Care Quality Commission

Alzheimer's and Dementia Support Services

Alzheimer's and Dementia Support Services

Inspection report

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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

This was an announced inspection that took place 28 and 29 June 2016.

Alzheimer's and Dementia Support Services is a registered charity. Their Support at Home Plus service provides personal care and support to adults living with dementia and those who care for them in their own homes in the Dartford, Gravesham and Swanley areas. The service provides support to enable individuals to live as independently as possible. At the time of our inspection 55 people were using the service. The main office is located in Northfleet, Kent.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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 previous registered manager had left 3 weeks prior to inspection and had started the process to de-register with the CQC. Interim management cover had been put in place and support was being provided by the operations manager and chief executive officer. A new manager was being recruited and shortlisting for the post was due to start the week following the inspection. The chief executive officer told us that the newly appointed manager would be registering with CQC as soon as they had completed their initial induction and training.

People were referred to health care professionals when needed and in a timely way. Personal records included people's individual care plans, likes and dislikes and preferred activities. The staff promoted people's independence and encouraged them to do as much as possible for themselves.

Staff sought and obtained people's consent before they provided support. Relatives told us that staff communicated effectively with the people they cared for, responded to their needs promptly and treated them with kindness and respect. People and their relatives were satisfied with how their support was delivered.

People's privacy was respected and people were supported in a way that respected their dignity and independence. People received the support they required to ensure they had enough to eat and drink to maintain their health and wellbeing.

Policies and procedures were available for staff to support practice. There was a whistle blowing policy and staff were aware of their responsibility to report any bad practice.

There were robust recruitment practises in place to ensure that staff were safe to work with people. Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to report any concerns.

Staff had completed the training they needed to care for people in a safe way. They had the opportunity to receive further training specific to the needs of the people they supported.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how risks of recurrence could be reduced.

People's individual assessments and care plans were reviewed regularly with their participation. People's care plans were updated when their needs changed to make sure they received the support they needed.

All members of care staff received one to one supervision sessions to ensure they were supporting people based on their needs. Staff told us they felt valued under the leadership of the chief executive officer and operations manager. However annual appraisals had not taken place, a new appraisal system was scheduled to start in October. We have made a recommendation about this in our report.

Medicines were stored, managed and administered to people in a safe way. There was regular auditing of medicines and staff competencies were checked to ensure standards were maintained.

The provider sought and obtained feedback from people and their relatives on the quality of the service. People and their relatives had access to the complaints procedure and knew how to make a complaint. The provider analysed the results and acted upon the comments they received.

The chief executive officer and operations manager notified the Care Quality Commission of any significant events that affected people or the service. Quality assurance audits were carried out to identify how the service could improve and remedial action was taken when necessary.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

Staff were trained in the safeguarding of vulnerable adults and were knowledgeable about recognising the signs of abuse.

People had risk assessments centred on their individual needs that provided clear instructions for staff to follow and keep them safe.

Thorough staff recruitment procedures were followed in practice.

Is the service effective?

The service was effective.

All staff had completed the training they needed to meet people's needs effectively.

People's needs were met by staff who were aware of their needs, likes and dislikes and who developed effective professional relationships with them.

People's consent was sought before care was provided and people's capacity to consent to care or treatment was assessed and recorded in line with the Mental Capacity Act 2005.

Is the service caring?

The service was caring.

People were treated with kindness and respect. Staff communicated effectively with people and responded to their needs promptly.

People were aware how to make a complaint.

People were involved in the planning of their care.

Staff respected people's privacy and promoted people's independence.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before support was provided. People's care plans were personalised to reflect their wishes and what was important to them.

People's support plans and risk assessments were reviewed and updated when their needs changed.

People knew how to complain and people's views were listened to and acted upon.

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focussed on people. Staff felt supported by the chief executive officer and operations manager who welcomed their involvement about how the service was run.

People and staff' feedback was sought and suggestions for improvement were acted upon.

There was an effective system of quality assurance in place. The management team carried out audits to identify where improvements to the service could be made.

Care Quality Commission

Alzheimer's and Dementia Support Services

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.

The inspection was carried out on 28 and 29 June 2016 and was an announced inspection. Notice of the inspection was given because we needed to be sure that the manager, staff and people we needed to speak with were available.

The inspection team consisted of one inspector. Before our inspection we looked at records that were sent to us by the registered manager and the local authority to inform us of significant changes and events. We reviewed our previous inspection reports.

Before the inspection, we had not asked the provider to complete 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. A current PIR was not available and we took this into account when we inspected the service and made the judgements in this report. We reviewed the previous inspection report and PIR. We also reviewed information which had been shared with us by the local authority and other people, and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law.

We spoke with six relatives of people who were supported in their home to gather their feedback. The people we contacted were unable to provide feedback themselves due to hearing impairment or short term memory loss. We also spoke with the provider, the chief executive officer, operations manager and three members of care staff.

We looked at records that included three people's support plans, reviews and risk assessments. We consulted three staff files, staff training records, satisfaction surveys, quality assurance checks, audits and sampled the service's policies and procedures.

A previous inspection took place on 14 February 2014; the service had met the standards of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Good

Is the service safe?

Our findings

People told us they felt safe when being supported by staff. People told us "The carers are very good, I feel safe with them" and "I always feel safe with the carers they know what they are doing." Relatives told us "My [relative] has Alzheimer's and she feels safe with the carers, they chat with her and put her at ease" and "My relative is definitely safe with the carers."

People were supported by staff who had completed safeguarding training and updates. Staff told us that, if they had a concern about a person, they would report this to a senior staff member and record their concerns. Staff were able to identify different types of abuse and were aware of the role of agencies, such as the local authority and the police, in the safeguarding process. The management team took appropriate action in reporting concerns to the local safeguarding authority and acted upon recommendations made. A member of staff told us "I was concerned a person was being neglected. I reported it to the office and they spoke with the social worker" and "I look for any signs of abuse, record it in the notes and report it to the office to follow up."

People's support plans showed risk assessments had been completed with the involvement of the person who used the service, where possible. Risks were reviewed regularly and updated when people's needs changed. Staff understood what they needed to do to keep people safe. A person's risk assessment and care plan had been updated following an urgent referral to Occupational Therapy and a plan was in place pending the provision of equipment to support moving and handling. Staff told us "We assess and identify all risks including access to the property as well as inside" and "A person had difficulties on the stairs so I contacted the office to request grab rails to be installed; they made the referral and the person had grab rails installed three days later."

There was an efficient accident and incidents reporting system that was monitored by the chief executive officer and the operations manager. Reports of incidents such as falls or hospitalisation were analysed to identify trends and see if lessons could be learned and future risk of recurrence minimised. They were discussed at weekly management meetings that included the care coordinators, chief executive officer, and the operations manager.

Medicines were appropriately recorded and administered to keep people safe. Staff said "I have to sign each box I administer. If there's something they don't take I record it and the reason why." Where it had been identified the procedure had not been followed, spot checks of staff practice, medicine competency checks and additional training had been provided. The level of support people needed in regard to their medicines was detailed in their care plan, such as prompting. Staff had received training in the safe management of medicines.

Recruitment procedures were thorough to ensure suitable staff were employed to keep people safe. This included checking employment references and carrying out Disclosure and Barring Service (DBS) checks. Gaps in employment history were explained. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own.

They were subject to a probation period before they became permanent members of staff. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

There were enough staff to meet people's needs. The chief executive officer told us, "We currently run reports of carer availability to identify if we can accommodate needs for new packages. We will not take a new package if we cannot meet a person's needs." There was a system in place for the recruitment of new staff; the operations manager said "We set figures for recruiting staff within a period based on numbers of people that require support. Our target exceeds our need as we are working with Darent Valley Hospital to support people being discharged from hospital and we would like to increase our capacity to do this."

Good

Is the service effective?

Our findings

People with Alzheimer's and dementia were supported by staff who received training to meet their needs. Relatives told us "The staff know a lot about dementia, they are very good at what they do" and "I think they [staff] are very skilled in the way they care for people."

A training matrix identified when training was due and had been done. The coordinator and trainer checked the matrix and book staff training. Staff told us "I did mental capacity act training last month, stoma care last week and moving and handling training has been booked" and "After my training I downloaded forms to share with staff and also a leaflet to share what I had learned." Staff had undertaken specific training such as Dementia awareness and Parkinson's to meet people's specific needs.

Staff told us their induction was comprehensive and included shadowing experienced members of staff. Staff were offered additional opportunities to shadow and received additional support from their supervisor when necessary. Staff files included records of training undertaken as part of the induction and competency checks were completed before staff were allowed to work on their own. Probation records included spot checks of staff practice and medicines competency checks. An induction plan and checklist to support current practice was in the process of being implemented.

Staff felt supported and said "I make notes of things to talk about in supervision but I can call anytime for help or to talk about something", "Supervision takes place three monthly. If I have an issue to raise I can speak with a senior or management, there is always support there" and "The supervisions are written down with the actions so at the next one we review to see if it's been done". Supervision records included discussions about people's needs and staff professional development was appropriately recorded and included the monitoring of any actions planned during previous supervisions. A new system of annual appraisals was scheduled to start in October. The supervisions policy stated that supervisions should take place 4 times per year, the records we saw showed supervisions took place every 2 to 6 months. People were not at risk because staff had access to an effective network of support during and outside of office hours. We recommend that the service seeks advice and guidance from a reputable source, such as Skills for Care, about establishing and maintaining a robust schedule of supervision and appraisal for all staff.

People were referred to appropriate health professionals if staff had concerns about their wellbeing. Staff had reported their concern that one person was not eating enough and appeared to losing weight and this prompted a referral to their GP. Staff told us "We have been able to increase the number of visits to offer more support with meals." This meant the person received the support they required to ensure they had enough to eat and drink to maintain their health and wellbeing.

Staff sought and obtained people's consent before they supported them. People, their next of kin or their legal representatives had signed care plans to evidence their consent to care and treatment. Relatives told us "The care worker helps by offering mum a choice of items from the wardrobe" and, "The care worker always asks what she would like to eat."

We discussed the requirements of the Mental Capacity Act (MCA) 2005 with the operations manager. 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. We checked whether the service was working within the principles of the MCA. They demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. A system was in place to assess people's mental capacity when necessary and referrals were made to relevant health and social care professionals for assessments and best interest meetings. A referral to social services had taken place when staff had reported concerns about a person's mental capacity. As a result, a mental capacity assessment, best interest meeting and a further referral to the Court of Protection had been carried out, to protect the person's rights. Staff were trained in the principles of the MCA and were knowledgeable about the requirements of the legislation. Staff said "People have the right to make their own decisions if they have the mental capacity."

Good

Is the service caring?

Our findings

People were supported by staff who were compassionate and developed a rapport with them. Staff were sensitive to people's memory loss as a result of having Alzheimer's and dementia. A relative told us "He enjoys the conversations with the carer" Staff said "I read their care plan to see what their interests are and where they came from, so we can talk about it."

Relatives confirmed staff were not task oriented and spent time with people talking and reminiscing "The care workers spend time talking with him" and "My husband likes to sing old songs and the care worker will sing along with him."

People were supported by staff who encouraged them to be as independent as possible. A relative told us "The staff remind her what things are so that she can do things for herself." A member of staff said "I feel it is important that we help people with dementia to live independently in their own homes for as long as they can."

Care plans detailed how people wished to be addressed and relatives told us staff spoke to them by their preferred name. For example some people were happy for staff to call them by their first name and other people preferred to be addressed by their title and surname.

People were involved in making decisions about the support they received. One relative we spoke to said "They involved my dad in the assessment, they sat and chatted with him." The care plans contained evidence of people being involved and making decisions such as, 'Assisted to lounge where he chose egg sandwich for breakfast.'

Care records included information about people's life histories, family and interests. This information should help staff form meaningful and caring relationships with people who used the service. People or their legal representatives when appropriate had signed their own care plans and reviews where possible. Family members said they had opportunities to express their views about the care and support their relative received. They told us "Mum is involved, she is there and answers their questions."

People's privacy and dignity was maintained by staff who were sensitive to their needs. Relatives told us "They always ask if he is ready to have a shower and close the door" and "They always ask him how he is before helping him get ready." Staff told us "We use a towel to cover their body or wear a dressing gown and make sure the door is shut" and a relative confirmed "The staff always use a towel to protect her dignity."

We noted that confidential care records were held securely in the provider's office; this helped to ensure that the confidentiality of people who used the service was maintained. Staff were aware of issues of confidentiality when visiting people and were sensitive to what they wrote in the notes in people's homes. Staff told us they did not talk about other people when they carried out their work.

Good

Is the service responsive?

Our findings

The service had received written compliments and thank you cards from relatives of the people they cared for that said 'The friendly care workers coming in were helpful and kind, carrying out their tasks in a gentle manner', 'Thank you, mum has improved under your care' and 'The support, advice, kindness and caring we received has been so appreciated.'

People had initial assessments completed by a service coordinator before the support was provided. These assessments identified what people wanted their care package to achieve, and the type and frequency of support they required. They included comprehensive information about people's specific needs such as the support they required due to memory loss as a result of Alzheimer's and dementia. This included support with meals and drinks, continence management and assistance with getting up and moving around. A relative told us "The coordinator did the initial assessment. The support was tailored to his needs. When he found someone coming every day was too restrictive they listened to his preferences and now he has someone three times a week."

People received practical support to pursue their interests in the community when it had been agreed during the planning of their care. As a result people had access to facilities in their community to carry out their preferred activities. One person was assisted to do their weekly shopping. Their relative told us "We give [our relative] the money and the care worker takes him shopping. The care worker helps him buy the meals he enjoys eating for example curry, chicken chow mein or spaghetti bolognaise." A member of staff told us "I support a person to go to local coffee shops because they enjoy going out for tea and cake" and "Another person likes to look at clothes in the shops and when they can't manage to walk around I get a wheelchair for them so they can still enjoy it."

Staff were made aware of people's likes and dislikes to ensure the support they provided was informed by people's preferences. These were recorded before support was provided when people were involved with the planning of their care and support. People's personal histories included information about activities and employment that the staff used to engage them in conversation. Care workers recorded notes of conversations they had with people which included 'Very chatty about the Queen's birthday party' and 'He remembered his wife passing comforted and reassured him.' Staff told us "One person likes to listen to music so we learned the channels they like by trial and error so we can put on music they enjoy."

People's individual assessments and support plans were reviewed regularly a coordinator told us "At the six week review we update the care plan with information from the client profile because we would have learned more about the person. Then they are reviewed six monthly or before that if their needs change." People were involved in these reviews and support plans were updated appropriately to reflect any changes. When people were not able to participate, relatives were invited to attend. A relative told us "There is a review every six months and they give me plenty of notice so I can be there" another relative said "They visit regularly to do the review and I am involved in the decisions about the support plan."

People and their relatives received information about the service and how to complain. The operations

manager told us "We have a log of incidents we use to record and collect data about complaints. We get so few complaints we provide a tailored response and deal with them on a case by case basis." The chief executive officer had audited the complaints that had been received in the last twelve months. Two complaints had been made; they were responded to and investigated within set time frames and had been resolved. During the audit the chief executive officer had identified that relatives who did not live with the person needed access to the complaints policy and this was due to be sent out by post with the next invoice.

Good

Is the service well-led?

Our findings

There was not a registered manager in post at the service at the time of our inspection. The previous registered manager had left 3 weeks before the inspection and had started the process to de-register with the CQC. A new manager was being recruited and shortlisting for the post was due to start the week following the inspection. Interim management cover had been put in place and support was being provided by the operations manager and chief executive officer. They were both available throughout this inspection and we observed positive interactions between the managers and staff who felt able to approach them with any queries or concerns. Staff said "The operations manager and chief executive officer have an open door policy we can go to them at any time if we have questions or need support" and "I feel supported by the management team, support hasn't lessened since the registered manager left".

Our discussions with people, the management and staff showed us that there was an open and positive culture that focussed on people. Two local authority case managers who oversaw people's wellbeing told us, "It's a brilliant service for people with dementia", "They are experienced and professional. They provide waking nights when people are discharged from hospital to orient them, reassure them and keep the safe" and "I was impressed with how they handled a particular case. They noticed a person was not taking their medication as prescribed so they provided additional support over the weekend. The person would have been at risk if they hadn't acted straight away."

Staff demonstrated a good understanding of the service's philosophy of care. They told us their role was to promote people's independence by supporting them to live at home for as long as possible.

The service worked in partnership with stakeholders and strategic group commissioners and was in the process of establishing a service called 'Safeharbour – dementia hub'. 'Safeharbour – dementia hub' is intended to be a 'one-stop-shop' for dementia support that will serve the local community providing information and advice relating to dementia services. Surveys had been sent to people, their relatives and staff to gather their views on what they thought 'Safeharbour – dementia hub' could offer to the local community. The chief executive officer said "The results of the surveys identified people would like more trips out and more respite services. We are looking at how we can deliver this through Safeharbour – dementia hub."

The provider had systems in place to monitor the quality of the service. This included audits carried out periodically throughout the year which were completed by the chief executive officer in the temporary absence of a registered manager. The audits covered areas such as care plans, staff records, the safe management of medicines and health and safety. Where audits had identified shortfalls, action had been taken to address them. A medicines audit had identified a member of staff had not followed the administration of medicines procedure correctly. As a result, one to one discussions with the member of staff, spot checks of practice and competency checks had taken place and additional training had been provided. Disciplinary action was taken by the management team appropriately. An audit of the invoicing system had identified amendments were required for couples who received joint visits. The chief executive officer said "We are currently recruiting for a finance manager to improve the invoicing system." Where

recording issues had been found this had been addressed with staff, forms had been amended and practice had been improved.

Staff said regular team meetings took place where they could discuss any concerns or ideas to improve the service people received. Staff said "We have a staff survey annually, I feel the managers listen to me." During staff meetings staff had identified the need for a written guide for the 'On-call service' which is a service provided by a member of staff outside office hours to respond to people's phone calls and ensure cover for staff absences. As a result, a step by step guide had been put in place and this was being used by staff.