Leonard Cheshire Disability

Alder House - Care Home Physical Disabilities

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 comprehensive inspection took place on 14 May 2018 and was unannounced.

Alder House is a care home. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection. Alder House accommodates up to 22 people with physical or sensory disabilities. At the time of our inspection, there were 20 people living at Alder House.

At our last inspection, we rated the service Good. At this inspection we found the evidence continued to support the rating of Good, and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

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 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.

Why the service is rated Good.

People received care and treatment which was planned and delivered in a way that ensured their safety and welfare. There were enough staff to ensure people's care and support needs were met. Staff had been recruited and employed after appropriate checks had been completed. People's medicines were managed safely and medicines were administered by staff who had received training to do so. There were systems in place to minimise the risk of infection.

People were safeguarded from the potential of harm and their freedoms protected. Staff were provided with training in safeguarding adults from abuse, Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service support this practice.

People received a service which was responsive and centred around their needs. People's care plans provided clear guidance to staff on how people wished to be supported, and were regularly reviewed. The environment at Alder House was appropriately designed and adapted to meet people's needs.

Staff received training and structured supervision to enable them to acquire the skills and knowledge to meet people's care needs. Staff were kind and caring in their approach with people. Staff treated people with dignity and respect and promoted people's independence.

People were supported to eat and drink enough, ensuring their dietary and nutritional needs were met. Staff worked effectively with other health care professionals to ensure people's health needs were met.

People were provided with the opportunity to participate in activities and pursue their hobbies and interests. There was an effective complaints procedure in place, and complaints had been dealt with in line with the registered provider's policy.

There were systems in place to continually monitor the quality of the service, and to drive improvements. This included people being encouraged to feedback about the quality of the service, and make suggestions for improvements.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Alder House - Care Home Physical Disabilities

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This comprehensive inspection took place on 14 May 2018 and was unannounced. The inspection team consisted of two inspectors 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.

Before our inspection we reviewed information available to us about the service. The registered provider had completed a Provider Information Return (PIR). The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed safeguarding alerts and notifications that had been sent to us. A notification is information about important events which the registered provider is required to send us by law.

We spoke with seven people, the registered manager, deputy manager, four care staff and one volunteer. Following our inspection, we received feedback about the service from two health care professionals.

We reviewed four people's care records, looked at three staff files and reviewed records relating to the management of medicines, complaints, training and how the registered persons monitored the quality of the service.

Good

Is the service safe?

Our findings

People felt safe living at Alder House. One person said, "The staff are nice, no one has ever hurt me." Another person said, "If I wasn't safe, I would have gone a long time ago." Staff had received training in how to safeguard people from the risk of abuse. Staff were aware of the signs to look for that someone was being abused and knew how to report any concerns to keep people safe. Staff demonstrated a good understanding of the different types of abuse, had a clear understanding of the service's safeguarding and whistleblowing procedures and what action to take if they felt people were at risk; this included reporting to external organisations such as the local authority and the Care Quality Commission. The registered manager was aware of their responsibility to liaise with the local authority if safeguarding concerns were raised.

There were systems and processes in place to identify, mitigate and for the on-going review of the risks to people living at Alder House. People's care plans included detailed risk assessments. This meant any identified/potential risks were mitigated and staff were provided with a clear description of any risks, together with guidance on how to manage these.

Rotas were planned to ensure adequate staffing levels. The registered manager informed us staffing levels were flexible and were reviewed on a daily basis to ensure appropriate staffing levels at all times. They went on to inform us they were recruiting to three care staff vacancies, however, due to the location of the home and access to local transport links, recruitment was challenging. The impact of not having a full complement of permanent care staff had made some people anxious. Pending recruitment to the care posts the registered manager told us, wherever possible, a consistent team of agency staff were used. During our inspection, we observed sufficient numbers of staff supporting people in a timely way and interviews taking place for the vacant care staff posts.

Where people were supported to take medication, this was managed and administered safely. Medicines were stored in a locked trolley and were administered by staff who had received appropriate training. Records showed, regular checks were undertaken to ensure people had received their prescribed medication safely. Where people had been prescribed 'as and when' medicines such as analgesia, protocols were in place.

Staff told us they were not allowed to start work at the service until relevant checks had been completed. This included obtaining references, ensuring applicants provided proof of their identity and completion of a criminal record check with the Disclosure and Barring Service (DBS). However, the staff recruitment records we looked at were disorganised. We found some documentation was missing for two members of staff. This included confirmation of a DBS check for one member of staff. In another staff file, we found no photograph for the member of staff, and no evidence to support their qualifications as stated on their CV, or reasons for leaving their previous employment. This information is important to ensure the registered provider employed people who were deemed safe to work with vulnerable people. Immediately following our inspection, the registered manager forwarded to us copies of the missing documentation. We also found interview records did not document the names and roles of the staff conducting staff interviews. We discussed our findings with the registered manager who confirmed they would ensure this information was

included for future interviews. They explained the administration officer was currently in the process of sorting out the staff recruitment files and they would be undertaking a comprehensive audit of staff files at the end of May 2018. Staff disciplinary procedures were in place to respond to any poor practice.

People were cared for in a safe environment and appropriate monitoring and maintenance of the premises and equipment was on-going. The service employed a maintenance person to carry out general maintenance and day to day repairs.

People were protected from the risk of the spread of infection. The service had an 'infection control' champion, and staff received infection control training. Staff had access to personal protective equipment (PPE) such as disposable aprons and gloves. The registered manager had sourced individual shower chairs for people living at Alder House. This not only supported people's dignity but also reduced the risk of infection. During our inspection, we found the environment at Alder House to be clean and there were no malodours.

Processes were in place to record incidents and accidents. These were monitored by the registered manager and the registered provider. This meant if any trends were identified, prompt action would be taken to prevent reoccurrence. The registered manager informed us incident and accident records were not closed until the registered provider's health and safety team were satisfied all appropriate actions had been completed.

Systems were in place to keep people safe in the event of an emergency situation such as fire and personalised emergency evacuation plans (PEEPs) were in place for people.

Good

Is the service effective?

Our findings

Systems were in place for the ongoing review of people's care and support needs to enable staff to deliver effective personalised care to people.

Staff received training to enable them to acquire skills and knowledge to deliver effective care. All staff received an induction when they started work at Alder House, this included shadowing other staff, familiarising themselves with the provider's policies and procedures and getting to know people. They were also provided with a staff handbook. The registered manager told us new staff were required to complete the Care Certificate. The Care Certificate is a nationally recognised training programme for staff new to the care sector. The registered manager showed a strong commitment to staff's learning and development. One member of staff told us, "I've never had so much training as I do here. We do refresher training too; it's good as it really helps us." Some staff had been supported to enrol on an apprenticeship team leader course to support them in their role. A member of staff told us, "The course is really good, I have to do lots of research and am gaining a lot out of it."

Staff received structured supervision and an annual appraisal, and detailed supervision records were maintained. One member of staff told us, "I like my job. I am supported to develop my skills and can discuss this in supervisions." Supervisions and appraisals are important as they are a two-way feedback tool for managers and staff to discuss work related issues, training and development needs.

Alder House is a single storey building. The design and layout of the premises promoted people's wellbeing. All areas of the home were wheelchair accessible and handrails were in situ along corridors to support people with mobilisation. There were en-suite facilities in people's bedrooms and track ceiling hoists in place. People had access to communal lounges, a large dining room, an activities room, therapy room and communal gardens. People's artwork was displayed along corridors. Since our last inspection, two additional bedrooms had been built to a high specification including movement sensor lights. The registered manager told us a redecoration programme was in development. This included bringing all bedrooms up to the same standard and, following feedback from people living at Alder House, replacing carpeted flooring with flooring more suitable to aid people using wheelchairs.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where required, we saw appropriate DoLS authorisations were in place to lawfully deprive people of their liberty for their own safety. Staff understood the principles of the MCA and the importance of gaining people's consent prior to care tasks being carried out. Although people's care plans clearly evidenced their choices and preferences about the delivery of their care, some care plans we reviewed had not recorded people's consent to confirm they had consented to their care. Also, we saw one person's records showed consent had been given by a relative in relation to the person's care, however they did not hold a lasting power of attorney for health and welfare, and therefore did not have the legal right to do so. Furthermore, on further review of the person's records we saw the person had been deemed as having capacity to make

decisions. Although there had been no negative impact on the person, and staff were aware the person had capacity to make decisions, improvements were required to ensure accurate and concise records were kept. We discussed our findings with the registered manager who confirmed they would take immediate action to ensure consent to care was sought and recorded, and care records accurately reflected people's capacity to make decisions.

People were supported to drink and eat enough. Care plans recorded people's dietary needs and preferences and staff were able to demonstrate their knowledge of these. Pictorial menus were available and people were able to choose alternatives if they chose not to eat the planned menu. Where people were at risk of poor nutrition, or had swallowing problems, records showed staff worked closely with the speech and language team (SALT) to provide appropriate care and support in line with the SALT's team recommendations.

The registered provider employed a physiotherapist and there was a dedicated treatment room. We saw a physiotherapy planner in place for people living at Alder House. The service worked with health care professionals to ensure this area of service delivery was effective in meeting people's individual needs.

People were supported to access health services such as GP, chiropodist and dentist. Care plans contained the contact details of health professionals involved in people's care and recorded the outcome of appointments and contacts with health care professionals which ensured staff had up to date information. People had Health Action Plans and Hospital Passports. These are documents which include important information about individual's medical and support needs. They are used as a quick reference for sharing information with other healthcare professionals. This ensured continuity of care and reduced people's anxiety, for example if they were admitted to hospital.

Good

Is the service caring?

Our findings

Staff and management were committed to ensuring people received the best quality care. Staff provided a caring environment for people who lived at Alder House. A healthcare professional told us, "In my professional capacity I have found the staff to be caring, they have always verbally expressed compassion and friendliness to the residents."

During our inspection we observed positive interactions between staff and people. One member of staff told us, "I treat [people] as if they are my own family, my mum or my grandparents. I love them but still ensure I am professional and am mindful of boundaries." A healthcare professional told us, "[Name of deputy manager] really cares about people. The staff are caring and know people and their needs well." A volunteer told us, ""It is really good here. I have been coming for 25 years and I can't find fault. The whole staff are caring. I think it is a very happy home."

Where possible, people were involved in the planning and review of their care. Care plans contained detailed information on people's likes and dislikes, life stories, interests and hobbies and families and friends.

People were supported by staff who understood the importance of helping people to maintain their independence. Care plans contained detailed information on what people were able to do to ensure their independence was promoted and maintained.

People told us they were treated with respect and dignity. We observed staff knocking on doors before entering people's rooms. Staff also respected people's choices on how they preferred to spend their time, for example in their own rooms, in communal areas or accessing the local community. One person told us, "[Staff] show me respect and dignity. They always shut the door, sometimes I have to remind them about closing the curtains."

From April 2016, all organisations which provide NHS or adult social care are legally required to follow the Accessible Information Standard (AIS). AIS aims to make sure that people who have a disability, impairment or sensory loss are provided with information they can easily read and understand so they can communicate effectively. The provider was meeting this standard. People also had access to various assistive technology to enable them to communicate and live as independently as possible, such as computer boards and personal electronic controllers. In one person's communication care plan it stated, 'Staff to ensure my communication aid is plugged in and fully charged at all times, and it is placed on the stand on my chair. This is the only means of communication with others.'

People were supported to maintain links with friends and family. This included the provision of facilities to enable people to contact family members by Skype; this was particularly important for people who had family members who were unable to visit regularly. During our inspection, one person was using Skype, they said, "That's my [relative]. She is at home in Poland. I watch her cooking, and she can see me and we talk. I can see her at home." Another person told us, "I can have visitors at any time."

People's sensitive and personal information was kept safely and securely.

Good

Is the service responsive?

Our findings

There was a strong commitment to person centred care and people's care plans contained detailed information. Prior to people staying at Alder House, a comprehensive assessment of their care and support needs was carried out to make sure the service would be able to support them safely and effectively. The information from the assessment process was used to develop people's care plans.

Care plans were detailed and person centred and covered a range of care needs such as mobility, medication, communication, dietary, cultural and personal care needs. Staff told us that the information within the care plans were easy to follow and were updated to reflect people's current needs. People who were able to were involved in the review of their care and, where appropriate, relatives were also invited to be involved in the review process. If an individual's needs changed these were discussed at daily handover meetings. This meant there was clear up to date information available on how staff were to support people. One person told us, "I have an individual person centred care plan, and I am happy with it. We review every six weeks. Last time I asked for a change in the way my meds are given. It used to be in the morning before I got up, but I found myself choking, so now it's given when I am up, it works better for me." Feedback from health and social care professionals also told us the service was responsive to people's individual needs and was positive about the standard of care and support people received.

The service employed two activities coordinators who worked flexibly across seven days. They were supported by a team of volunteers and were proactive in promoting links with the local community and the organisation had in-house activities such as yoga, cooking and bingo. People were actively encouraged and supported to follow their interests and take part in social activities; for example, some people accessed a memory café in the local community and some people were supported to attend their favourite football teams' matches. Another person independently went to watch greyhound racing at a local stadium. We spoke with one of the activities co-ordinators who clearly enjoyed their role. They showed us the activity room which was full of games, puzzles and craft supplies etc. There were also computers people could access if they wished. People told us that they had a choice whether they wanted to participate in the activities. One person told us they did not see themselves as having a disability and it was extremely important for them to be able to raise public awareness about people living with disabilities. They went on to say staff were being very supportive and were helping them to attend an interview with a radio station.

People were aware of how to raise any concerns or complaints. The service had a clear policy in place for dealing with concerns and complaints and the registered provider monitored all complaints as part of its auditing processes to ensure they had been dealt with appropriately and to enable them to identify and trends or reoccurring issues. Records showed complaints had been dealt with appropriately in line with the registered provider's policy.

At the time of our inspection, no one living at the service was receiving end of life care. The care plans we looked at did not contain information to ensure people's preferences and choices for their end of life care are clearly recorded and regularly reviewed. We discussed this with the registered manager, and they confirmed to us they would ensure care plans were updated to record this information.

Good

Is the service well-led?

Our findings

The service requires and did have a registered manager. 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 registered manager was supported by a deputy manager with the day to day management of the service. Both managers demonstrated their commitment to ensuring people received good quality care.

Although we received mixed feedback from staff about the management of the service and staff morale, the majority of staff we spoke with told us they were supported and enjoyed working at the service. They told us both the deputy and registered managers were approachable and available for support and guidance at any time. When we discussed staff feedback with the registered manager, they explained to us how they were making changes to drive improvements to service delivery. As part of this process, they were working with staff to enable an effective staff team and were being supported with this by the registered provider.

Regular staff meetings were held and topics such as updates on people using the service, training and recruitment were discussed. Staff told us they were able to discuss any concerns and suggestions for improvements to the service.

The registered manager sought the views of people living at Alder House. This was done in a number of ways such as daily interactions and resident meetings. There was a suggestion box in the main foyer of the home where people and staff could put forward suggestions and ideas to improve service delivery. When we asked the registered manager for an example of any suggestions which had been implemented, they showed us a Velcro signing in and out board. This helped people who found it difficult to write to show whether they were at home and also enabled them to see which staff were on duty including the designated first aider and fire marshal on each shift. The registered provider also carried out an annual questionnaire to help drive improvements across all its services, however the responses from the last questionnaire were unable to be broken down to enable us to view the feedback from people living at Alder House.

The service worked in partnership with other agencies to support care provision and 'joined up' care. Records showed where the service had communicated with other health and social care professionals to ensure positive outcomes for people living at Alder House. A health care professional told us the service worked very well with them and they had no concerns about the care people received. They went on to confirm that any recommendations made by them were actioned by staff and, if staff had any concerns, they would contact them for advice. Another health care professional told us they had previously experienced some difficulties in terms of the staff team's responsiveness to implementing their recommendations. They went on to say they were working closely with management and informed us improvements had been made.

The registered manager kept themselves updated by accessing websites such as 'Skills for Care' and the

'Care Quality Commission', and attending senior managers' meetings to keep themselves updated on best practice and guidance relevant to the management of the service. There were systems in place to continuously monitor the quality and safety of the service. These included managing safeguarding concerns, complaints, incidents and accidents, and the completion of audits such as medication, health and safety and fire safety. Records showed that management took steps to learn from any incidents and took relevant action to mitigate reoccurrence.

Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager was aware of their responsibilities and had systems in place to report appropriately to CQC about reportable events.