Keychange Charity

# Keychange Charity Romans Care Home

## Inspection report

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Date of inspection visit:
06 June 2017
07 June 2017

Date of publication:
09 August 2017

## 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? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on 6 and 7 June 2017 and was unannounced.

Keychange Charity Romans Care Home is registered to provide accommodation and care for up to 30 older people with a variety of health and support needs, including some people living with dementia. At the time of our inspection 23 people were living at the home, including one person who was staying for a short break. Keychange Charity Romans Care Home is a large detached house close to amenities in Southwick. Communal areas include a main lounge, dining room and large conservatory adjacent to the dining room. A secure, fenced garden is located at the rear of the premises. Accommodation is provided for people over three floors, with lift access.

At the time of our inspection, the registered manager had left the service and had applied to de-register with the Care Quality Commission; plans to recruit a new manager had not yet been put in place. 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 day-to-day management of the service was being undertaken by two deputy managers.

Robust systems were not in place to monitor and measure the quality of the service overall at the home. Some monthly checks had been completed, but there was no audit in place for the management of medicines.

Staff had a good understanding of the Mental Capacity Act 2005 and associated legislation. However, one person, who had bedrails, did not have the necessary consent or best interests decision in place. This was discussed with management who stated appropriate steps would be taken to rectify this.

Relatives and people spoke highly of the care they received and written comments were positive. People felt they were involved in developing the service through residents' meetings and formal monthly surveys about different aspects of the home. Staff felt supported.

People felt safe living at the home. Staff had been trained to recognise the signs of potential abuse and knew what action to take if they had any concerns. Risks to people were identified, assessed and managed safely with appropriate guidance for staff. Staffing levels were sufficient to meet people's needs, although comments from people were mixed. Some people felt there were enough staff and others said there could be a shortage, especially at busy times of the day. Safe recruitment practices were in place. Medicines were managed safely.

Staff had been trained in a range of areas, received regular supervisions and attended staff meetings. People felt that staff were well trained and approachable. Training was delivered to staff in an electronic format. New staff followed the Care Certificate, a universally recognised qualification. People had

sufficient to eat and drink and were offered a range of choices in their meals. Drinks were readily available throughout the day and night. People had access to a range of healthcare services and were supported by healthcare professionals.

People were looked after by kind and caring staff who knew them well. People spoke positively about the caring nature of staff and that staff responded promptly to their needs. People's spiritual needs were catered for. People were encouraged to express their views and to be involved in all aspects of their care. They were treated with dignity and respect.

Care plans provided information about people and guidance for staff on how they wished to be cared for. Care plans were in the process of transferring from written records into an electronic format. Detailed information had been drawn up on every aspect of people's care. A range of activities was available to people which were planned by an activities co-ordinator. People felt there was enough to keep them busy. Complaints were managed in a responsive manner.

## 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.

People were protected from harm by staff who had been trained to recognise the signs of potential abuse and knew what action to take.

People's risks had been identified and assessed appropriately. Guidance was in place for staff on how to mitigate risks.

Staffing levels were adequate and safe recruitment practices were in place.

Medicines were managed safely.

### Is the service effective?

Good

The service was effective.

Staff completed training in a range of areas and had regular supervisions. Staff meetings took place.

In the main, consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

People had sufficient to eat and drink and were supported by a range of healthcare professionals and services.

### Is the service caring?

Good

The service was caring.

People felt staff were kind and caring and that positive relationships had been achieved.

People were supported to express their views and in making decisions about their care.

People were treated with dignity and respect.

## Is the service responsive?

Good

The service was responsive.

People received care that was responsive to their needs. Care plans contained comprehensive information about people and detailed guidance for staff.

A range of activities was organised by the activities co-ordinator in line with people's choices.

Complaints were dealt with in a satisfactory manner.

## Is the service well-led?

Requires Improvement

Some aspects of the service were not well led.

There was a lack of systems in place to measure and monitor the quality of care delivered overall.

The previous manager had de-registered with the Commission, but no steps had been taken to recruit a new manager at the time of our inspection.

People felt involved in developing the service through residents' meetings and formal surveys.

Staff felt supported and made positive comments about the home.

# Keychange Charity Romans Care Home

**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 took place on 6 and 7 June and was unannounced.

One inspector and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience at this inspection had expertise in older people and dementia care.

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 any improvements they plan to make. We checked the information that we held about the service and the service provider. This included previous inspection reports and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, five staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with seven people living at the service, spoke with two relatives and a friend of one person living at the home. We chatted with people and observed them as they engaged with their day-to-day tasks and activities. We spoke with the deputy managers, two care assistants, the cook and

the registered manager of one of the provider's other homes.

The service was last inspected on 3 March 2015. The service was published "Good" following that inspection.

Good

# Is the service safe?

## Our findings

We asked people whether they felt safe living at the home and everyone we spoke with said they felt this was a safe place to be. One person said, "I feel safer here than in my bungalow" and another person commented, "The staff support me when I need it and I feel safe". A third person told us, "When I call, they usually come quickly and I do feel safe". We observed that for the majority of the day there was always at least one staff member present in the conservatory or dining room.

Closed-circuit television monitored people who tried to gain access through the front door at the home, so staff could see who was visiting before they opened the door. This helped to keep people safe from intruders. Staff knew what action to take if they suspected people were at risk of abuse. One staff member explained, "We're here to protect the vulnerable and we have to know who's coming in. It's about protecting people from harm. I'd report anything suspicious". Another staff member told us about the importance of maintain an environment that was free of hazards. They said, "If you have sight problems, you would evaluate the room and check for hazards". They added, "We always let people know what we're doing so they don't get confused or scared". This staff member talked about a safeguarding incident they had been involved with once where a staff member had been dismissed as a result of harm they caused to a person. They explained the action that had been taken by the provider and we saw that guidance was available to staff in the staff room and in the care office. Staff had been trained in safeguarding adults at risk.

Risks to people were managed so they were protected and their freedom was supported and respected. People's risks had been identified and assessed appropriately. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. Risk assessments provided guidance to staff on how to support people safely. People told us they felt their risks were managed appropriately and their independence was encouraged. One person said, "The staff are very safety conscious" adding that they had a fall recently which resulted in injury. As a result, steps were taken to ensure that similar incidents did not reoccur for other people living at the home. Another person said, "They did sort rooms out on the ground floor for some residents when the lift broke down". A third person told us, "I feel I can do things for myself and staff do try to let me be as independent as I can be".

We looked at risk assessments contained within people's care records. One person who had a high rate of falls had moved rooms from the first floor to the ground floor, opposite the care office, so staff could monitor them and reduce the risk of falls. A range of risk assessments was in place for people such as for mobility, skin integrity, moving and handling and nutrition. Daily records were kept that recorded when people with continence issues had their pads changed and people at risk of developing pressure ulcers, because of being cared for in bed, were regularly turned by staff. Bed rail assessments were completed for people at risk of falling out of bed and appropriate professionals were consulted where needed. Premises were managed safely. Handrails in corridors enabled people to walk safely in communal areas. A stairgate at the top of a flight of stairs prevented people from falling. Daily environmental checks were completed by staff and these were recorded by staff on a mobile device. Windows had safety catches in place and radiators were covered. People had access to a secure garden which surrounded the home. Accidents and

incidents were recorded and appropriate action taken to prevent the risk of reoccurrence. We asked one staff member about risk assessments at the home and they said, "If I felt there was an issue, I would refer to someone in charge".

There were sufficient numbers of suitable staff on duty to keep people safe and meet their needs. At the time of our inspection, 23 people were living at the home. They were supported during the day by four care staff in the morning and three care staff during the afternoon. In addition, a deputy manager was also working on the floor between Monday and Saturday. At night, two waking night staff were available. Domestic, catering and maintenance staff were employed at the home. People who required hoisting were accommodated in rooms on the ground floor, so could be responded to quickly by staff. One of the deputy managers told us that people's call bells were monitored and how often people summoned staff for support. This enabled staffing levels to be assessed based on people's needs and health care requirements. We asked staff whether they felt there were enough staff on duty. One staff member told us, "Sometimes we struggle in the mornings if people are unwell". Another staff member said, "It would be better with more staff. It can be demanding, especially people with dementia and Parkinson's". People felt there were generally enough staff on duty and said the staff response to their calls was reasonable. Other people commented there could be a shortage of staff at busy times of the day. Comments from people were mixed, such as, "The staff do what they can, but they could do with more", "At times they are a bit short-staffed" and "Staff numbers are adequate". We checked staffing rotas and these showed that staffing levels were consistent over the time period examined. Occasionally, agency staff would be used to ensure safe levels of staffing were in place.

Safe recruitment practices were in place. Staff files we checked showed that potential new staff had completed application forms, received a job specification, two references had been obtained to confirm their suitability and good character for the job role and checks made with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and help prevent unsuitable staff from working with people in a care setting.

People's medicines were managed so they received them safely. One person said, "Staff give me my medication when I should have it and they let you choose if you want painkillers". Another person told us, "I am getting my medication at regular times". A third person explained, "I self-medicate and I have a lockable drawer in my room for my medication". Medicines were stored in a medicines trolley. All medicines were prescribed for people and topical creams were stored in the care office. Some people had been assessed as competent to administer their own medicines and their medicines were stored in lockable cabinets in their rooms. Medication administration records (MAR) had been completed appropriately by staff to show that people received their medicines as prescribed. Every month, the MARs were checked and reviewed by senior staff to ensure they had been completed appropriately. We were told that only senior staff administered medicines and records confirmed they received the necessary training.

Good

# Is the service effective?

## Our findings

People received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. People thought the staff were well trained, knew their needs and did a good job. Some people mentioned that staff seemed flexible and multi-tasked. One person told us, "Staff are well trained and they do get on and do what they should". Another person said, "Staff seem well trained and are all very professional". Staff completed training in a range of areas such as fire prevention, infection control, safeguarding, medicines, food safety, health and safety, first aid, moving and handling, dementia and mental capacity. Training was delivered electronically in the main, although moving and handling training was delivered face to face. One staff member said, "We do all our courses on line. The last manager put all training on electronically. If there's any problem, you can always ask someone". We looked at the staff training plan which showed that staff had completed their training as needed. All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. Staff were encouraged to study for additional qualifications such as diplomas in health and social care.

The deputy manager said that staff received supervision meetings every three months and records confirmed this. Supervisions included spot checks being undertaken, for example, observing staff when they delivered personal care. Annual appraisals were completed to measure staff performance. Staff told us they found the training useful and felt supported by management. Staff meetings were organised every six months. We looked at records of staff meetings that had taken place. One staff member said, "[Named deputy manager] wants to do a meeting soon to see whether we have any suggestions. The deputy managers listen to us and we can discuss anything".

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw a mental capacity assessment had been completed for one person and an application had been made for DoLS. For another person, we saw they had bedrails in place, but staff told us the person was unable to consent to this. However, there was no mental capacity assessment to reflect this and no application had been made for DoLS. We discussed this issue with the deputy manager and with the registered manager of one of the provider's other homes. The registered manager agreed this was an oversight and would take steps to redress the situation. We contacted the home after the inspection and were told that a DoLS application had been completed for this person and a best interests meeting had taken place, so that the decision relating to the use of bed rails

had been taken lawfully.

We asked staff about their understanding of mental capacity and DoLS. One staff member said, "People with dementia, sometimes they may not understand, so we need to go into more detail for them". Another staff member explained, "Deprivation of Liberty is about taking away people's independence. You can't take someone's liberty away from them. Some people have capacity even with dementia. People are to be encouraged to make their own decisions, even if it's the wrong decision".

People were supported to have sufficient to eat and drink and were encouraged to maintain a healthy diet. We observed people have their lunch in the dining room. Fourteen people were served by five staff, who wore protective aprons. One staff member was serving meals to people in their rooms. The meal consisted of a choice of two main courses, desserts and drinks of water and juice. People were asked for their choice of meal the previous day and people appeared to be enjoying their lunchtime meal from our observations. Drinks were freely available throughout the day and a refreshment station was located in the dining room. We asked people about the food on offer and feedback was positive. One person said, "The food is ample and you get a choice". Another person said, "Normally the food is okay". A third person commented, "Sometimes I eat in my room and at other times I go down. They bring drinks around about three times a day". A fourth person said, "The food's fantastic and enough portions". In addition to the main meals of the day, we saw a snack box was available in the dining room, containing, crisps and biscuits, which people could help themselves to. We spoke with the cook who told us they always tried to cater for people's preferences and that menus were discussed at residents' meetings. The cook said they often had theme days, for example, Chinese or Indian, where meals reflected different cultures. The previous Friday had been National Donut Day, so people had enjoyed eating a variety of doughnuts. Special diets were catered for and the cook was able to explain about these. One person had been assessed by a speech and language therapist and, following their advice, their food was pureed and fluids thickened to aid with swallowing. Menus were arranged over a four weekly cycle and changed in the summer and winter.

People were supported to maintain good health and had access to a range of healthcare professionals and services. People told us they received support from the chiropodist, dentist and optician. People also reported that a GP visited and would be called if they were unwell. One person said, "They are always checking on me. If you have a medical problem, they are quick at getting the doctor in to see you". A relative said, "We, as a family, believe Dad made the right choice to come here. The facilities are just what he needs at present and he is extremely happy". A second person told us, "If you need to visit the hospital, a staff member will go with you if the family can't do it". Care plans recorded when people had appointments with health and social care professionals and any actions arising.

Good

# Is the service caring?

## Our findings

Positive, caring relationships had been developed between people and staff. People and their relatives felt the care delivered was good and that staff were kind, caring, helpful, attentive and respectful. We observed staff contact with people was of a kind nature and some good interactions were evident throughout our inspection. Staff responded promptly to people's needs, getting them a drink or assisting them to the toilet. People had their personal hygiene needs supported and were dressed appropriately for the time of year. We were told that visiting clergy supported people in their cultural and spiritual needs and one person confirmed this saying, "I receive Communion every Sunday". People spoke positively about the staff who cared for them. One person said, "The staff are very caring and understanding. If you need help you can call for it and they do come quickly". Another person said, "The staff are good here and they are all good to me". A third person told us, "All the girls are lovely and they always have a laugh with me". Staff felt they had time to spend with people. One staff member, when meeting new people, explained, "I will introduce myself and sit with people and find out what they like to do. It's nice to understand more about them and their families".

We observed throughout our inspection that people were supported to express their views and were consulted on day-to-day decisions relating to their care and treatment. We asked people how they were involved in their care. One person said, "I do feel they involve me in decisions about my care". A second person told us, "Staff always ask permission before attending to me". A relative commented, "They always keep me informed about things about Mum". In one person's care plan we read, 'I have outlived my family and friends. A solicitor takes care of my needs'.

People told us they were treated with dignity and respect. One person said, "The staff are very polite and respectful". Another person told us, "Staff are very respectful and give me my dignity". We observed staff treating people with respect, for example, covering people up when they were sitting in their chairs. A member of staff explained, "With washing, I make sure they're covered up. I talk to people and explain what's happening and I'm patient with people. If they refuse care, we document it". We asked another staff member about dignity and respect and they explained, "Hopefully I treat people the right way. You have to think about your own family, my mum, and how I would like her to be treated".

Good

# Is the service responsive?

## Our findings

People received personalised care that was responsive to their needs. Care plans provided detailed information about people in a person-centred way. The essence of being person-centred is that it is individual to, and owned by, the person being supported. A person-centred approach to care focuses on the person's personal needs, wants, desires and goals so they become central to the care process. People's needs take priority. People's personal histories, likes and dislikes were recorded in their care plans. One person said, "I do feel I get the care I need" and a relative commented, "They seem to respond to resident's needs well". We asked people whether they were looked after by male or female care staff. People told us they did not mind about the gender of staff who supported them. One person said, "There are some men working here and they are okay at looking after me". A second person told us, "I do have a male looking after me, but it doesn't bother me".

Care plans provided detailed information about people and comprehensive guidance for staff. Care plans documented risks staff should be made aware of and a summary of information about people. For example, we read in one care plan about the person having swallowing difficulties and being referred to a speech and language therapist for advice and guidance. We read too that they could not communicate very well and spent time in bed. People's care needs were recorded under headings such as, physical, cognition, psychological, social and end of life care. Under the heading of 'physical', information was recorded on people's personal hygiene, nutrition, communication, sight, hearing, oral health, foot care, mobility and motor control, falls, continence, personal safety and risks, medication and dressing. Care staff recorded when they attended to people through the use of an electronic system where staff recorded any care interventions that took place throughout the day and night. For example, interventions such as when people required turning to protect their skin integrity, fluid intake and output, hygiene, blood pressure, blood sugar and night checks, without having to fill in any additional paperwork. Care plans were in the process of being transferred from written records into an electronic format and were reviewed monthly. We asked staff whether people and relatives were involved in reviewing care plans and were told that relatives were involved in the 'old style' care plans, but not with the new system as yet. However, relatives would be able to view their family member's care plans within the new format as soon as the new system had bedded in.

A range of activities was organised for people by the activities co-ordinator who worked two hours a day between Tuesday and Friday. On Mondays, staff would organise activities and people might go out. We were told that people decided what they wanted to do on the day. On Mondays, church volunteers visited the home. At weekends, we were told that people spent more time with their families or a film night might be organised. We looked at the calendar in place for June 2017 which showed activities included ball games, manicures, arts and crafts, gentle exercise, carpet bowls, flower arranging and 1:1 sessions for people who stayed in their rooms. People had access to daily newspapers at the home. Activities were recorded to show the activity people had participated in and time staff spent with people, including going on outings. We talked with the activities co-ordinator who said, "I try to be flexible with the programme and respond to requests by residents. The carers help out at other times". One person told us, "We do have activities on Tuesday to Friday and we have enough to do; you can please yourself in the afternoon".

Another person said, "There is quite a good daily programme of activities in the morning, a reasonable balance". A third person told us, "I get out with relatives or they [staff] take us out for coffee. Visitors can come when they like".

Complaints were listened to and learned from. One complaint had been received within the year to date and this related to one person being unable to stay at the home because of funding issues. This had been dealt with appropriately. People told us they did not have any complaints, but would report any if they needed to. One person said, "No. I've never had a complaint. I have no problem reporting complaints to the seniors". A second person commented, "No complaints, but I feel comfortable about bringing something up. I'm sure they would sort a problem out".

Requires Improvement

# Is the service well-led?

## Our findings

Some audits had been completed to monitor and measure the quality of the service, but there was a lack of audits overall to provide a full picture of what was happening at the home. Some audits had been completed relating to commodes, first aid boxes, bedrails, people's blood pressure and weights and in relation to housekeeping, for February and March 2017. The previous registered manager had completed some monthly checks, but there was no audit in place in relation to the overall management of medicines. At inspection, we struggled to find some records regarding the auditing and governance of the home. We saw no evidence to suggest that the gaps in auditing had any adverse impact on the quality or safety of the service being provided. However, we have identified it as an area for improvement. Senior staff told us they did not feel involved in the running of the home. One staff member felt there were opportunities to develop the home, but that their ideas had not always been listened to by the previous registered manager. We spoke with the provider's area manager who recognised there had been some issues in the management of the home. They told us that they had invested in a resource to promote meaningful activities for people, but that this had not been take advantage of.

We discussed our concerns about the lack of auditing with the area manager and with the registered manager of one of the provider's other homes. They agreed this was an area for improvement and stated they would work with the deputy managers to develop a robust system of audits to drive continuous improvement.

The previous manager had notified the Commission of their intention to de-register as manager at the home. In the interim, two deputy managers were covering the day-to-day management of the home until a new manager could be recruited. However, at the time of our inspection, the area manager told us that the vacancy had not yet been advertised, but that they proposed this be done in the near future.

Relatives spoke positively of the care that their loved ones received at the home. In an email, the previous manager had written, 'I have been asked to pass grateful thanks to all staff that dealt with [named person] and his admission to hospital. The family want you all to know that the A and E staff were very impressed how well [named person] was cared for. They thought we were a nursing home, not residential'. The relative had also written and stated, '[Named person] is cared for with love and you have to go a long way to find that type of care anywhere else'. Another relative stated, 'You do such a wonderful job caring for Mum, so thank you so much'. A person we spoke with said, "I am spoilt here and have been all the time. The best thing here is I get things done for me and I'm not lonely". Another person said, "I am very happy with things as they are". A third person told us, "I'm so happy. I came here for three days and have been here since!".

We asked people whether they were involved in developing the service and some people said they were aware that residents' meetings took place. We looked at the minutes of meetings which took place in 2017 and four meetings were planned during the year in March, May, July and September. At the last meeting which had taken place in May 2017, 11 people had attended. Items under discussion included staffing, activities, external entertainers, food and people's rooms. People were also asked for their feedback through formal, monthly surveys, the last one of which had been completed in April 2017. Each survey had a

particular theme. For example, the April survey asked people about healthcare and alternative therapies. People had commented on dentistry, physiotherapy and eye care. People were asked if they were interested in any alternative therapies. Other surveys completed were in relation to activities, church, medicines, dignity and respect and food. People told us, "We have had a questionnaire", "They do seem to listen and sort problems out" and "Meetings for residents are held once a month and you can bring up any issue you like. They are well attended".

The provider had a Statement of Purpose which stated, 'Our aim – to create communities with a Christian ethos that are well-led; where staff are enabled to give the best of care that is responsive and person-centred, in an environment which makes people feel safe and supported'.

People were asked about the management of the home. One person said, "Management are very approachable and I can go to see the manager any time". Another person told us, "There is an open culture here. I experienced this home when my mother-in-law was here and I chose to come here myself". A third person said, "The deputy managers are very informative and do follow things up; they know the residents very well". Staff felt supported by management. One staff member said, "No home is perfect, but it's a small home and I think it runs quite well. It's the staff and people that make a place homely". They added, "People are sometimes from the locality, so we know the same people". Another staff member, when asked what was good about the home, said, "The residents and the staff. I love the residents and management are really good too".