

Keychange Charity

Keychange Charity Sceats Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Good ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Good ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

Keychange Charity Sceats Care Home provides accommodation and personal care for up to 30 older people. At the time of our inspection 17 people were using the service.

This was a comprehensive inspection to follow up on our previous inspections carried out in April and June 2016. Our visit was unannounced meaning the provider and staff did not know we would be coming.

Keychange Charity Sceats Care Home was placed in 'special measures' by CQC as a result of our inspection in April 2016. In June 2016 we saw some improvements had been made. Following this inspection, in September 2016, the service is no longer in 'special measures'.

There was no registered manager 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 provider had appointed a manager who had applied to CQC to become registered manager.

From speaking with people, relatives, staff and other health and social care professionals it was clear that the improvements we noted in June 2016 had been built upon. The provider, manager and staff had demonstrated a desire to improve the service provided and achieved considerable success. The improvements we have reported on now need to be sustained.

People received a service that was safe. Staff understood their role and responsibilities in keeping people safe from harm and knew how to raise any concerns. Risks were assessed and plans put in place to keep people safe. There was enough staff to safely provide care and support to people. Medicines were well managed and people received their medicines as prescribed. Infection control measures were in place.

Staff received regular training and the support needed to meet people's needs. People were supported to make choices and decisions. People had enough to eat and drink. Arrangements were made for people to see their GP and other healthcare professionals when required. People's healthcare needs were met and staff worked with health and social care professionals to access relevant services. A programme of works to improve the living environment had begun. The provider had plans in place to complete these works. The provider needs to ensure these are completed.

People received a service that was caring. They were cared for and supported by staff who knew them well. Staff treated people with dignity and respect. People were supported to maintain relationships with family and friends.

People received person centred care and support. People were encouraged to make their views known and the service responded to this by making changes. However, there were not enough activities offered to

people.

Significant changes had been made to the management of the service since April 2016. These had resulted in an improvement to the leadership and management. The provider and manager had developed and implemented their action plan following our inspections in April and June 2016. The provider now had systems for checking on the quality of the service provided. They had worked positively with other health and social care professionals to achieve a change in culture which had improved how the service was delivered. The improvements made now need to be sustained and the provider must ensure consistent and effective leadership and management is in place.

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.

Risks were assessed and plans put in place to keep people safe.

Staff understood their role and responsibilities in keeping people safe from harm and knew how to raise any concerns.

There was enough staff to safely provide care and support to people.

Medicines were well managed and people received their medicines as prescribed.

Infection control measures were in place, with staff following good practice guidelines.

Is the service effective?

Requires Improvement 

Staff received the training and support needed to meet people's needs.

People were supported to make choices and decisions.

People had enough to eat and drink and their intake was monitored in accordance with their individual needs.

People's healthcare needs were met and staff worked with health and social care professionals to access relevant services.

The planned improvements to the home need to be completed to ensure an environment that is homely and effectively meets people's needs.

Is the service caring?

Good 

The service was caring.

People were cared for and supported by staff who knew them well.

Staff treated people with dignity and respect.

People were supported to maintain relationships with family and friends.

Is the service responsive?

People received person centred care and support.

People were encouraged to make their views known and the service responded to this by making changes.

People were not offered enough activities.

Requires Improvement ●

Is the service well-led?

The changes to the leadership and management of the service had resulted in significant improvements. The improvements made now need to be sustained and built upon.

A manager had been appointed by the provider and was awaiting an interview with CQC to become registered manager.

Systems were in place to monitor the quality of the service provided.

The vision, values and culture of the service had been communicated and was understood by staff.

Requires Improvement ●

Keychange Charity Sceats 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

When we inspected the service in April 2016 we found there were breaches of the Health and Social Care Act 2005 (Regulated Activities) Regulations 2014. We issued three warning notices. These related to Regulation 12 (safe care and treatment) Regulation 17 (good governance) and Regulation 18 (staffing). We also issued a requirement notice as a result of identifying a breach of Regulation 11 (need for consent). The service was placed in 'Special Measures'. The purpose of special measures is to:

- Ensure providers found to be providing inadequate care significantly improve.
- Provide a framework within which we can use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.

Services placed in special measures are inspected again within six months. Following our inspection the provider sent us an action plan stating the action they would take.

We visited the service on 22 June 2016 to check the provider had taken the appropriate action to rectify those breaches referred to in the warning notices. We found at that visit, the provider had taken action. However, we issued a requirement notice in relation to Regulation 12 as they had not fully implemented their action plan regarding keeping people safe through assessing and managing risks to people. They sent us a further action plan explaining the action they would take to improve this. We rated the service as 'requires improvement' with 'special measures' remaining in place.

You can read the reports from these inspections by selecting the 'all reports' link for Keychange Charity

Sceats Care Home on our website at www.cqc.org.uk.

This was a comprehensive inspection carried out by two adult social care inspectors.

Prior to this inspection, we looked at the information we had about the service. This information included the statutory notifications the provider had sent to CQC. A notification is information about important events which the service is required to send us by law. Before the inspection, we 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 planned to make. We reviewed the information included in the PIR and used this to inform our planning.

We contacted the local authority quality assurance team and three health and social care professionals as part of the pre-inspection planning process. Their feedback has been included in the main body of the report.

Some people were able to talk with us about the service they received. We spoke with eight people using the service. Not every person was able to express their views verbally. Therefore we carried out a Short Observational Framework for Inspection session (SOFI 2). SOFI 2 is a specific way of observing care to help us understand the experience of people who could not tell us about their life in the home.

We also spoke with relatives of four people using the service. We spoke with ten staff, including the manager, deputy manager, five care staff, the cook, the maintenance person and a member of housekeeping staff.

We looked at five people's care records, three staff recruitment files, training records and other records relating to the management of the service.

Is the service safe?

Our findings

People we were able to talk with said they felt safe living at the home. Comments included; "We are all very happy" and, "I think it's nice here. Yes, I feel safe. The staff are good". Relatives also confirmed they felt people were safe. One relative said, "I'm happy with my wife's care, I think she's safe and well cared for".

People were protected against the risks of potential abuse. The manager and staff had a good understanding of their role in keeping people safe. They understood their responsibilities for reporting accidents, incidents or concerns. Staff told us they would report any concerns to the manager or senior staff. They said if they were not available they would report directly to the local authority, the Care Quality Commission (CQC) or the Police. The manager and staff had appropriately reported concerns in the previous six months. The provider had worked positively with the local authority throughout the multi-agency review that followed our inspection in April 2016. This had included them deciding to concentrate on improving the service prior to any new people moving in. This showed they had prioritised the safety of people using the service.

Risk assessments to keep people safe were in place. These had been rewritten within the last six months and covered a variety of aspects of people's care and their daily living. Where specific action to keep people safe was required a risk management plan had been put in place. These identified how potential risks or hazards were to be minimised and gave guidance for staff on how to keep them safe. We noted some inaccuracies in these. For example, one man's plans referred regularly to 'she' and not 'he'. We discussed this with the manager. They said they would ensure risk assessments and management plans were all reviewed to ensure they were accurate and written correctly. Risk management plans also highlighted how people were to be supported retain their independence whilst any known hazards were minimised to prevent harm. Staff had a good understanding of these risk assessments and management plans.

People and relatives told us there was enough staff to meet their needs. Three staff were available to provide care and support to people on weekdays with four in the mornings on weekends. Staff told us this was because the manager was not always at the home on weekends to help out. Staff said they felt there was enough staff to meet people's need. We looked at the staff rotas for the four weeks prior to our visit and found staffing had been planned in advance to ensure sufficient staff were available to care for people. Throughout our inspection we saw that people's needs were met promptly. The manager said, "There is enough staff to meet people's needs. When more people move in we will review the staffing levels".

Checks were carried out before staff started work to assess their suitability to work with vulnerable people. These checks included a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check an applicant's police record for convictions that may prevent them from working with vulnerable people. References were obtained from previous employers. The manager explained how they made a decision regarding an applicant's suitability if any concerns were identified in these pre-employment checks.

People were kept safe from the risks associated with the administration of medicines. The provider had changed their pharmacy supplier and staff said they were happier with the new arrangements. We observed

staff administering medicines. Staff administered medicines safely to people. Staff responsible for administering medicines had received training. People received their medicines as prescribed. Some people were prescribed 'prn' medicines. These are medicines to be taken when needed. They included medicines for the management of pain. There were clear individual guidelines for staff to follow to know when and how to offer these to people. Changes had been made to the arrangements for the storage of medicines. These ensured medicines were now stored safely and in accordance with the relevant guidance. The provider's policy on the safe storage and administration of medicines had been updated to reflect the changes made. The provider had plans in place to make the former hairdressers room into a new medicines room, following which the trolley in which medicines were kept would be moved into the room. The manager said this would mean they could monitor the temperatures medicines were stored at more easily.

Accidents and incidents were clearly recorded. These identified action that had been taken to keep people safe. For example, one person had received injuries as a result of falls. They had been referred to specialists in falls prevention and their risk assessment and management plan reviewed. Accident and incident records were reviewed by the manager to identify any themes or trends.

There were arrangements in place to keep people safe in an emergency and staff understood these and knew where to access the information. There was guidance on how people would be evacuated in the event of a fire. Fire evacuation drills were held for people and staff to practice this. Arrangements had been put in place to ensure all equipment was checked and serviced in accordance with manufacturers and best practice guidelines.

The home was clean and odour free. Care staff had received training in infection control. They told us they had access to equipment they needed to prevent and control infection. They said this included protective gloves and aprons. We saw staff using protective equipment to minimise the risk of infection. The home had an infection control lead. We spoke with this person who demonstrated a good understanding of the principles regarding the prevention and control of infection. Staff we spoke with said the standards of hygiene, cleanliness and the awareness of infection control measures had all improved significantly in the last six months.

Is the service effective?

Our findings

People we spoke with said their needs were met. Relatives also said they felt the service met people's needs. During our visit we saw people's needs were met. Staff provided the care and support people required.

People were cared for by staff who had received training to meet people's needs. We viewed the training records for staff which confirmed staff received training on a range of subjects. Training completed by staff included, first aid, infection control, fire safety, food hygiene, administration of medicines and safeguarding vulnerable adults. Staff said the training they had received equipped them to meet people's needs. Newly appointed staff were subject to a probationary period at the end of which their competence and suitability for the work was assessed.

Staff received regular individual supervision. These are one to one meetings a staff member has with their manager. Staff members told us they received regular supervision. Staff records showed these were held regularly. Supervision records contained details of conversations with staff on how they could improve their performance in providing care and support. Staff said they found their individual meetings helpful.

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and whether any conditions on authorisations to deprive a person of their liberty were being met.

The 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 are called the Deprivation of Liberty Safeguards (DoLS).

The provider had policies and procedures on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Senior staff had received training on MCA and DoLS. Care plans contained an assessment of people's capacity to make specific decisions. These were individual to the person and identified when the person was most likely to be able to make a decision and how it should be explained to them to maximise their understanding. For example, if a person was more able to understand a decision in the morning and if explained by a particular staff member. Staff we spoke with understood the main principles of the MCA.

The provider had submitted applications for a DoLS authorisation for seven people. This was because the person lacked capacity to make a particular decision and, their liberty was being restricted. These applications had been submitted to the appropriate authorities in a timely manner. A system was in place to monitor the progress of these applications, which included dates any had been authorised and when they would lapse. This meant the provider was able to manage this process to ensure people would not be

deprived of their liberty without the correct authorisation being sought.

Independent advocacy was arranged if people required this. A move to another part of the country was being considered for one person. This was so they could be nearer to family. They lacked the capacity to understand and make this decision. An independent mental capacity advocate (IMCA) had been contacted to assist in making a 'best interest' decision. The IMCA visited the person whilst we were at the service. We saw staff positively supported this visit and provided assistance as required.

People chose what they wanted to eat. Menus were planned with the involvement of people. These were varied and included a range of choices throughout the week. On day one of our inspection the menu board in the dining room was blank. On day two it had been completed. People had access to a variety of drinks throughout the day. People's food and fluid intake was monitored to make sure they had enough to eat and drink. We observed people at lunchtime on day one of our inspection. We saw lunch was an enjoyable, sociable event. The food was presented well and looked appetising. People told us they enjoyed the food. They said, "The food is good, I can choose what I want", "My favourite meal is a roast. I get this regularly. There is a good choice of food" and, "The food here is really nice". People seemed to enjoy the lunch time experience. Staff were available to assist people when they needed it.

Care records showed relevant health and social care professionals were involved with people's care. Plans were in place to meet people's needs in these areas and were regularly reviewed. There were detailed communication records in place and records of hospital appointments.

We found the provider had continued to make progress on improving the environment. Redecoration had begun on 13 July 2016. Considerable work had been completed on this and work was ongoing. Work had been carried out to improve the kitchen including some re-plastering, tiling and decoration. External work had been carried out to improve the appearance of the building. Some identified work had not been fully completed. This included re-decoration of bathroom areas, replacing carpets and other flooring. However, the provider had a plan in place with time-scales for the completion of the outstanding work.

We noted some furniture in communal areas was very worn and smelt. We saw some minor issues the staff were able to rectify when pointed out. For example, the lightbulb in the lounge not working and unused furniture not stored appropriately. A number of people using the service were living with dementia. Some signage and redecoration had been put in place as a result of research on what assists people with dementia.

Is the service caring?

Our findings

People were cared for by staff who knew them well. Staff were able to tell us about people's interests and individual preferences. The relationships between people at the home and the staff was friendly and informal. People were comfortable in the presence of staff and sought out their company.

People told us the staff were kind and caring. Comments included; "The staff are very good. You couldn't get better 'nurses'. They are lovely", "The staff are very friendly and all very nice people" and, "The staff are very good". Relatives also spoke positively about staff. They said, "The care is much improved since the new manager took over" and, "My father likes male staff for personal care, which happens when they can. Generally the care is good. We don't have to worry now like we did".

Staff were friendly, kind and discreet when providing care and support to people. People responded positively to staff which showed they felt comfortable with them. Staff spoke to people in a calm and sensitive manner and used appropriate body language and gestures. We saw a number of positive interactions and saw how these contributed towards people's wellbeing. For example, one person became quite upset as a result of discussions with an advocate regarding their wishes. Staff recognised they were upset and sat with them holding their hand. They were gentle, kind and comforting. They clearly knew the person well as they were able to talk with him about his life as a farmer. They listened carefully to his concerns and provided reassurance.

People's preference in relation to support with personal care was clearly recorded. This included how they wished to be supported in bathing and showering. Individual morning and evening care routines were in place and staff were knowledgeable about these. People and relatives were involved in writing their care plans. This had resulted in information important to people's wellbeing being included.

People were supported to maintain relationships with family and friends. Staff said they felt it important to help people to keep in touch with their families. People who showed us their rooms and were keen to show us photographs of family members and talk about contact they had with them. Care records contained contact details and arrangements. Relatives said staff supported people to maintain contact with family. They also commented that they were able to visit at any time and always made to feel welcome.

Staff promoted people's independence. People's care plans documented the assistance they required but also reinforced the things they could do for themselves.

Care records included an assessment of people's needs in relation to equality and diversity. Staff we spoke with understood their role in ensuring people's equality and diversity needs were met and had received training on this.

Each person had an identified key worker, a named member of staff. They were responsible for ensuring information in the person's care plan was current and up to date and they spent time with them on a one to one basis. Keyworkers completed a monthly review with the person that was kept with their care plan.

Care had been taken to record any information relevant to people becoming unwell or in the event of their death. The service was not providing care for anyone assessed as requiring 'end of life' care. However, the manager told us they would work with other health and social care professionals to try to ensure people could remain at the home for as long as they or their families wished to.

Some people had a DNACPR in place. This is a statement that the person is not to be given cardio pulmonary resuscitation in the event of it being required to sustain life. These had been appropriately completed with the involvement of the person where possible and those closest to them. The statements had been signed by their GP. People's care plans clearly recorded this decision. Staff knew where this information was and told us they would ensure people's wishes were respected by other health and social care professionals

Care staff we spoke with told us they would be happy to recommend the service to a friend or family member of theirs. A number of them said they wouldn't have been able to say that six months ago.

Is the service responsive?

Our findings

During our inspection we saw staff responded to people's needs and provided care and support in a person centred manner. The manager said one of their key objectives was to provide an even more person centred service. Staff we spoke with spoke passionately about ensuring the service was able to identify and meet people's individual needs. They were able to tell us about people's hobbies and interests, their previous lifestyles and their likes and dislikes.

Care plans had been recently reviewed. Those we looked at provided a good picture of people as individuals, identified their needs and gave clear guidance on how their needs were to be met. People and, where relevant, their relatives had been involved in devising these plans. Other health and social care professionals had been consulted and their advice built into people's plans.

People's changing care needs were identified promptly and were reviewed with the involvement of other health and social care professionals where required. Staff confirmed any changes to people's care was discussed regularly at team meetings or through the shift handover process to ensure they were responding to people's care and support needs. Staff told us this was important to ensure all staff were aware of any changes to people's care needs and to ensure a consistent approach.

Guidance was in place to ensure that events and unforeseen incidents affecting people would be well responded to. For example, we saw care plans contained important details about a person that hospital staff should know when providing treatment. This information helped to ensure that people received the support they needed if they had to leave the home in an emergency. Staff were clear that when a person was admitted to hospital, a copy of the medicines record, their medicines and information from their care records would be shared with hospital staff.

Some people and relatives said there were not enough activities for people. They particularly felt it would be beneficial for there to be more trips out. Comments included; "It would be good if (Person's name) could get out more", "I'd like more trips" and, "There could be more going on. Staff do their best but it needs to be better organised". We saw an activity plan was in place. However, the activities identified did not take place during our visit. Staff said they tried to stick to the activities planned but were not always able to. They said they would like to see more activities offered to people. We spoke with the manager about this. They said they were recruiting for an activities organiser and felt this would improve once the post was filled. The lack of activities on offer to people requires improvement.

We looked at how complaints were managed. There was a clear procedure for staff to follow should a concern be raised. Complaints received had been managed effectively and action taken as a result. We saw action had been taken to address these concerns. The registered manager had signed these off as being completed. This showed they were monitoring the action taken to address people's concerns. A record of compliments received was also kept. Staff told us feedback on compliments was feedback to them at team meeting and, where relevant, individually.

Residents meetings were held regularly. We looked at the record of the most recent meeting and saw a variety of areas had been discussed including, activities, menus and staffing. Relatives said meetings had been arranged for them to give feedback on the service provided. They also said they would be able to raise any concerns with staff or the manager and were confident they would be listened to. Several relatives were complimentary about how the provider had informed them of the findings of our previous inspections and, the action they had planned to make improvements.

Is the service well-led?

Our findings

The manager of the service had commenced employment with Keychange in April 2016. Shortly after our inspection in April they had been appointed as acting manager. In June 2016 they had been employed permanently to the post of manager. They had therefore, along with the provider's operations manager, been responsible for developing and implementing action plans to address the concerns we raised during our inspections in April and June 2016. Throughout this process they had demonstrated a desire to work with other health and social care professionals to improve the service received by people.

People and relatives spoke positively about the manager of the service. Comments included; "Things have really improved. The manager needs to keep on top of it though", "There has been massive improvements; the cleanliness, the food, the care, it's much better than it was. The new manager has done a great job".

Staff also spoke positively about the manager. They said, "The manager is very support, she" listen and take action", "The service is now well managed. Staff want to be here" and, "The manager and the operations manager are great". The manager told us they had received effective support from the provider's operations manager. They also said the provider had arranged for them to receive some assistance from registered managers working in other services managed by the provider. They told us this help had been very useful.

Other health and social care professionals told us they felt the leadership and management of the service had improved considerably. They said staff were encouraged to seek their assistance and supported to follow their advice and guidance.

The vision, values and culture of the service were now clearly communicated and understood by staff. Staff we spoke with all spoke passionately about providing high quality, person centred care.

Effective systems were in place to monitor the quality of care and support that people received. These included feedback from people documented in care plans and surveys sent to people and relatives and, group meetings. These had resulted in changes being made to the service provided.

Comprehensive systems were in place to check on the care and support provided to people. These included audits of care plans, health and safety, medicines and servicing of equipment. We saw these had been carried out as scheduled with corrective action identified and followed up by the manager.

Concerns regarding people's health and safety had been shared with the appropriate authorities in a timely manner. Health and social care professionals we spoke with were now more confident concerns would be acted upon appropriately.

The manager and senior staff knew when notification forms had to be submitted to CQC. Notifications are information about important events which the provider is required to tell us about by law. Since our last inspection CQC had received notifications as required.

The most recent CQC reports and ratings were prominently displayed in the lobby area of the home. The provider had also ensured the most recent assessment of their performance and ratings could be accessed through their website.

The PIR we requested had been completed thoroughly and submitted on time. The information had been completed by the manager. It contained information relevant to the questions we asked about the performance of the service and, the improvements they planned to make. These were consistent with the action plan(s) provided to us following our previous inspection(s) and the ongoing action plan developed by the provider.

The provider had amended their action plan to identify the actions that had been completed. They had continued to add to the plan and it was clear from talking with the manager and staff that the plan was being implemented. New actions had been identified. These included the appointment of a deputy manager, to improve management oversight and supporting the manager to commence a diploma in the leadership and management of health and social care. The manager spoke positively about the opportunities for research and learning this would entail.

At the end of our inspection we provided feedback on what we had found up to that point. The feedback we gave was received positively with clarification sought where necessary. This showed a willingness to listen, reflect and learn in order to sustain and further improve the quality of service provided to people.

Whilst we noted, and have reported on, the significant improvements to the service and the positive performance of the leadership and management of the service. We are mindful of having identified a failing of management oversight in April 2016. The provider recognised this and made changes. However, learning from this needs to be embedded and systems put in place to ensure improvement is sustained and, that any problems are identified by the provider themselves as quickly as possible.