HC-One Limited

Alexander Care Centre

Inspection report

21, Rushy Mead
Lewisham
London
SE4 1JJ
Tel: 020 8314 5600
Website: www.hc-one.co.uk

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

Alexander Care Centre provides personal care and accommodation for up to 78 older people, some of whom have dementia. At the time of our inspection there were 76 people living at the home. The accommodation was split into three units. The building was accessible throughout to people with restricted mobility and a car park was available.

Our inspection visits on 12, 14 and 18 August 2014 were unannounced. When we last inspected the home on 16 April 2013 the regulations we inspected were being met.

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

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People living at the home and their relatives said they felt they were safe there. Staff were aware of signs that might indicate someone was at risk of harm and knew the action to take in such circumstances.

Staffing levels were set according to people's needs. Staff were trained and supported to care for people well. They worked alongside health professionals and were aware of when specialist attention was necessary and who to contact to ensure people got the support they required.

People were treated with respect and warmth and their individual needs were considered and met.

The quality of the service was assessed by the registered manager and the provider so they could identify any improvements that were necessary. The views of people and their relatives were requested and listened to.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. Staff were knowledgeable about how to recognise signs of potential abuse and aware of the reporting procedures. Assessments identified risks to people and management plans to reduce the risks were in place.

Staffing levels were appropriate to keep people safe and meet their needs.

The requirements of the Mental Capacity Act 2005 (MCA) Code of Practice and the Deprivation of Liberty Safeguards (DOLS) were met. Staff understood the legal requirements in relation to MCA and DOLS.

Is the service effective?

Good

The service was effective. Staff were well trained and supported to meet people's needs.

Staff liaised with health professionals and followed advice to look after people well. Staff supported people to get medical attention when needed.

People enjoyed the meals and menus took into account their preferences and their cultural, dietary and nutritional needs.

Is the service caring?

Good

The service was caring. People were treated with respect, kindness and compassion. People's dignity and privacy was respected. Staff knew the people they cared for well and were committed to helping them achieve a good quality of life.

Is the service responsive?

Good

The service was responsive. People's individual needs were considered. Advice was sought from specialists when required and this was used to make sure the service appropriately responded to people's changing needs.

People enjoyed taking part in a range of activities. Trips out were arranged.

People and their relatives were asked their views about the service and they were listened to.

Is the service well-led?

Good

The service was well led. Staff told us they were well supported by the manager. The culture in the home was open. People, relatives and staff could raise concerns with the manager who would listen and take action when appropriate.

The service was regularly assessed by the manager and the provider with a view to improving people's quality of life. The home took action to reflect and learn from incidents to ensure that improvements were made.

Alexander Care Centre

Detailed findings

Background to this inspection

The inspection team consisted of an inspector, a pharmacist inspector and a specialist advisor, who was a registered nurse with experience of caring for people with dementia.

Our visits to the home were unannounced. Before the inspection we reviewed the information we held about the home. 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 improvements they plan to make. We also reviewed the information we held about the service.

We spoke with 12 people living in the home and five relatives. We undertook general observations in communal areas and during meal times. We used the Short Observational Framework for Inspection (SOFI) during a meal time. 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 15 staff members including the registered manager, the deputy manager, three team leaders (two of whom were registered nurses), five care staff, members of the catering team, the activity co-ordinator and the administrator. We spoke with two people from the provider's learning and development team.

We had contact with four professionals who visited the home. These included the GP, a clinical psychologist, a practice development nurse from a hospice and a podiatrist. We met two of these professionals during our visits. The others responded to e-mails we sent requesting their views of the home.

We viewed personal care and support records for six people and recruitment records for three staff and training records for the staff team. We looked at other records relating to the management of the service.

Following the inspection we asked the registered manager to send us some additional information including training records and reports of visits made to the home by senior managers, and this was provided.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Good

Is the service safe?

Our findings

A person told us they "feel safe living at the home" and if they had any concerns would be able to talk about them with the manager or staff. Another person said that they would "let the manager know" if they experienced or witnessed anything that they felt was unsafe. A visitor told us they felt their relative was safe living at Alexander Care Centre.

There were processes in place to protect people from the risk of abuse. Staff had received training in safeguarding people from abuse. They were knowledgeable and could describe the different forms of abuse. They were clear about the action to take if they felt anyone was at risk of harm. They knew how to use the organisation's whistleblowing procedure when necessary. The staff team had been trained in equality and diversity issues. This assisted staff to have an awareness of discrimination and the harm people may experience as a result.

Staff assessed risks to make sure everything was done to prevent harm to people. Risks were identified as part of the pre-admission assessments and management plans were put in place. Examples we saw of risk assessments addressed a range of matters, including people's risk of falling, use of bed rails, developing pressure sores, choking and poor nutritional status. Risk assessments and care plans had been reviewed in response to assessments. For example we saw a care plan that had been written in response to a person losing weight unintentionally. Care plans were reviewed regularly and in response to changing needs. For example if a person fell their risk assessment and care plan was reviewed so that preventive action could be taken and observations were made for at least 24 hours to ensure people experienced no ill effects.

Staff managed situations when the behaviour of people living at the home presented risks to themselves or others. We saw notes of an incident where one person had been distressed and another person had been at risk of harm. The notes described how the staff had taken action to avoid anyone being hurt and the preventive action taken to avoid such a situation recurring. We observed a situation which could potentially have led to conflict between people living at the home. We saw that a member of staff had seen the situation and approached and spoke to the two people in a calm way and diffused the situation.

We looked at medicines storage, stocks and records for people living at the home. We saw appropriate arrangements were in place for obtaining medicines. Appropriate supplies were available to enable people to have their medicines when they needed them. We looked at the medicine administration records for 40 people. We saw arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them, there were no gaps on the administration records and any reasons for not giving people their medicines were recorded.

Medicines requiring cool storage were stored appropriately and records showed that they were kept at the correct temperature, and so would be fit for use. We saw that controlled drugs were managed appropriately. We saw the provider did daily and monthly audits to check the administration of medicines was being recorded correctly. Records showed any concerns were highlighted and action taken.

Staff had received training in fire safety, health and safety and some (17%) had received training in first aid. A staff member was designated as the fire officer and another as the first aid officer on each shift, and took the lead in dealing with emergencies. Records confirmed that regular checks of fire systems were made and a fire risk assessment was in place.

Recruitment processes were safe. We looked at three recruitment records and found appropriate checks and references were taken up before staff began work at the home. Appointments to posts were confirmed when staff had successfully completed a six month probationary period.

Planned staffing levels were based on the numbers and needs of the people who lived at the home. A rota was planned to provide sufficient numbers of staff in all units. People told us they did not have to wait long for assistance and received it when they needed it. We heard few call bells during our visits to the home. Arrangements were made to meet people's needs, for example, if a person had a planned hospital appointment and needed to be accompanied by staff, the staffing levels were adjusted to ensure this was possible. Each unit was staffed by a team of nurse and care staff. Our observations were that there were

Good

Is the service safe?

sufficient staff to meet people's needs. Staff told us they felt the numbers were adequate and they rarely felt short staffed. When staff were absent unexpectedly a team of 'bank staff' was available to fill vacant shifts.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Staff had been trained in the MCA and in the DoLS. In discussion they showed that they understood that people's liberty could not be deprived without authorisation. An application had been made to restrict the liberty of one person living at the service under DoLS, and the outcome was awaited.

The building was safe and appropriate for the needs of the people who lived there. There was a lift, which allowed access to both floors, which was large enough to accommodate a person on a stretcher. All doorways were wide and there was level access allowing people with mobility needs and wheelchair users to move around easily. The communal areas were clean, open and bright.

Audits of the service's infection control measures were carried out every three months. The audit included checks that safe hand hygiene procedures were followed and that cleaning routines were in place. Areas needing improvement were identified. Staff had access to personal protective equipment (such as aprons and gloves) and we saw them in use during our visits. Arrangements for safe waste disposal were in place.

Good

Is the service effective?

Our findings

Staff said they felt the training provided assisted them in their work. One member of care staff said they had "learned so much from the training here".

Staff had completed training relevant to the needs of the people living at the home including dementia care, positive behaviour support, person centred care and dignity and respect in care. They had also completed a range of health and safety courses including safe moving and handling, food hygiene and infection control. We discussed training with the activity co-ordinator who had completed training regarding the needs of the people living at the home.

All staff received regular supervision and an annual appraisal. These processes gave staff formal support from a senior colleague who reviewed their performance, identified training needs and areas for development. Other opportunities for support were through staff meetings, handover

meetings between staff at shift changes and informal discussions with colleagues. Staff told us they felt well supported. They said there was a good sense of teamwork and staff cooperated with each other for the benefit of the people who lived at the home. A member of staff told us "I enjoy my work" and felt that the team worked well together and was "supportive".

People told us they enjoyed the meals. One person said, "The food is good, there's loads of it". Another person said, "The food is very good." We saw that people were encouraged to drink and choices of drinks were available regularly throughout the day. People were offered snacks throughout the day.

We observed lunches in all three areas. We saw people were offered choices of the meals available and if they did not like any of the options an alternative was brought for them that was more to their taste. For example staff noticed that one person was not eating the meal they had chosen and when they said they would like some porridge catering staff brought it for them. Choices about meal times could be made, for example one person said they did not want to eat their lunch when it was served and staff said they would save it for them to eat later.

We saw several people who were assisted by staff to eat their meals. When staff helped them they sat at the same level as the person, told them what the meal was and assisted them at a pace that suited them. We saw that senior staff were available in dining areas and offered advice about how best to assist people if they were not eating or needed additional assistance.

Care and catering staff knew about people's individual needs and preferences in relation to the meals. We saw that care records included completed assessments to check if people were at risk of malnutrition. Staff had received training in using the 'Malnutrition Universal Screening Tool' (MUST) and used this to assess whether people were at nutritional risk. If they were, their meals were designed to increase their intake of calories, specialist advice was sought and records made of their food and fluid intake. A visitor told us their relative had gained weight since they had moved to the home and they believed this was a sign of their improved well-being.

People's needs in relation to their meals were considered. Risk assessments regarding the risk of choking were completed and meals were prepared in accordance with their needs. For example the chef told us about people who needed a soft diet and others who needed their meals to be blended. Staff were aware of the action to take if someone had difficulties swallowing. If people required a diet suitable for their health needs, such as diabetes this was provided.

Care plans addressed people's range of health needs and the care was in line with people's identified needs. Visits were made by the GP each week and more often if required. Other professionals who provided care for people and advice for staff included psychologists, specialist nurses, speech and language therapists, physiotherapists and podiatrists. The advice they gave was included in care plans and put into practice in the daily care.

One of the health professionals said that staff requested medical assistance appropriately. They said staff were attentive to people's medical needs. They said staff were "proactive and reactive", explaining that they responded to signs of ill health and promoted people's well-being. We observed a visitor raising a concern about their relative's health with a nurse. The nurse responded immediately by requesting an appointment with a specialist who could assess the person's needs for further attention.

The building was designed to assist people to get around. People told us they liked their bedrooms and were pleased

Good

Is the service effective?

to have private space they could personalise with their possessions and photographs. Each bedroom had en-suite facilities and this gave them privacy. We noted that dining chairs had arms which assisted people to rise from them easily and some of the armchairs in sitting areas were at a height that made it easier to get up. In one of the communal areas the chairs were arranged around the edge of the room and this limited the opportunities for interaction between people. The manager said that a refurbishment plan was going to be introduced to create a more 'dementia friendly' environment.

People told us they liked the garden and one person whose bedroom looked onto the garden said they enjoyed watching squirrels there. Another person said they would like to go into the garden more often. The manager said that the garden was to be improved.

Good

Is the service caring?

Our findings

A person who lived at the home told us "the care is wonderful", another said there were many people who stayed in the home because of the staff's "compassion". We saw people being treated with kindness and warmth. Staff showed an interest in how people were feeling and asked if they could assist them with anything.

Visitors told us they were confident their relatives were treated kindly and had "no complaints" about the care they received.

A member of staff said they liked their work because "staff really care" for the people who lived at the home. We observed staff using people's names in conversation with them and people looked at ease with staff as they smiled and talked. We saw one person go with a staff member to the person's bedroom singing together in a relaxed and comfortable way.

We heard that people's views were sought and acted on. One person said the staff met their individual needs and they were "very accommodating". We heard people could choose when to go to bed and when to rise. People had choices presented to them, such as whether to take part in activities, what they wished to do.

People were supported by staff who knew their likes and dislikes. In discussion with staff they were familiar with people's needs and could describe them to us. Care records included a section that detailed their interests and backgrounds. A section in the records was called "what people like and admire about me" and this detailed positive features of people's personalities and achievements. This helped staff to see people's individuality.

Staff were aware of situations when people did not have the capacity to make specific decisions independently. In these situations meetings were held to reach decisions in their best interests as required by MCA. The meetings involved people with a personal or professional interest in the person's welfare and well-being and the information we received confirmed that they had been called appropriately.

People were treated with respect and regard for their dignity. Six care staff had undergone training in how to put these concepts into practice in the home and had been designated as 'dignity champions'. This role ensured that they promoted practice which preserved people's dignity.

We observed that staff closed doors when people were using the toilet and being assisted with personal care. People were well dressed and groomed and had the opportunity to have their hair done by hairdressers who visited each week.

The home had been accredited in the 'Gold Standard Framework' which promoted good practice in end of life care. Staff had received training in this area of their work and the home had links with a hospice team which provided advice and support about end of life care. We saw that people's wishes regarding the end of their lives were recorded in advance care planning documents. A display in the hallway of the service had photographs of people who had died and acted as a memorial to them. A service of remembrance was held in the home to celebrate their memories.

Good

Is the service responsive?

Our findings

A person living at the home said the staff were quick to respond when they used their call bell to request assistance. They said, "You have only got to press the button and they are there." We heard few call bells during our visits to the home and all were answered promptly.

Assessments and care planning included input from people or their relatives or representatives. For example we saw a record where it was stated that the person's relatives had been consulted about the planning process. People told us they felt their needs were met at the home, one person said they wanted to give "credit when it's due and it's certainly due here" explaining they wanted to praise staff for helping them in the way they needed.

Care records were audited at intervals to make sure these addressed people's needs appropriately. We saw on records that the registered manager made notes when they identified an improvement to be made to ensure a person's needs were adequately met. When people's conditions care plans were reviewed and specialist advice sought and changes were communicated to the staff team.

A health professional we spoke with said "overall the care is excellent" and said they were confident in the nursing care provided at the home, particularly for the people who were living with dementia. Another health professional we spoke with told us staff were responsive to the needs of the person they were involved with. They said staff could identify deterioration in the person's condition and take prompt action to help them.

A range of activities was available for people who lived at the service. The home had a minibus and it was used to provide outings, usually twice a week. People told us about outings to Greenwich Park, Dulwich Park, and Brighton. Occasionally another minibus was borrowed from another home run by the provider so that a larger group could go out together.

In one of the lounges we noted that chairs were arranged around the edges of the room and some people had tables from which they ate their meals. People in the other units ate their meals in dining rooms and tended to sit with the same people at dining tables which gave opportunities for friendships to be formed.

There were opportunities for people to express their spiritual needs. Religious representatives visited the home and one of the staff members was a minister and provided spiritual support. People told us they could go to places of worship if they wished and one person told us members of their congregation accompanied them to church.

People's cultural backgrounds were included in care planning documents and we heard that efforts were made to meet their needs. A member of the catering staff told us that the menu included dishes which reflected people's cultural needs three times a week.

People and their relatives knew how to make a complaint. A relative told us they had raised a concern recently and felt they had been listened to and action taken to resolve the matter. Another relative said they would feel able to talk to senior staff if they had concerns about their relative's care. Complaints were investigated properly and in a timely manner.

Meetings for relatives and people who lived at the home were held each month. We saw minutes and saw that at each one people were encouraged to give feedback and their opinions about aspects of the home, such as care standards, catering, activities and the building.

Good

Is the service well-led?

Our findings

The home had a registered manager in post as required by their registration with the CQC. The manager was experienced and had worked at Alexander Care Centre for over a year.

A member of staff described the management style in the home as approachable and felt there was a fair and transparent culture. They said, "We are so open, there's no barrier." They said the manager had "an open door policy and anyone can go to [the manager's] office and say what they feel." They said their views and opinions were valued by the registered manager and this was one of the reasons they felt "happy" in their work. They said that "management are really concerned for staff" and said the registered manager understood that this assists them to provide good care for people.

At the time of our visits the deputy manager had been temporarily seconded to another of the provider's services, but came to the home during our inspection to support the manager. The management structure was clear and understood by people, their relatives, staff and visiting professionals. Each of the three units had a team leader to whom care staff and nurses reported.

Notifications of events had been made to CQC as required. There were systems to learn from incidents. The form on which they were recorded included a section to detail the action taken to prevent such incidents, such as reviewing risk assessments and to record the date notifications were made and people's relatives were informed. Reports of incidents were made to the provider so that patterns could be detected and action identified to prevent recurrence. A team of staff from the home met monthly to look at falls that had happened in the home. The team included the activities co-ordinator, nursing, care and maintenance staff. They examined the circumstances around falls which had occurred and agreed action to reduce their frequency.

The provider had monitoring systems which involved checks and audits of a range of issues in the home. These included staffing levels, health and safety, infection control, complaints, catering and care plans. The registered manager carried out spot checks at night time to ensure care standards were being met. Unannounced visits were made to the home by representatives of the provider with the aim of assessing quality. We saw reports of these visits and saw they included observations of meal times, discussion with staff and people using the service and recommendations for improvements if any were identified.

People were asked their opinions through the meetings which took place for them and through questionnaires. The feedback report we saw from the questionnaires conducted with people living at Alexander Care Centre showed high levels of satisfaction with the home. The only areas identified for improvement were for some rooms to be redecorated and for new furniture to be provided. The manager informed us that action was underway to address these matters.