Keychange Charity

Keychange Charity Rosemary Mount Care Home

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

Keychange Charity Rosemary Mount Care Home provides residential care for up to 29 people with a range of health and support needs, including people living with a learning disability, dementia or frailty of old age. At the time of our inspection, 27 people were living at the home. Keychange Charity Rosemary Mount is situated in East Worthing close to transport links. All rooms are of single occupancy and accommodation is over two floors, accessible by a lift and stairs. Communal areas include a large entrance hall, sitting room, dining room and a further smaller sitting room where people can receive visitors in privacy. People have access to gardens at the rear of the home.

At our last inspection we rated the service as 'Good' overall. We rated the key question of 'Safe' as 'Requires Improvement' because of concerns relating to the administration of medicines. At this inspection, we found that improvements had been made and this key question has improved to '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.

At this inspection we found the service remained 'Good'.

People told us they felt safe living at the home. Staff had been trained to recognise the signs of potential abuse and know what action to take if they suspected abuse had occurred. People's risks were identified, assessed and managed safely. Staffing levels were assessed based on people's care and support needs. New staff were recruited safely. Medicines were managed safely. If things went wrong, lessons were learned and improvements made. The home was clean, tidy and smelled fresh.

People received effective care from staff who had completed relevant training and received regular supervisions and annual appraisals. People had a choice of what they wanted to eat and drinks were freely available. A range of healthcare professionals and services were available to support people with their health needs. 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 supported this practice.

Positive, caring relationships had been developed between people and staff. People were positive about the care and complimentary about the staff who supported them. People were encouraged to be involved in decisions relating to their care. They were treated with dignity and respect.

Care was planned in a personalised way to meet people's support needs, likes and dislikes. Activities were organised based on people's interests and what they would like to do. Outings were organised which people enjoyed, in addition to activities provided in-house. People knew how to make a complaint and who to speak with. No complaints had been recorded in the last year. If they wished, and if their care needs

could be met, people could live out their lives at the home.

The home was well led and staff felt supported by the management team. People and a relative were asked for their feedback about the service and any improvements identified were acted upon. A system of audits had been implemented which was robust and drove continual improvement.

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?

Good

The service has improved to Good.

Medicines were managed safely.

People were protected from the risk of abuse by staff who had been trained in safeguarding adults at risk. Risks to people had been identified and assessed and risk assessments provided guidance to staff.

Staffing levels were sufficient to meet people's needs flexibly. Recruitment of new staff followed safe practice.

The home was clean and tidy.

The registered manager shared any concerns raised with staff and with relatives as required. Lessons were learned if things went wrong.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Keychange Charity Rosemary Mount 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.

This comprehensive inspection took place on 26 November 2018 and was unannounced. The inspection team comprised an inspector 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. Their area of expertise was in older people and dementia care.

Before the inspection, we checked the information we held about the service and provider. This included previous inspection reports and any statutory notifications sent to us by the registered manager. A notification is information about important events, which the service is required to send to us by law. The provider completed a Provider Information Return (PIR). We used information the provider sent us in the PIR. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with six people who lived at the home and one relative. We observed people interacting with staff throughout the inspection. We spoke with the registered manager, two deputy managers, a senior member of care staff and a care assistant.

We looked at care plans and associated records for three people. We reviewed other records including the provider's internal checks and audits, staff rotas, three staff files including recruitment and supervision

records, the training plan, accidents and incidents, records of medicines administered to people and complaints.

Good

Is the service safe?

Our findings

At the last inspection, blister packs were left on top of the medicines trolley when medicines were being administered. The medicines trolley was left unlocked on occasion when medicines were administered. People could have accessed medicines that were not prescribed for them. We identified there was no risk or impact to people as this was an isolated incident. At this inspection we found medicines were managed safely. We observed medicines being administered to people at lunchtime. The member of staff waited patiently while people took their medicines, then completed the Medication Administration Record (MAR) in confirmation. One person said, "I'm given my medicines from the trolley. I have them every day and staff make sure I take them". Medicines were stored securely and temperatures checked within the medicines room to make sure they were within safe limits. We looked at medicines that were required to be recorded in a separate book. We found that two medicines had not been recorded. A staff member had thought this was the responsibility of district nurses since they administered the medicines. As soon as we brought this to their attention, the medicines were documented as required. Staff had been trained in the administration of medicines. Audits completed by the provider and from the issuing pharmacy were robust.

People told us they felt safe living at the home and they were encouraged to be as independent as possible. One person said, "It's not regimented. I'm allowed to do what I want. I walk with my walker and use the lift too. Staff let me be as independent as I can be". People were protected from the risk of abuse by staff who had completed training in safeguarding adults at risk. Staff knew what action to take if they suspected abuse was taking place in line with the local authority's safeguarding policy.

Risks to people were assessed and managed safely. We looked at a range of risk assessments within people's care plans. These included assessments in relation to people's risk of developing pressure areas, mobility and nutrition. When people sustained a number of falls, a referral was made to the local authority's falls team for advice and guidance. Accidents and incidents that had occurred were reported and analysed to mitigate risks. The safety of the premises had been audited and regular checks made around the home. Maintenance staff had regular oversight of the home. Servicing of equipment, including gas, water and electricity checks had been completed as needed, to ensure people's safety around the home.

There were sufficient numbers of suitable staff to support people and to meet their needs. Staffing levels were based on people's care and support needs and were flexible. One person said, "They check the bells to make sure they're working and come as quickly as they can. Sometimes when they're short-staffed, agency come in". Staff felt there were enough staff and said that agency staff would be used to fill any gaps in the staff rotas. The registered manager explained that they tried to use the same agency staff to provide people with a consistency of care. New staff were recruited safely. Appropriate checks were undertaken including with the Disclosure and Barring Service (DBS). References were obtained and people's employment histories were checked.

People were protected from the risk of infection by staff who had completed the relevant training. We observed the home to be very clean and tidy. One person told us, "They clean our rooms every day" and another person commented, "They change our towels every day". Staff wore protective personal

equipment, such as disposable aprons and gloves, when delivering care to people or when serving food.

Lessons were learned and improvements made when things went wrong. We discussed concerns that had been raised directly and anonymously to the Commission with the registered manager. The registered manager had shared the information of concern with staff to find out if it was accurate. We found no evidence to corroborate the accuracy of the concerns raised which we investigated fully at the time of our inspection. The registered manager had a good understanding of their responsibilities under Duty of Candour. They explained the importance of being honest and truthful with relatives if mistakes were made. They told us, "If anyone raises concerns, we always inform staff. We share any information as needed, with staff and relatives".

Good

Is the service effective?

Our findings

Staff had completed a range of training considered essential to their job roles; this enabled them to deliver effective care and support to people. The majority of training staff completed was on-line, with the exception of moving and handling training and first aid, which were face to face. The training plan showed that staff were up to date with their training in areas such as dementia, fire safety, health and safety, infection control, medicines, food hygiene and safeguarding. New staff studied for the Care Certificate, a universal qualification relating to work based training. New staff completed their induction by shadowing experienced staff. Staff were encouraged to study for additional qualifications in health and social care such as National Vocational Qualifications. Staff told us about the training they had completed and said that it helped them to understand how care should be delivered to people. Staff said they had regular supervisions, at least two per year with their line managers and an annual appraisal of their performance. Records confirmed this.

People were supported to eat and drink enough and to maintain a balanced diet. Drinks were freely available to people throughout the day. We observed people having their lunchtime meal. Most people chose to eat in the dining room and were served by staff. People were chatting together and appeared to enjoy the meal. Choices were provided if people did not like what was on offer. Tables were attractively laid with cloths, napkins, condiments and vases of flowers. One person told us, "The food is good and there is always an alternative. Staff will get you whatever you want and I can eat where I want". Special diets were catered for including soft texture, pureed and diets for people with food allergies. People's weights were recorded, with their permission, so that any increase or decrease in weight could be identified. Where needed, a referral could then be made to a healthcare professional to obtain advice on any actions required.

People were supported to live healthier lives and had access to a range of healthcare professionals and services. For example, one person had difficulties with swallowing because of an injury sustained several years ago. Advice had been sought from a speech and language therapist and guidance provided to staff on what types of food were safe for the person to eat. Care plans showed that people saw healthcare professionals such as GPs, dentists, chiropodists and opticians. One person said, "We have a chiropodist and the doctor came here to see me about my chest infection". People with particular health conditions had access to specialist nurses and consultants as needed. We saw that people were referred to professionals such as the Living Well with Dementia Team and Parkinson's disease nurses. Information about people's health needs was collated and hospital passports ensured that health staff had the relevant information about people if they needed to be admitted to hospital.

An environment had been created at the home that encouraged people to be as independent as possible. Gardens were accessible and two raised flowerbeds had been created to encourage people with gardening. The registered manager told us that they used any donations or money from fundraising to improve the home. For example, a summer house had been purchased from fundraising.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We found that the home was compliant and working lawfully in relation to their responsibilities under MCA and DoLS. Staff also had a good understanding of the importance of gaining consent in line with legal requirements and good practice.

Good

Is the service caring?

Our findings

People were looked after by kind and caring staff and positive relationships had been developed. We observed numerous occasions when staff were interacting with people. Staff showed patience and understanding when chatting with people. People were relaxed and happy in the company of staff. One person told us that their husband had lived at the home until the end of his life. Because the person had been so impressed with the care he received, they came to live at the home when they needed residential care. They explained, "I have a good relationship with them. They cared for my husband". Another person was complimentary about the staff and said, "They're very nice here and they do all they can". A third person told us, "I feel it is one of the best homes, I'm very lucky. All the staff are really lovely". A relative said, "I looked at several care homes. I think this place is marvellous, it's the whole package. I don't have anything bad to say".

People were supported to express their views and to be actively involved in decisions relating to their care and support. We asked staff how they might encourage people in this. One staff member explained to us the importance of giving people choices, seeing what they would like to do and then providing any support needed. Staff knew people's likes and dislikes and how they wanted to be cared for. When serving drinks to people, staff checked with people what they liked to drink and knew, for example, if they took milk or sugar with tea or coffee.

Visitors were made to feel welcome when they came to the home. The registered manager told us there were no restrictions on visiting times. The reception area at the front home of the home was bright and inviting with comfortable chairs for people to use when meeting with their relatives or friends.

People were treated with dignity and respect and had the privacy they wanted. Referring to how they would treat people with dignity and respect, one staff member told us, "I always think people are like my grand-parents. You respect them in the way you speak to them. It's about shutting the door when you're with people and keeping any information private. It's also about making sure people dress properly". Records relating to people were kept securely and confidentially.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. Care plans documented people's care needs including their likes, dislikes and preferences. Care staff knew people well and how they wished to be supported according to their care plans. Care plans included information about people's medical conditions, emotional wellbeing, cognition, physical and social needs. Information was provided to people an accessible way and in line with the requirements of the Accessible Information Standard. For example, one person had lost their ability to communicate verbally, so they communicated through signs, gestures and referring to pictures. The registered manager told us they were working with a speech and language therapist to put together a 'voice activated book'. The person would press the relevant button in the book and it would 'talk', thus meaning they could express their needs and wishes. Another person had to undergo major surgery, so staff had obtained accessible information about the operation, so the person was able to understand what would happen to them. Staff also used technology such as Skype, so that people could talk with their relatives and friends on-line.

As much as they were able, people were involved in reviewing their care with staff. One person told us, ""They have discussed my care plan with my son", which was their preference. Where changes were needed, these were documented and implemented by staff to ensure people's current care needs were met. Thought had been given to people who had protected characteristics and to ensure they were not discriminated against. People who had chosen to live a different lifestyle were supported by staff to do so. Staff members were treated equally and account taken of their preferences, such as in relation to religion, culture or sexual preferences. One staff member said, "We treat everyone the same, we don't treat anyone differently".

Activities were planned with people according to what they wanted to do. Activities co-ordinators were employed by the home and offered a range of activities during the week. A voice activated system in the lounge was used by staff to help with activities and to play music. People who preferred to stay in their rooms took part in activities on a 1:1 basis. External entertainers visited the home. The provider had an arrangement with an organisation that provided minibus outings for people. These were organised based on where people wanted to visit. For example, people had chosen to visit local garden centres, a farm outing and a local shopping centre. One person said, "We have three or four outings a year. I've been to the cinema, Arundel and out for dinner and to the garden centre. There's about five or six people on the bus at a time". People's spiritual needs were catered for and a member of the clergy paid regular visits for people who wanted this. Services were organised and a Christmas concert was being planned for. Local school choirs also visited and had proved to be popular with people.

Concerns and complaints were handled in line with the provider's policy. We were told that no formal complaints had been received in the last year and that any issues people raised with staff were responded to straight away, rather than being logged. People knew who to speak with if they had any concerns. One person said, "I would talk to whoever the senior person was on that day. In four years, I've only had a couple of niggles and nothing every needs to be escalated; it's sorted out".

People were supported at the end of their lives to have a comfortable, dignified and pain-free death. We were told that no-one at the home was currently on end of life care, although some people were receiving palliative care. Staff could complete end of life training as part of their vocational qualifications. The registered manager explained how they tried to make staff feel comfortable about dealing with death and to overcome any fears when dealing with the body of a dead person. The registered manager demonstrated a compassionate approach in relation to end of life care. Care plans recorded people's wishes for the end of their lives and their funeral plans.

Good

Is the service well-led?

Our findings

The home was well-led and a registered manager was in post. 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 demonstrated her understanding of her responsibilities and notifications had been sent to CQC as required. The rating awarded at the last inspection was on display in the reception area.

The provider had a clear vision and strategy to deliver high quality care that was person-centred and provided good outcomes for people. According to the provider's statement of purpose, the aim was to, 'create caring 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'. The registered manager was a role model in helping this aim to be delivered and supported staff in this. We observed that staff were supported by managers to be the best they could be and relationships were warm and friendly. An 'open-door' policy enabled staff to talk with the managers whenever they wished and we observed this happening. The registered manager demonstrated a caring attitude towards her staff and did not expect them to do anything she would not be prepared to do herself. The registered manager said they would often work alongside care staff at the home and this enabled her to have a good understanding of the day-to-day issues and running of the home.

People and staff were involved in developing the way the home was run. Residents' meetings were held and relatives were invited along to these too. One person said, "There are regular meetings for problems and suggestions". We were told that people would receive a copy of the minutes of residents' meetings if they had been unable, or chose not, to attend. Areas discussed included menu choices and planning, activities, staffing and upcoming activities. People had been involved in choosing garden furniture. Surveys were completed by people and staff. The latest survey completed by people was from April 2018 and results were positive. The results of the staff survey had only recently been received and had not been analysed at the time of this inspection. However, staff were enthusiastic about working at the home; one staff member said, "I love it, I really enjoy it".

The service learned and identified any improvements needed through a range of audits. These were comprehensive and detailed. Audits we looked at monitored areas such as medicines, falls/incident reporting and analysis, premises, fire checks, health and safety, cleaning and maintenance. The registered manager completed observations around the home which were recorded and any issues identified were followed-up and acted upon. Representatives of the provider visited the home and recorded any actions that were needed which were implemented.