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

Overall summary

We inspected Alliston Road on 15 & 16 September 2015. This was an unannounced inspection. At the last inspection in December 2014 we found breaches of the legal requirements. This was because risk assessments and care plans were not always up to date and information was missing. There were poor arrangements in place for the management of medicines. Meaningful engagement and interaction and activities were not available to people. At this inspection we found improvements had been made and that they now met the previous legal beaches.

Alliston Road provides accommodation for up to 43 older people who have dementia care needs. There were 35 people living at the home when we visited. There was a registered manager at the service at the time of our inspection. 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.

Summary of findings

The experiences of people who lived at the home were positive. People told us they felt safe living at the home, 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 there were plans in place to monitor and reduce risks. People had access to relevant health professionals when they needed them. Medicines were stored and administered safely.

Staff undertook training and received one to one supervision to help support them to provide effective care. 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). 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. People told us they liked the food provided and we saw people were able to choose what they ate and drank.

People's needs were assessed and 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. 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.

The service had a clear management structure in place with clear lines of accountability. Staff told us the service had an open and inclusive atmosphere and senior staff were approachable and accessible. The service had various quality assurance and monitoring mechanisms in place. These included surveys, audits and staff and resident meetings.

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 able to explain to us what constituted abuse and the action they would take to escalate concerns.

Risk assessments were in place which set out how to manage and reduce the risks people faced

Medicines were stored and administered safely.

Recruitment records demonstrated there were systems in place to ensure staff were suitable to work with vulnerable people. There were enough staff at the service to help people to be safe.

Is the service effective?

Good

The service was effective. Staff undertook regular training and had one to one supervision meetings.

The service carried out assessments of people's mental capacity and best interest decisions were taken as required. The service was aware of its responsibility with regard to Deprivation of Liberty Safeguards (DoLS) and was applying for DoLS authorisations for people that were potentially at risk.

People had choice over what they ate and drank and the service sought support from relevant health care professionals where people were at risk of dehydration and malnutrition.

People had access to health care professionals as appropriate.

Is the service caring?

Good

The service was caring. Care was provided with kindness and compassion. People could make choices about how they wanted to be supported and staff listened to what they had to say.

People were treated with respect and the staff understood how to provide care in a dignified manner and respected people's right to privacy.

The staff knew the care and support needs of people well and took an interest in people and their families to provide individual personal care.

Is the service responsive?

Good

The service was responsive. People's needs were assessed and care plans were developed and reviewed with their involvement. Staff demonstrated a good understanding of people's individual needs and preferences.

People had opportunities to engage in a range of social events and activities that reflected their interests, according to their choices.

People knew how to make a complaint if they were unhappy about the service.

Is the service well-led?

Good

The service was well-led. The service had a registered manager in place and a clear management structure. Staff told us they found the manager to be approachable and there was an open and inclusive atmosphere at the service.

Summary of findings

The service had various quality assurance and monitoring systems in place. These included seeking the views of people that used the service.

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.

The inspection team consisted of two inspectors, three pharmacy inspectors, a policy officer who talked to people and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. During the inspection we spoke with 16 people living at Alliston Road and two relatives. We also spoke with the registered manager, the service manager, one senior support worker, three support workers, the cook, kitchen assistant and a domestic worker. We also talked to a visiting health professional.

We observed care and support in communal areas and also looked at some people's bedrooms and bathrooms. 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 looked at 18 care files, staff duty rosters, 13 staff files, a range of audits, complaints folder, minutes for various meetings, staff training matrix, accidents and incidents folder, safeguarding folder, activities timetable, health and safety folder, food menus, and policies and procedures for the home.

Good

Is the service safe?

Our findings

At our last inspection of this service in December 2014 we found that risk assessments were in place however the risk assessments were not always up to date and had missing information. It was not always clear when a review had been completed. Also we found there were poor arrangements for the management of medicines that put people at risk of harm. During this inspection we found these issues had been addressed.

Care files each contained a set of risk assessments, which were up to date, detailed and reviewed regularly. These assessments identified the risks that people faced and the support they needed to prevent or appropriately manage these risks. Risk assessments included people's personal care, medicines, falls, communications, social needs, and mobilising. For example, one person had been assessed at risk with medicines as they would refuse them at times. The risk assessment gave staff guidance such as “staff to explain what medication is for” and “allow plenty to time to administer medication.” We also saw personalised evacuation plans in the event of a fire in the care files we reviewed. We saw people had consented to and participated in these risk assessments wherever possible.

All prescribed medicines were available at the service and were stored securely. Medicines which were not in blister packs were checked daily. Records of medicines received, administered and disposed of were clearly completed. Risk assessments were in place for medicines, for example when people were refusing to take medicines and for one person who was self-administering medicines. When topical medicines were applied, and food supplements given, this was recorded on the Medication Administration Record (MAR) along with other medicines administrations. People’s allergy status was noted. The temperature of all three medicines storage areas was monitored twice a day, and we saw from the monitoring records that these medicines were kept at the correct temperatures to remain effective. However, we did note one incident with regards to eye drops being used past its 28 day expiry date. The senior staff member told us they would dispose the eye drops.

Staff were responsible for administering medicines to people. The registered manager had carried out competency assessments for all staff administering medicines. The supplying pharmacist had provided medicines management training in August 2015, and was due to provide training the week of our inspection. Information sheets were available for medicines, including what medicines were prescribed for, and the potential side effects.

We asked about arrangements for when people wanted to self-administer their medicines. Staff told us that they were supporting one person to self-administer some of their medicines, with a risk assessment in place. However, the care plan was not clear about the medicines being taken.

Two people were prescribed medicines for challenging behaviours and protocols were in place to give staff sufficient guidance on when these should be used. Records showed that these were not overused and the reason for administering a dose was recorded.

The service had safeguarding policies and procedures in place to guide practice. We saw posters, with contact details for the local authority for reporting any issues of concern, were on display. Staff told us they had received training in safeguarding adults. On a last inspection in December 2014 we saw safeguarding training being delivered to staff. Staff understood what abuse was and how to respond appropriately if they suspected that people were being abused. One staff member told us, “First I would report to my senior. If they did nothing I would go to the manager and then go to CQC.” The same staff member said, “They talk about whistleblowing in training.” We saw records that safeguarding had been discussed in staff meetings. Staff we spoke with knew about whistleblowing procedures and who to contact if they felt concerns were not dealt with correctly.

The registered manager told us and we saw records that showed there had been five safeguarding incidents since the last inspection. The manager told us three safeguarding alerts were open and being investigated. The registered manager was able to describe the actions they had taken when the incidents 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.

The service had a robust staff recruitment system. We saw that appropriate checks were carried out before staff began work. References were obtained and criminal records checks were carried out to check that staff did not have any

Good

Is the service safe?

criminal convictions. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people living at the service.

There were sufficient staff on duty to provide care and support to people to meet their needs. The senior support worker told us staffing levels were based on people's needs. We observed that call bells were answered promptly and care staff were not hurried in their duties. We looked at the duty roster and saw that planned staffing levels were maintained. One staff member told us, "We have been given new staff." Another staff member said, "We have enough staff. If someone is sick they will get someone in straight away."

We saw the premises and equipment were managed in a way intended to keep people safe. During our inspection we checked the overall cleanliness and the state of the environment and we found that the home was appropriately maintained. Regular checks were carried out on emergency lights, alarm systems, water temperature and quality, fire doors and fire equipment. The service had an in-house maintenance person and a system in place to report and deal with any maintenance issues. Staff we asked about the system told us they knew how to report issues and their handyman was quick to respond. Records showed that the handyman carried out 'walk-through' inspections of the premises regularly, in addition to planned checks, and that action had been quickly taken if faults were identified.

Good

Is the service effective?

Our findings

People and their relatives told us the staff were very good and supported them well. One person said, “The staff are all very pleasant and they work hard. They know us as individuals.” Another person told us, “The staff are very good to us here.” One relative commented, “The staff are very happy to help.”

The service had a policy on the supervision of staff which stated staff should receive supervisions every four weeks and have an annual appraisal. The registered manager told us and we saw records that supervisions were not up to date over a three month period because senior staff were being recruited for that time period. The registered manager and staff confirmed that regular supervisions were now being conducted and we saw records of this. Topics covered in supervisions included safeguarding, key working, care planning, activities, medicines, communication, health and safety, and appraisals. One staff member told us, “Supervision is monthly and I had it two weeks ago. We talk about my needs and the clients.” Another staff member said, “Supervision has started every month. They will ask how we are coping, service user issues and additional training.” Appraisals had not been completed for this year however the registered manager told us new templates had been agreed and appraisals were to be completed in the next six months.

Staff we spoke with told us they received regular training to support them to do their job. One staff member told us, “The service manager identified manual handling training for us and we got it.” Another staff member said, “We get good training. Last week we had dementia training.” We looked at the training matrix which covered training completed. The core training included manual handling, safeguarding, health and safety, dementia awareness, medicines, and Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed training courses booked for the rest of the year included risk assessments, fire safety, food safety, and first aid. 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.

The registered manager and staff 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. The registered manager knew how to make an application for authorisation to deprive a person of their liberty. There were currently five DoLS applications that had been authorised. Where people had been assessed as not having mental capacity to make decisions, the registered manager was able to explain the process followed 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 in a timely manner. This meant that the CQC were able to monitor that appropriate action had been taken.

Record 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.

The cook was aware about the people who were on specialised diets and explained the meal preferences for these people which was reflected in the documentation 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. People told us and we saw records that showed people had requested an alternative meal not on the food menu. One person told us, “If I don’t like what’s on the menu I ask for an alternative." Another person said, “I do get what I ask for.” People we spoke with were complimentary about the quality of the food. One person told us, “The food is OK and I am a very fussy eater." 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.

People were asked their food choices on the day and we saw records of this. Food choices were discussed with people during residents meetings and we saw on the day of our visit that people were offered choices about what they ate.

As part of our visit, we carried out an observation over the lunch time period. Food menus were displayed on each table with condiments. The lunchtime was relaxed and we saw people could eat in the dining room, lounge area or

Good

Is the service effective?

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 heard one person whilst being assisted to eat by a staff member say, “I love you.”

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 relative told us, “Sometimes staff accompany [relative] to medical appointments when the family cannot go along." Another relative said, “He’s [relative] has put on weight, is walking more and his general well-being has improved.” On the day of our inspection we spoke to a health professional visiting people at the service. The health professional told us, “The staff do ask us to look at people who are not well when we are visiting.” The same health professional said, “We tell staff to look for early signs of pressure sores and they do.”

Good

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, “They [staff] really do care about us and know us as individuals.” Another person said, “Staff are very kind and very nice. I couldn’t fault them. You come first.” A relative told us, “He’s [relative] happy so we’re happy.”

The atmosphere of the service was friendly and calm. Staff regularly enquired how people were and asked if they needed anything. Staff chatted with people who used the service and their family members and people appeared to enjoy the interactions. One person told us, “The staff are very nice and sociable. Help when they can”.

Staff knew the people they were caring for and supporting. Each person using the service had an assigned key worker. The staff members we spoke with were key workers for people. They were able to describe how they developed relationships with people which included talking to the person to gather information on their life history and likes and dislikes. One staff member told us, "We monitor the person’s bathing and showering, toiletries and clothes."

Care records included information about people such as life history, place of birth, schools, job history, hobbies, significant and memorable events, and likes and dislikes. This information helped staff generate discussions of interest and develop positive relationships with people.

People spoke freely with the staff and discussions which took place showed staff had taken time to get to know people. A lot of staff had worked at the service for a number of years and had established positive relationships with people. One staff member said, “You have to talk to people to get to know them.” The same staff member told us, “I don’t look at them as people with dementia. I look at them as people.” People’s rooms were personalised with family photographs and their own possessions.

People were supported to maintain friendships. People’s care plans contained information about their family, friends and those who were important to them. Relatives and friends were welcomed to the service and there were no restrictions on times or length of visits. People confirmed that they were able to keep in touch with their family and friends and were supported to do the things they wanted to do.

People’s privacy and dignity was respected. Staff knocked on people’s doors before entering their room. They called people by their preferred name and had clearly built a good rapport with them by seeking their permission before carrying out tasks and respecting their wishes. One staff member told us, “This morning a lady would not let me give her personal care. I left her for a while and then I talked to her and she agreed to personal care.” People we spoke with told us they could get up and go to bed when they wanted and this was reflected in the documentation we looked at. One person said, “I go to bed when I want.”

Good

Is the service responsive?

Our findings

At our last inspection of this service in December 2014 we found that care plans were not always up to date and had missing information. We also found that meaningful engagement and interaction and activities were not available to people. During this inspection we found these issues had been addressed.

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.

Care plans were person centred and provided staff with clear guidance about how to meet people's needs. People's spiritual, cultural and diverse needs, likes, dislikes, wishes and preferences were recorded. Some of the areas that were considered were personal care, dressing, toileting, oral care, skin care, nutrition, mobility, mental health, medicines, and hobbies. The service responded to people's changing needs. For example, one person had been assessed with poor mobility. An occupational therapist had been requested to do a review. Records showed the occupational therapist had recommended two staff to support the person with transfers and the care plan was updated to reflect these changes.

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. Staff knew about the changes promptly because the senior staff told staff in daily handovers as well as updating the records. One member of staff told us, "The managers update the care plans every month and come to us if any changes." Another staff member said, "At handovers we find out what happened the night before." This enabled the staff to adapt to how they supported people to make sure they provided the most appropriate care.

People had access to planned activities and local community outings. One person told us, "We had a trip to the pie and mash shop on the high street." Another person said, "There has been bingo and quizzes." One staff member told us, "Activities are happening more than ever now." During our inspection we saw staff sitting with people playing games, doing arts and crafts and providing beauty treatments. We observed other people listening to the radio, watching television and reading the newspaper. We heard a care worker asked someone if they preferred the radio or television on.

There was a weekly calendar of activities on display which included karaoke, bingo, hairdresser, make up and manicures, arts and crafts, keep fit and dance, board games and entertainers visiting once a month. On the second day of our inspection we observed an entertainer in the lounge on the ground floor singing for people. People were smiling, clapping and singing along to the music. Staff told us and records showed the service had started a men's group that met regularly. The group played games, watched sport and socialised.

The registered manager told us since our last inspection the service had appointed care staff to be 'activity champions'. Activity champions attended handovers to discuss what activities were happening on the day and then lead on those activities. One activities champion told us, "We encourage group and one to one activities."

Residents and relatives meetings were held on a regular basis to provide and seek feedback on the service. We saw from minutes of meetings which had included food menu, complaints and activities. We saw people's suggestions were listened too. One staff member said, "We asked them what they want to do. One person came up with the idea to visit the pie and mash shop." Records confirmed and people told us they attended the pie and mash shop.

Most people told us they knew how to make a complaint. One person said, "I'd complain to the manager." The home had a complaints procedure which was on display in the communal areas of the home. The complaints procedure was available in large print for people. 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. The registered manager told us there had been no complaints since our last inspection.

Good

Is the service well-led?

Our findings

People who used the service and their family members told us they thought the service was well managed and they spoke positively about the registered manager and the senior staff. One person said, "[Senior staff member] very good. If you ask him for something he will do it."

Staff felt there was a supportive and open culture at the service and that they felt able to discuss anything with the management team. Over the past six months the service had seen a number of changes and many improvements had been made to the service provided. This work remained on-going and the registered manager explained current work underway. For example, the registered manager had introduced new care planning and risk assessments systems, implemented activity champions and increased activities in the service, recruited new senior staff and moved people who were not suitable for the service to more suitable placements. Staff were enthusiastic about the changes and felt the changes made were for the better. One staff member said, "The management team has been up and down but now is getting really good." The same staff member told us, "We feel comfortable as we have our own manager. We are more confident. She helps in every sense and is very honest." Another staff member told us, "The manager is ok. She tries her best to make things go right. I've seen a lot of improvements and communication is better."

Individual staff meetings for care workers, senior care workers, domestic staff and kitchen staff were held regularly to enable staff to discuss issues relevant to their role. The last staff meeting for care workers was held on 2 September 2015 and included topics such as supervision, code of conduct, appraisals, record keeping, relative meetings and medicines. Previous topics in meetings had included training, health and safety, fire safety, key working, safeguarding and infection control. One staff member told us, "Staff meetings are good. We talk if things are not working. We can move forward and I like them." Another staff member said, "Staff meetings are every month. We discuss everything like clients, medication, supervision and training." Staff handover meetings took place at the beginning of each shift. This informed staff coming on duty of any problems or changes in the support people required in order to ensure that people received consistent care.

The service carried out annual quality surveys with people living at the service. The next survey was due to be carried out in October 2015.

Systems were in place to monitor and improve the quality of the service. Records showed that the registered manager and the service manager carried out regular audits to assess whether the home was running as it should be. We looked at the audits conducted since the last inspection. The audits looked at the medicines, safeguarding, accidents and incidents, staffing, health and safety, care plans, risk assessments and supervisions. These audits were evaluated and, where required, action plans were in place to drive improvements. We saw where any deficiency or improvement was required, prompt action was taken. For example, the medicines audit had identified improvements needed with recording of medicines. We saw the service introduced a daily medicines audit to identify issues and the number of recording errors had improved. The registered manager told us and records confirmed they were doing regular night spot checks. This meant they were able to monitor the quality of service provided during the night time period.