessed and their preferences identified as much as possible across all aspects of their care. Risks were identified and plans were in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. There were sufficient numbers of suitable staff employed by the service. Staff had been recruited safely with appropriate checks on their backgrounds completed.

Medicines were stored and administered safely. However topical medicines were not always recorded correctly and stored appropriately. We have made a recommendation about the management of topical medicines.

Staff undertook training and received regular supervision to help support them to provide effective care. Staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). MCA and DoLS is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. We saw people were able to choose what they ate and drank.

People's needs were met in a personalised manner. We found that care plans were in place which included information about how to meet a person's individual and assessed needs. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

The service had a complaints procedure in place and we found that complaints were investigated and where possible resolved to the satisfaction of the complainant.

Staff told us the service had an open and inclusive atmosphere and the registered manager and deputy

manager were approachable and open. People, relatives and staff felt the registered manager had improved the quality of the service since they had started. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and relative meetings.

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

We always ask the following five questions of services.

<b>Is the service safe?</b> The service remains good.	<b>Good</b> ●
<b>Is the service effective?</b> The service remains good.	<b>Good</b> ●
<b>Is the service caring?</b> The service remains good.	<b>Good</b> ●
<b>Is the service responsive?</b> The service remains good.	<b>Good</b> ●
<b>Is the service well-led?</b> The service remains good.	<b>Good</b> ●

# Alliston Road

## 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.

Before we visited the home we checked the information that we held about the service and the service provider. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning team that had placements at the home, the local Healthwatch and the local borough safeguarding team.

This inspection took place on 23 & 24 May 2017 and was unannounced. The inspection team consisted of two inspectors, a pharmacist inspector, nursing dementia specialist and an expert by experience, who had experience with older people with dementia. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

During our inspection we observed how the staff interacted with people who used the service and also looked at people's bedrooms and bathrooms with their permission. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with nine people who lived in the service and seven relatives during the inspection. We spoke with the registered manager, the deputy manager, one senior care worker, five care workers, the maintenance person and the chef. We looked at 11 care files, staff duty rosters, seven staff files, a range of audits, minutes for various meetings, eight medicines records, finances records, accidents and incidents, training information, safeguarding information, health and safety folder, and policies and procedures for the service.

# Is the service safe?

## Our findings

People and their relatives told us they felt the service was safe. One relative said, "[Relative] is a lot safer than when she was living in her home." One person when asked if they felt safe told us, "Oh yes, we all think so." Another person told us, "We're safe."

The service had up to date safeguarding and whistleblowing policies that gave guidance to staff on how to identify and report concerns they might have about people's safety. Staff were able to explain to us what constituted abuse and the action they would take to escalate concerns. Staff said they felt they were able to raise any concerns and would be provided with support from the senior management team. One staff member told us, "I would report right away to the manager. If he did nothing I would report higher." Another staff member said, "Our role would be to go to the senior carer. If nothing done we can whistle blow to CQC and social services."

The registered manager told us and we saw records that showed there had been safeguarding incidents since the last inspection. The registered manager was able to describe the actions they had taken when the incident had occurred which included reporting to the Care Quality Commission (CQC) and the local authority. This meant that the service reported safeguarding concerns appropriately so that CQC was able to monitor safeguarding issues effectively.

Risks to people's safety had been assessed and records of these assessments had been made. These were individual to each person and covered areas such as falls, diabetes, manual handling, mobilising, environment, and evacuation from the building in the event of an emergency. Each assessment had clear guidance for staff to follow to ensure that people remained safe. For example, one person had been diagnosed with type 2 diabetes. The guidance for this person stated, "Family comes in once a week and would normally bring [culturally specific] food and drinks. Staff to ensure that they record what [person] has eaten and is not given sweet drinks." The care records confirmed staff had followed this guidance. Staff we spoke with demonstrated that they were aware of risks to people and that the guidance had been followed.

Accident and incident policies were in place. Accidents and incidents were documented and recorded and we saw instances of this. We saw that incidents were responded to and outcomes and actions taken were recorded.

Sufficient staff were available to support people. People and their relatives told us there was enough staff available to provide support for people when they needed it. One person told us, "Yes plenty of staff." One relative said, "There has always been [staff members] here when I come." Another relative told us, "During the day there is sufficient staff." The registered manager confirmed that new staff members had been recruited to increase existing levels. The staff we spoke with told us that staffing levels had improved recently and there were enough staff to meet people's needs. They told us they were usually able to cover staff absence but that regular agency staff were used if required. One staff member told us, "They have really good agency staff who have been here a long time." Observations during the inspection showed staff members were not rushed in their care duties and call bells did not ring for extended periods of time. A staff

rota was produced detailing how many staff was needed to provide care and we found that the number of staff required was the same as the number of staff on duty.

The service had robust staff recruitment procedures in place. Records confirmed that checks were carried out on prospective staff before they commenced working at the service. These included employment references, criminal records checks, proof of identification and a record of the staff's previous employment. This meant the service had taken steps to help ensure suitable staff were employed.

The premises and equipment were managed in a way intended to keep people safe. The home environment was clean and the home was free of malodour. Regular checks were carried out on hoists, emergency lights, bedrails, alarm systems, windows, water quality and temperature, wheelchairs, radiators, dishwashers, fridges, and fire equipment. The service had an in-house maintenance person and a system in place to report and deal with any maintenance issues. One person told us, "We have no complaints on cleaning and tidying." A relative said about the service, "There is no smell and hygienic as well."

At this inspection, we checked medicines storage, medicines administration record (MAR) charts, and medicines supplies for eight people who used the service. All the prescribed medicines were available. Medicines were supplied by a local pharmacy on a monthly basis. Most tablets and capsules were dispensed into a monthly monitored dosage system. The rest were dispensed into individual boxes. All medicines were prescribed by a GP. Staff had a system for checking all the medicines received each month to ensure that none were missing. Each MAR chart was also checked to ensure that they matched the MAR charts from the previous month. Records showed that people were receiving their medicines safely, consistently and as prescribed. The MAR charts were computer generated by the pharmacy that supplied the medicines. The MAR charts had a photo to assist the identification of the people receiving medicines. Allergy status information was also available.

All medicines were stored in locked medicines trolleys within the clinical rooms. The medicines trolleys were attached to the wall when they were not in use. Each clinical room had a key and could only be accessed by relevant members of staff.

Staff recorded the ambient room temperature of each of the clinic rooms daily. We saw that there were temperature readings above the recommended 25°C however the service had brought in air conditioning units to try and reduce the ambient temperatures. The impact of this was minimal at the time of the inspection. Staff recorded the minimum, current and maximum fridge temperatures. All the readings were between the required ranges (2°C - 8°C).

Unwanted medicines were segregated and stored in boxes in the clinical rooms. They were returned to the local pharmacy each month. Staff kept records of medicines that were disposed of.

Controlled drugs (CDs) were stored in one of the clinical rooms in an appropriate CD cabinet. Controlled drugs are drugs which are liable to abuse and misuse and are controlled by the Misuse of Drugs Act 1971 and associated legislation. Records showed that stock levels for CDs were checked weekly by two senior carers. We checked the CD during this inspection and saw that the quantity in stock matched the quantity recorded in the CD register.

We observed a morning drug round during the inspection. The senior carer wore a 'do not disturb' tabard during medicines administration. The senior carer used a no touch technique to remove the medicines from their packets. Water was offered to each resident to assist with medicines administration. The senior carer documented on the MAR chart immediately after each individual resident to prove medicines were

administered.

When PRN (as required) medication had been prescribed we saw staff had recorded whether the medication had been given or not. We saw that all PRN medicines were supported by written instructions which described situations and presentations where PRN medicines could be given.

Records were documented on topical medicines administration record (TMAR) charts to indicate the application of creams and ointments. The TMARs were also computer generated by the local pharmacy. The site of application of the cream was not always included on the dispensing label. In addition, we saw gaps on the TMAR chart for one resident. This meant that we were not assured that the topical preparations had been applied in line with the GPs instructions. We saw that topical preparations were stored in people's bedrooms. Whilst each person had a locked cupboard for storing medicines, the creams were not locked away in the rooms that we checked. This meant people were at risk of accessing medicines which could cause potential harm.

We recommend that the service seek current guidance on the recording and storage of topical medicines.



# Is the service effective?

## Our findings

People who used the service and their relatives told us they were supported by staff who had the skills to meet their needs. One person said about the staff, "Oh brilliant." Another person told us, "The carers are angels and the [male care staff] are saints."

Staff received regular supervision. Records showed that care workers received supervision on a monthly basis. Topics covered in supervision sessions consisted of wellbeing, safeguarding, care plans, key working, training, team work and health and safety. A staff member told us, "Supervision is useful. I get support. The registered manager supervises me. He is very approachable." Another staff member said, "Supervision is with my senior. I would say it is monthly. It makes you learn new things." A third staff member told us, "My chance to express myself."

Records showed that only one appraisal was carried out in 2016. The registered manager told us, "I've been here since February 2017 and saw that no appraisals had been carried out in 2016. We have just attended appraisals training and will be rolling them all out in June and July 2017. Also, supervision is regular and we have been carrying out probation meetings so I am managing staff performance well." Records confirmed that the registered manager had attended the appraisals training. We were satisfied the registered manager had identified our concerns and addressed them.

Staff we spoke with told us they received regular training to support them to do their job. Records confirmed this. One staff member told us, "The training is very good." Another staff member said, "A lot of training going on. I did first aid and food hygiene recently." Records showed the training included manual handling, managing behaviour that challenges, dignity in care, risk assessment awareness, fire safety, medicines, infection control, first aid, food hygiene, dementia awareness, introduction to swallowing, Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), nutrition, and equality & diversity.

New staff had been provided with induction training so they knew what was expected of them and to have the necessary skills to carry out their role. Records confirmed this. One staff member told us, "I shadowed for about two weeks." Another staff member said, "I'm still on probation. Goes on for about six months. They [senior staff] check in on me." The service had recently implemented the Care Certificate. The Care Certificate is a staff induction training programme specifically designed for staff that are new to the care sector. The registered manager told us, "This is something we've just started. I'm doing it for new staff first and then rolling it out to existing staff. For the more experienced staff we'll be rolling it out to them for skill matching so that we can better utilise people's skills. For example some care workers are very good at organisation and care plans."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

The registered manager and staff we spoke with had a good understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager knew how to make an application for consideration to deprive a person of their liberty. We saw applications were documented which included detailing risks, needs of the person, and ways care had been offered and least restrictive options explored. Where people had been assessed as not having mental capacity to make decisions, the registered manager was able to explain the process she would follow in ensuring best interest meetings were held involving relatives and other health and social care professionals. The service informed the Care Quality Commission (CQC) of the outcome of the applications. We saw evidence of these principles being applied during our inspection. Staff were seen supporting people to make decisions and asking for their consent throughout the inspection. People told us that staff members always asked their consent before helping them. This consent was recorded in people's care files. This meant the service was meeting the requirements relating to consent, MCA and DoLS.

Records showed people's needs were assessed in order to identify their support needs regarding nutrition. Details of people's dietary needs, food preferences and likes/dislikes were recorded in their care plan. Daily food and fluid intake was monitored for people who were at risk of malnutrition. Records showed people's weight was monitored regularly. If there were significant changes they would advise the GP and referrals made to a dietician. Records confirmed this. One staff member told us, "We have a couple of people here who need support eating and we monitor with charts and we weigh service users every month to see if there are any notable changes. If there are, we will make a referral to a dietician to come and reassess them. We've done that recently."

People and their relatives told us they liked the food. The cook was aware of the people who were on specialised diets and explained the meal preferences for these people which was reflected in the care plans we looked at. We saw drinks were offered throughout the day and during the mealtimes to people. The cook told us that people could ask for alternatives to the food choices for that day. There was a rolling food menu in place which included at least two hot meal options and desserts. People told us and we saw records that showed people had requested an alternative meal not on the food menu. On the day of the inspection the main meal on offer was meat pie with vegetables however chicken and fish were available as well. We overheard a staff member say to one person, "Do you want chicken or fish. You want to try a little bit?" One person when asked about the food told us, "Yeah I like it." Another person said, "The food at lunchtime is OK. I had liver the other day and it was beautiful." A relative told us, "My [relative] suffers from constipation but they [staff] are good at making sure she eats more fruit and veg." Systems were also in place to meet peoples' religious and cultural needs, for example arrangements had been made to supply food that reflected people's culture.

As part of our inspection, we carried out an observation over the lunch time period. Food menus were displayed on each table. The lunchtime was relaxed and we saw people could eat in the dining room, lounge area or their own bedroom. We saw where people needed support to eat this was done in a relaxed manner by staff, going at the pace that suited the person and remaining with them until they finished their meal. We overheard a staff member say to a person they were supporting with feeding, "Is it nice?"

People were supported to maintain good health and to access healthcare services when required. Care records showed people received visits from a range of healthcare professionals such as GPs, district nurses,

podiatrists, dentists, chiropodists, opticians and dieticians. One person told us, "[GP] comes in on a Tuesday and you can see him." One relative told us, "They [staff] always make sure that if [relative] needs to see the doctor."

## Is the service caring?

### Our findings

People and their relatives told us that they were well treated and the staff were caring. One person told us, "We are happy." Another person said, "[Staff] are very nice." A relative said, "They are loving and caring staff." The same relative said, "There is a homely atmosphere." Another relative told us, "I was worried before [relative] came here as I heard such bad things about care homes but me and my family think this care home is brilliant."

The atmosphere of the service was friendly and calm. Staff regularly talked to people and asked if they needed anything. Observations showed people enjoyed the interactions. One relative told us, "The staff are very welcoming." One staff member told us, "You have to have love in your heart and empathy. Everyday different but same days stressful but staff have love in their hearts." Another staff member said, "I am new but getting on with people. You don't get upset when they call you names. It's part of the job." A third staff member said, "When I see the people that we support that are happy and healthy and their relatives see them looking good, it's a sense of joy and fulfilment. We need to give them persistent care and tending to individual needs."

Staff knew the people they were caring for and supporting. Each person using the service had an assigned key worker. A keyworker is a staff member who is responsible for overseeing the care a person received and liaised with professionals or representatives involved in the person's life. Staff we spoke with were able to tell us about people's life histories, their interests and their preferences. One staff member said about key working, "I liaise with outside agencies and families. Sometimes families need support."

People's privacy and dignity was respected. Staff told us they knocked on people's doors before entering their rooms and we saw this during the inspection. One staff member told us, "Make sure if any personal care curtains shut and door shut. Everything we do in a dignified way." Another staff member said, "When giving personal care we have to close to door. Before going in to people's rooms we have to knock. We do respect privacy." A relative told us, "Nothing is done in public view. It is all discretely done. [Relative] is always kept clean and fresh." Another relative said, "They [staff] get to know individuals."

People were supported to live as independently as possible. Staff we spoke with shared examples how they encouraged and supported people to be independent. One staff member told us, "I try to build confidence. Help [people] walk and [use] wheelchair to build independence." Care plans were written in a way that promoted independence for people. For example, one care plan stated, "[Person] is able to care for her own personal hygiene needs. She would normally ask for assistance from staff if required." Staff were available in the communal areas of the home to support people when they wished.

People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "We would take any person. They [LGBT] should have a person centred approach. We would encourage them." One staff member said, "At the end of the day you leave your beliefs at the door. You are there to

support the person." Another staff member told us, "Shouldn't be a problem if person was lesbian or gay. A person is a person regardless."

## Is the service responsive?

### Our findings

People told us they enjoyed living at the service and received the care they needed and expected. One person told us, "We would all say yes to coming and living here. We are all better off being here." A relative said, "There was an incident a couple of weeks ago. We all thought a resident had died, but she hadn't. But the staffs reaction was so quick and spot on. I was so impressed."

People had their needs assessed by the registered manager or a senior member of staff before they moved into the service to establish if their individual needs could be met. Relatives told us they were also asked to contribute information when necessary so that an understanding of the people's needs was provided. Information from the pre-admission assessment form and the local authority assessment form was used to develop care plans and risk assessments with people and/or their relatives. However pre-admission assessments we looked at contained minimal information. We spoke with the deputy manager about this. She told us this issue had been identified and discussed in the last senior carers meeting. Records confirmed this. We were shown a pre-admission assessment completed after the last senior carers meeting and the information provided was more robust.

Care plans contained detailed information and clear guidance about all aspects of a person's health, social and personal care needs, which helped staff to meet people's needs. They included guidance about people's daily routines, communication, life histories, health condition support and any behaviour support information. Some of the areas that were considered were personal care, dressing, skin care, oral care, eating and drinking, mobility, moving and handling, mental health and cognition, behaviours, medical condition, medicines, communication, cultural and spiritual needs and social interests. Staff knew about people's needs and their backgrounds and the care and support they required. One relative told us, "There is a care plan. I always give my input."

Records showed care plans had been reviewed regularly or as the person's needs changed. The plans had been updated to reflect these changes to ensure continuity of their care and support. Care plans were reviewed regularly and there was information and assessments on all aspects of daily living. Daily records were completed by staff and provided detailed information on people and how they had spent their day. These daily records were referred to as staff handed over to other staff between shifts.

People had access to planned activities and local community outings. The service employed an activities co-ordinator who worked every Monday and every other Thursday. The activities co-ordinator worked between three locations for the provider. The registered manager told us he had spoken to the activities co-ordinator to change some activities as the people who used the service were quite diverse. The registered manager told us he had started to bring in new activities. For example, on the second day of the inspection a person was brought in from the community to do culturally specific dance exercises with people.

During our inspection we saw group activities and one to one sessions with people. We observed a group of people involved with a quiz that was topical for the lives they had lived. People were engaged and enjoying the quiz. We also saw staff playing puzzles and drawing with people. People told us they had been to South

End on Sea last year. One person said, "We do at least once a year [seaside outings]. The last time we went to South End on Sea and we had fish and chips, and then to an Ice Cream Parlour. It was just lovely." One relative said, "Yes [relative] is actively involved." Another relative told us, "They do things. All through the day they talk and play with them. There is a lot of activities."

Residents and relatives meetings were held on a regular basis to provide and seek feedback on the service. Topics recorded for the meetings included new staff, audits, accidents and incidents, complaints, likes and dislikes, activities, care plan reviews and dementia week. One relative told us, "Letters are now sent out when the next family meeting is."

Most people and their relatives told us they knew how to make a complaint. One relative told us, "When I want to complain I go to [registered manager]." The service had a complaints procedure which was on display in the communal areas of the home. The procedure included timescales for responding to complaints and details of who people could complain to if they were not satisfied with the response from the service. Staff we spoke with told us they would report any complaints to the manager or senior staff. Records showed that complaints were responded to and actions were taken within the time frames set out in the complaints policy.

## Is the service well-led?

### Our findings

People who used the service and their relatives told us they thought the service was well managed and they spoke positively about the registered manager and the senior staff. One relative said, "The new manager is so positive. We are really pleased with all the changes the new manager has made. We are happy that he is here." Another relative told us, "[Registered manager] is very friendly and helpful." A third relative said, "The manager is very helpful. Since the new manager has been here he has implemented a lot of positive changes."

There was a registered manager in post and a clear management structure. Staff told us the registered manager was approachable and had made positive changes since starting in the role February 2017. They said they felt comfortable raising concerns with them and found them to be responsive in dealing with any concerns raised. One staff member told us, "He is lovely. He has a lot of compassion. Tough when he needs be. There has been a real buzz since he started." Another staff member said, "He is a good manager because everything is changing. It's a good atmosphere for the team." A third staff member told us, "He is easy to approach." Staff also told us the deputy manager was very supportive. One staff member said, "She is a good lady. She is a hard worker." Another staff member told us, "The deputy manager works very hard."

Staff told us the service had regular staff meetings. Staff said that team meetings were helpful and that all staff had input into discussions about the service. Records confirmed that staff meetings took place regularly. Agenda items at staff meetings included communication, handover, supervision, respect, activities, key working, care plans, training and report writing. One staff member told us, "We have a staff meeting next week. Gives you a chance to say what you think." Another staff member said, "The meetings can be very vocal. They [management team] respect people's views. You can bring things to the table."

The registered manager told us that various quality assurance and monitoring systems were in place. The registered manager was new in the role and told us when they started they had identified gaps in the service. Records showed the registered manager had created an improvement action plan in February 2017 and this had been updated and reviewed May 2017. The improvement action plan looked at recruitment, staff rotas, training, supervision, staff meetings, medicines, care plans, activities, food menu, and quality assurance. The improvement action plan had responsible people and target dates for each action. For example, the improvement action plan had identified that supervision needed to be more robust and structured. The action plan was to create a supervision matrix for the service. Records showed this had been completed and supervision was being completed regularly.

The registered manager told us and we saw records of a monthly audit. The audit included checking complaints, health and safety, care plans, staff files, training, safeguarding, surveys and medicines. Areas of concern from audits were identified and acted upon so that changes could be made to improve the quality of care. This meant people could be confident the quality of the service was being assessed and monitored so that improvements could be made where required.

The quality of the service was also monitored through the use of regular surveys for relatives of the people



who used the service. The last survey completed was for April 2017. Surveys for relatives included questions about staff and management, environment, activities, and any suggestions. We viewed completed surveys which contained positive results. Overall the surveys were positive. Comments from the relatives included, "The staff are always available", and "Very satisfied with the service. All the staff are second to none. Very well organised management structure." One relative told us about receiving a survey, "Yes and we filled it out too. Things have started to change as a consequence of that. We asked if they could put sanitizers on each floor near to the lifts, and two weeks later they did just that."

There were policies and procedures to ensure staff had the appropriate guidance, staff confirmed they could access the information if required. The policies and procedures were reviewed and up to date to ensure the information was current and appropriate.