Keychange Charity

Keychange Charity Alexander House Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We carried out an unannounced inspection of this service on 26 August 2015. At the last inspection on 3 July 2015 we found the provider did not have effective arrangements to manage risks relating to the premises and people using the service. In addition, the provider had not ensured that items of equipment were being appropriately serviced and maintained to make sure people and others were protected against risks associated with equipment and the premises. We found the service to be in breach of the regulations regarding the safety of the premises and safe care and treatment. We served a warning notice in relation to safe care and treatment which contained requirements for the provider to meet by 26 July 2015. At this inspection we checked whether the provider was now meeting the requirements of the warning notice as well as other legal requirements providers have to meet. We did not fully inspect the

Summary of findings

requirement relating to safety of the premises because timescales to be compliant as per their action plan had not been met. We will inspect fully against this requirement at our next inspection.

Keychange Charity Alexander House is a care home for up to 20 older people, some of whom have dementia. There were 19 people using the service at the time of our inspection.

There was no registered manager in post at the time of the inspection. They had left the service in May 2015. The Deputy Manager was managing the service with the support of the area manager. The deputy manager told us a new manager had been recruited and was due to start in September 2015. 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.

At this inspection we found the provider had not met the requirements of the warning notice. The action the provider had taken to keep people safe was insufficient and people remained at risk from harm due to leaving the home via unsecured fire doors. In addition people were still at risk of falling from a height due to inappropriate window restrictors being fitted on some windows.

Risk assessments and risk action plans were not always robust. Some risk assessment action plans, such as those for pressure ulcers and malnutrition, did not contain sufficient detail about how identified risks would be mitigated by staff. However, while risk assessments did not fully address the support people required with the risks of malnutrition we found people received the right support when staff were concerned they were at risk of malnutrition.

Staff understood the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process to make sure that people are only deprived of their liberty in a safe and correct way, when it is in their best interests and there is no other way to look after them. However, the service was not meeting their requirements to keep people safe under DoLS because they had not identified that a person had restrictions on them which could have amounted to them being deprived of their liberty. As the provider had not recognised this they had not applied for authorisation to deprive them legally. Previously, the provider had applied for DoLS for other people using the service in the correct way.

People felt safe and staff understood the signs people may be being abused and the action to take when they were concerned as they had received training in this. However, the provider did not always take the necessary action to keep people safe when alleged abuse between people using the service occurred. In addition accidents and incidents were not always clearly recorded to evidence people received the right support or to look for patterns and trends so action could be taken to prevent reoccurrence.

The provider did not have effective governance systems because they had not been able to make the improvements necessary to meet the requirements of the warning notice. Audits to assess, monitor and improve the quality of the service were not always adequate as they had not identified the breaches of legal requirements we found during this inspection.

There were not always enough staff deployed to meet people's needs in keeping them safe in the home and in meeting other needs.

The service recruited staff robustly as they checked staff were safe to work with people. Staff received sufficient support through supervision and appraisal to ensure they could do their jobs appropriately. There was a training programme in place and staff received the right training to carry out their roles effectively.

People had choice in the food and drink they ate. People also received the right support from staff to maintain their health with access to the various healthcare services they needed.

People were treated with kindness, dignity and respect and staff knew the people they were caring for. Information about people's life stories and preferences was gathered by the provider so staff could refer to this in understanding and supporting them in the ways they wanted. People were supported to maintain relationships with those that mattered to them as relatives and visitors were welcomed and encouraged. People were supported to take part in activities they were interested in and their spiritual and religious needs were catered for.

Summary of findings

The provider kept people, their relatives and staff up to date with information about the service. However, the service did not always actively gather feedback from these parties as part of monitoring and improving the service. People knew how to complain and a suitable complaints system was in place.

At this inspection we identified four breaches of regulations. In relation to the breaches of regulations for safeguarding people, staffing and good governance, you can see what action we told the provider to take at the back of the full version of the report. Because of our serious concerns in relation to the breach of regulation about the safe care and treatment of people we took enforcement action which you can also read about on the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not safe.

The provider had not met the requirements of the warning notice we served on 23 July 2015. Arrangements in place to identify, assess and manage risks were ineffective and did not ensure people and others were appropriately protected against the risks of harm.

Other risks to people were not always managed well, such as risks of pressure ulcers and malnutrition as the action plans to mitigate these risks lacked sufficient detail for staff to follow. The provider did not always take the right action to keep people safe when alleged incidents of abuse occurred. There were not always enough staff to meet people's needs.

Medicines management was safe. Recruitment checks ensured only suitable staff worked in the home.

Inadequate

Is the service effective?
The service was not always effective.

The service had not always identified circumstances when people could have been deprived of their liberty so the necessary application to deprive them of their liberty lawfully could be made.

Staff received sufficient support through training, supervision and appraisal. People received a choice of food and drink and were supported appropriately with their health needs.

Requires Improvement

Is the service caring?
The service was caring.

Staff treated people with kindness and compassion, dignity and respect and knew the people they were caring for. People were involved in making decisions about the way staff supported them.

Good

Is the service responsive?
The service was responsive.

People contributed to the assessment and planning of their care. They had access to activities they were interested in. There was a complaints system in place which people were made aware of. People knew how to complain.

Good

Is the service well-led?
The service was not always well-led.

Requires Improvement

Summary of findings

The service had not made the necessary improvements to meet the requirements of our warning notice. Audits were ineffective in assessing, monitoring and improving the service as the provider had not identified and resolved the breaches of legal requirements we found at this inspection.

The provider kept people, their relatives and staff up to date with information about the service. However, the service did not always actively gather feedback from these parties as part of monitoring and improving the service.

The service submitted notifications to CQC as required by law.

Keychange Charity Alexander House 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 inspection was undertaken to check that the provider had made improvements to meet the warning notice we served after our 3 July 2015 inspection, as well as to inspect other aspects of the service as part of a comprehensive inspection to give it a rating. This inspection took place on 26 August 2015 and was unannounced.

Before our inspection we reviewed all information we held about the service and the provider such as statutory notifications. We viewed the dignity in care champion's report produced in April 2015 by an external organisation and we also spoke with one relative.

During the inspection we observed how staff interacted with the people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with five people who used the service and two relatives. We also spoke with the acting manager (the deputy manager), the administrator, the maintenance person, two care workers, an agency care worker, the domestic assistant and the chef. We looked at five people's care records, three staff records and other documents relating to the management of the service.

Inadequate

Is the service safe?

Our findings

At our last inspection, we found risks relating to people's health and safety were not always well managed. In addition, the premises and equipment were not always maintained appropriately. We served a warning notice in relation to the safe care and treatment of people, which contained a number of requirements for the provider to meet by 26 July 2015, and a requirement notice in relation to the safety of the premises and equipment. In relation to the safety of the premises and equipment we found that the provider had taken action to rectify some of the issues we found but they were still within the timescale to make the necessary improvements. Therefore we did not fully inspect the issues we covered at our last inspection in relation to the maintenance of the premises and equipment. We will inspect against the outstanding issues at the next inspection.

At this inspection we found the provider had not met the requirements of the warning notice. In the warning notice we told the provider to make sure that appropriate and fit for purpose restrictors were fitted to windows so these could not be fully open to protect people from the risks of falling from a height. The provider had fitted restrictors to the windows, but some windows had been fitted with metal chains that were not robust enough. For one restrictor we saw a link was loose and we were easily able to unhook this. For another we tested the strength by pushing the window open and the restrictor broke on the third push. The maintenance person told us there were around ten windows which had the unsuitable type of restrictor. The Health and Safety Executive in its guidance 'Falls from windows and balconies in health and social care' states (on page two) 'Window restrictors should ….be robustly secured using tamper-proof fittings so they cannot be removed or disengaged using readily accessible implements (such as cutlery) and require a special tool or key.' This meant the provider had not fitted suitable restrictors to windows and people were still at risk of harm from falling out of windows. We informed the deputy manager immediately that the restrictors were unsuitable. The deputy immediately placed an order for suitable restrictors and arranged for them to be fitted as soon as possible.

In the warning notice we also set out how the provider had not ensured staff were provided with guidance about how to manage the risks relating to window restrictors and the fire alarm system. During the inspection we found staff were aware of how to respond should an alarm sound indicating a fire door had been opened which could mean that a person might have left the building without staff support. Staff told us they had been advised they must check which fire door had been opened by looking at panels on display around the home. Then they must go to that fire door as soon as possible to check people's safety. The deputy told us staff had been advised and reminded of this information during team meetings, handover and individual supervision. In addition, regular checks that the fire door alarms were working were also carried out by staff. However, the deputy manager told us there were no written instructions as to how staff should manage the risks. This meant staff did not have written guidance to refer to remind them of them of their responsibilities. The deputy told us she would put written guidance in place as soon as possible.

After our focused inspection on 3 July 2015 the provider sent us risk assessments relating to the risks of people leaving the home unsupervised through the fire doors. However we found these control measures were unsuitable because they were insufficient for staff to follow in keeping people safe. The provider told us they had carried out tests to time how long it would take staff to respond on hearing a fire door alarm. They found it could take up to a minute for staff to respond. However, the risks of people coming to harm from leaving the home during this time period were not considered in the risk assessments. In addition, the provider had introduced half-hourly checks of some people during the night. However, the risk assessments did not consider how staff would monitor people in between these checks to ensure they were safe within the building.

In addition we also found the risk assessments had considered some of the needs of the people who used the service. They did not describe any patterns individuals had in wanting or trying to leave the home, how staff should support individuals to monitor their whereabouts and how staff should respond if people wanted or tried to leave the home. During our inspection the deputy manager told us, and we saw, these risk assessments had not been reviewed after they had received our warning notice as the provider had not understood what was required.

During our inspection we also found the provider had placed magnetic key fobs on a nail by the side of each fire

Is the service safe?

door. Staff told us these were to deactivate the alarms to the fire doors so they could leave the home through the fire door without the alarm sounding. The deputy told us that although staff carried fobs they often went missing and it was useful to have the fobs there for easy access for staff. We found that staff had not considered and assessed the risks of people using the service who required staff supervision using these fobs to deactivate the alarm and leave the home without staff being aware. The deputy confirmed this had not been considered as a risk and so there was no documentation in relation to risk assessing this. The provider sent us a copy of the risk assessment they had produced after the inspection, although we saw it was generalised for all people requiring support in the community and did not consider risks to individuals, how risks would be monitored ongoing and how risks to people newly coming to live at the home would be assessed.

In the warning notice we served on the provider we also told the provider they were not meeting the regulation because they had not taken prompt action to arrange for an assessment to look at other ways the fire doors could be secured to promote people's safety, such as whether the fire doors could be secured using a magnetic system which is linked to the fire system so they could be opened if the fire alarm was activated.

During this inspection we found the provider had had a suitable assessment carried out which determined this linkage was possible. However, the provider had decided not to go ahead with this. This was because they were concerned that other emergencies could occur which would make this system unsuitable. The provider was also concerned about people who were not under DoLS being unable to leave the home through fire doors, particularly the ground floor fire door through which the garden could be accessed. There was no evidence of a risk assessment carried out in relation to this decision to determine what these emergencies could be and why the system would be unsuitable. The provider told us instead they were investing in increasing the number of waking staff each night to increase supervision of people in the home. They were exploring landscaping options to reduce the risks of people who required staff supervision outside the home from accessing the road, as well as a one way gate on the fire escape to prevent people accessing the roof. However, these options, besides the increased staffing, were not yet in place so the risks to people remained.

At this inspection we found the doors to the two sluice rooms were not lockable. This meant people were at risk from accessing machinery, hot water from taps and chemicals stored in these rooms. We informed the deputy manager of our concerns immediately and she ensured chemicals were no longer stored there and made arrangements to have locks installed. The provider's own health and safety risk assessment had not been effective because they had not identified these risks.

The provider had not carried out individual risk assessments relating to people's health and adequate action plans were not in place for staff to follow in supporting them. The provider had recently introduced an electronic care planning system. We saw that risks assessments and action plans for people particularly in relation to malnutrition and pressure ulcers were generalised and did not clearly identify the action staff should take to support people. For example, the action plan for each person who was at risk of malnutrition, stated staff should record their dietary intake for three days. However, the three days when this should be carried out, were not recorded so staff knew clearly what this meant. Similar generalised actions were listed for other risks to individuals.

Accidents and incidents were not always recorded clearly so that they could be analysed to identify for trends and patterns so action could be taken to prevent these from happening again. The provider had introduced an electronic system to record accidents and incidents. However, information in these such as details of action taken by staff as a response to the incident as well as the management response were not always recorded. For example for one incident where a person slipped down their chair three days before our inspection there was no incident report and no body map to document the bruises they sustained. The deputy manager told us she had investigated these bruises by asking the person about them but the person was not concerned about them and said they were not painful. However, this investigation was not recorded. This meant there was no audit trail to show the incident had been taken seriously and dealt with appropriately.

The deputy manager told us staff should record incidents on a standard accident and incident template in addition to the brief notes about them on the electronic system to capture sufficient detail. However, we found this had not

always been done. This meant there were insufficient arrangements for the provider to monitor accidents and incidents to identify trends and patterns and to check people received the right support after an accident or incident. When people fell the provider did not carry out a proper investigation such as a root cause analysis with a view to identify why they fell and to ensure the right support was in place for them to minimise the risks of further falls.

These issues were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found evidence that an incident of possible abuse happened in July 2015. There was another incident six days before our inspection between people using the service, which raised concerns about their safety and protection. However, the provider had not reported these to the local authority safeguarding team as required as part of keeping them safe. In addition there were no comprehensive incident reports relating to these incidents for the provider to have an accurate record of what occurred.

These issues were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found there were not always enough staff to support people living in the home, despite rotas showing staffing numbers on shift were in line with the numbers the provider had identified as being required. Some people commented staff did not spend enough time talking with them. One person told us, “They don’t have time to chat, we can be left to wait” and another person said, “Sometimes they are a long time coming but they always seem to be doing something.” A third person said, “Staff don’t have time to talk, they’re always doing something.” Some people commented they were not supported enough to go outside of the home and as often as they would like. One person said, “I’d really like to go out, I like going round the garden.” Another person said, “We don’t really go out, there’s no one to take us.” We raised this with the manager who said she would look into this further.

Two staff members told us that there were times in the day when it could be difficult such as during breakfast time and after lunch when staff were stretched. During our inspection we also observed there were not always sufficient staff in the home. During a quiz the staff member leading was repeatedly called away to do other tasks which disrupted the quiz. We observed the lounge area was not always covered by a care worker as staff told us should happen as they too were sometimes called away to do other tasks.

These issues were breaches of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found the provider had not taken all the necessary steps to address the actions identified in the legionella risk assessment. Legionella is a bacterium which can accumulate rapidly in hot water systems if control mechanisms are not in place. This meant that people may have been at risk of the spread of Legionella infection, which can cause ill-health. However, at this inspection we found the provider had taken the necessary action identified in the assessment with sufficient records in relation to this. This meant people were at less risk from Legionella infections.

At the last inspection we found a door leading to the kitchen immediately opened onto a set of stairs. A person with impaired mobility or poor eyesight who may be disorientated to time and place could have come to harm from this. At this inspection we found the provider had installed a keypad lock so only staff who knew the code could enter the kitchen.

Medicines management was safe. We observed staff administer medicines and saw this was done safely as staff carried out the right checks before administering medicines. Staff also engaged with people to explain what medicines they were receiving and to answer any questions people had in relation to this. Staff told us only staff who had been trained were permitted to administer medicines and records showed staff had received training in this. Staff told us they completed a test as part of their medicines training to assess their knowledge and we saw evidence of competency assessments carried out on staff. The deputy explained that these competency assessments were carried out if staff made medicines errors to check they were competent to return to medicines administration duties. When we checked medicines stocks we were able to confirm people had received their medicines as prescribed. Records of medicines administration showed no omissions in recording. Staff checked and recorded the amount of medicines in stock each time they administered medicines outside of blister packs. In this way they checked people

Inadequate

Is the service safe?

received their medicines as required. In addition, the pharmacy had recently carried out a comprehensive audit of medicines practices in the home. The report showed minor suggestions and staff evidenced they were taking these suggestions on board to improve practices further.

While the temperature of the medicines' storage areas and the medicines' fridge was recorded daily, there was no record of action taken if the temperature became so high it could make medicines ineffective. Staff told us the action they took to cool the storage area, but this was not recorded and the temperature was not checked later to check it had reduced. The deputy manager told us they would immediately remedy this issue to store medicines at the right temperature.

Recruitment practices were robust as the provider checked staff were suitable to work with people in the home. Among the checks, they looked at their criminal records, employment history, health conditions, satisfactory references and photographic proof of identification and suitable records of these were kept in staff files as required by law.

At the last inspection we found people were at risk from items of equipment not being appropriately serviced and maintained. There were insufficient gas safety inspections, an unsatisfactory electrical installation check with no evidence issues had been remedied, insufficient portable electrical appliance testing (PAT) and evidence of suitable testing for lifting equipment (LOLER tests). At this inspection we found the provider had carried out the necessary remedial work for the electrical installation and portable appliances had been tested. There was no evidence the provider had carried out suitable lifting equipment testing, although the deputy told us this had been done, or of additional gas safety checks in line with our findings. The deputy told us gas the additional safety checks had not yet been carried out since our last inspection. After the inspection we received the provider's action plan in relation to these issues. They also sent us evidence of some of the LOLER testing. We will check all the necessary action has been taken in relation to the safety of the premises and equipment at a later date.

Requires Improvement

Is the service effective?

Our findings

The provider was not always meeting the requirements in relation to the Deprivation of Liberty Safeguards (DoLS) and legislation to help protect people's human rights in relation to mental capacity and consent. The provider had applied for, and had been granted, authorisation to deprive several people of their liberty. However, there was no evidence that consideration had been given as to whether other people coming to live at the home required DoLS as part of the assessment process.

We identified one person who appeared to be having their liberty restricted. There were no assessments to consider if the restrictions on the person amounted to a deprivation of liberty and that the person might have been deprived of their liberty without authorisation. When we informed the deputy manager of our concerns they told us they would immediately apply for DoLS for them. Soon after the inspection they sent us confirmation DoLS had been authorised. Staff had received training on the Mental Capacity Act 2005 and DoLS, but they were unaware that some practices might be restrictions on people's liberty which needed to be authorised and how they should support people in these cases to ensure their best interests. People's care plans did not always contain the necessary level of detail in relation to this to guide staff. These issues were breaches of Regulations 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us, and records confirmed, they received regular supervision and annual appraisal to support them to meet people's needs. Staff said they felt they received enough support from management to carry out their roles. In addition, staff received the necessary training. Staff told us the training was good quality and valuable to them in their work. One person said, "I think staff here are well trained. They seem to know what they're doing. I can do most things for myself but I just know that they know how to help us." Records showed management monitored staff training requirements and a training programme was in place to refresh people's knowledge. The service engaged with an external company who provided a programme of training to staff to help them understand more about dementia and wellbeing of people.

The provider monitored people's weight and when they observed any changes they took action to support them. For example, when people's weight dropped significantly they referred them for specialist support from the GP or dietitian. Records showed the service had been successful in supporting people to maintain healthy weights through following guidance from specialists. Where people's care plans indicated they required staff support such as encouragement to finish their meals we saw staff provided this.

People made positive comments about the food and told us they were provided with enough food and drink, including fresh fruits. One person said about their lunch, "I enjoyed it." Records showed people were offered a choice of meal at mealtimes. One person said, "I choose what I want from the menu, there are two choices and if I don't like them the staff will offer something else, like a sandwich." Another person said, "I know I can ask for a second cup of tea or if I wanted one now I could ask and someone would make one." We observed the service was implementing a system to use pictures when offering people meal choices so people could see and choose what they wanted to eat.

However, the pictorial menu on display did not match the meals served on the day which meant the system was not always used effectively. In addition we observed the handwritten information about the meals was not always clear. During lunchtime we observed people were provided with an alternative if they did not like the food they were served. Although there were set times for meals and drinks there was sufficient flexibility to accommodate people's preferred patterns. For example, we observed a person was provided with lunch some hours after lunchtime because they preferred to eat later. In addition, we observed people were promptly provided with food and drink if they requested for these during the day.

People received the necessary support with their health needs. Records showed people accessed medical services such as GP and dentist regularly. In addition, people were referred to specialist services such as the challenging behaviour team where necessary.

Good

Is the service caring?

Our findings

People told us staff treated them well and were caring. One person said, “Staff are willing to help us” and another said, “They are kind.” We saw staff supported people to mobilise around the home with patience, allowing people to walk at their own pace. At mealtimes staff did not rush people to finish, appreciating people eat at different paces. We observed one person spend time rearranging their food and they told us, “I think I’ve just about got it how I want it now” before finishing their meal. Staff were aware of their longstanding desire do this at each meal and knew to leave them to it. When a person said they did not want lunch we saw staff encourage them in a gentle, kind way. Staff brought the person a table so they could eat in their armchair in the lounge instead of going into the dining area. The deputy manager told us how each day they encouraged a person who enjoyed the office environment to engage in some non-confidential office tasks to keep them occupied and stimulated.

We saw when people became disorientated and distressed about where they were, staff sat with them and provided reassurance. We also saw staff talking with people as they provided support to them individually around the home. In addition when people spoke to staff, staff listened to what they had to say and engaged with them warmly.

We saw staff treated and spoke to people in a dignified, respectful way. We observed staff knocked before entering people’s rooms and greeted them by their name. Staff supported people to be well presented with clean, pressed clothes. One person told us, “The laundry is very good. They iron my clothes beautifully and they don’t lose things like they did in the last place.” A relative told us, “I come frequently and [my family member] always looks nice with clean clothes.” Staff also provided people with privacy when they wanted to spend time alone in their rooms. We saw that staff closed doors when they went to provide personal care to people to maintain their dignity. Confidential information about people was held securely and we observed staff were careful not to discuss personal information about people where others could overhear.

Most staff had worked at the service for several years and our discussions with them showed they knew people well. They were able to tell us about people’s backgrounds and life stories, as well as their current family connections. Staff also knew about people’s personalities and their likes and dislikes. People responded well to staff because staff used their knowledge of them to comfort and reassure them. For one person staff knew they responded well to listening to music via their headphones and staff provided their music system for them when necessary.

Arrangements were in place so that people were involved in making decisions and planning their own care. The provider gathered information about people’s wishes for their own care through speaking with them and their family or friends where appropriate and this information was recorded for staff to refer to. This information included how people wanted to be cared for at the end of their lives. In addition a keyworker system was in place to further involve people in their own care planning. A keyworker is a staff member who works closely with a person to see they are receiving the care they would like.

Good

Is the service responsive?

Our findings

People contributed to the assessment and planning of their care as the service encouraged and promoted this. The service encouraged people and their relatives where appropriate to complete booklets about their life story, including their background, people who were important to them and their likes and dislikes. This was an ongoing project to gather this information. People's care plans contained details about people's preferences for specific areas of need. For example people's care plans for night time care set out what time they preferred to go to bed, whether they preferred to be checked on during the night and their preferred numbers of pillows. Although people's care was reviewed regularly to check whether the care they received was meeting their needs, care plan reviews did not always take place monthly as the deputy told us should be the case. The deputy told us they would ensure these reviews were done monthly from now on.

People received support from staff to do activities they enjoyed. One person said, "We do have people come in who sing." An activity programme was in place which we observed was followed during our inspection as there was a group quiz held in the afternoon in which many people actively participated. Records showed other activities included group exercises and bingo. Recently people and their relatives had participated in the home's summer party. The service was in partnership with "ladder to the moon", an organisation which provided ideas and resources for activities, held staff development days and coached staff to focus on and be creative in the activities they offered. The provider was also a member of the National Association of Providers of Activities, an organisation which specialises in encouraging activities in residential care and staff were able to access resources and ideas for activities through them.

The service was participating in an 18 month trial run by the University of Kingston and St George's University called Active Residents in Care Homes (ARCH project). The aims of this project were to bring greater physical, mental and social activity to elderly people living in care homes though engaging with people and their families, reviewing the environment and a programme of staff training and support.

The service operates with a Christian ethos and supports people to have their religious needs met. Staff told us every second Sunday, people from the local church visited for singing and bible reading and most people chose to attend this. A nun also visited regularly to give communion to the catholic people in the home and staff told us the home was open to people from all faiths and beliefs to come and live there if they so desired.

People received support from staff to maintain relationships with people who mattered to them. People told us their family members and friends were able to visit and we observed several people received visitors throughout the day and staff received them warmly. One person said, "My family come nearly every day. My [family member] is coming today."

People told us they knew how to complain and would do so if they needed to and the complaints procedures was included in information people were provided with in their rooms. One person told us, "If I complain, it generally gets sorted straight away." Another person said, "If I've got something to say, I say it. It usually gets sorted out."

Requires Improvement

Is the service well-led?

Our findings

People were not protected from the risks of unsafe or inappropriate care because the provider had not made suitable arrangements to audit health and safety in the home to keep people safe. For example, the provider had carried out an audit of all aspects of the health and safety of the service shortly before our last focused inspection where we found several health and safety issues. At this inspection the report of that audit was available and we saw it had not identified the health and safety concerns we identified in our inspections. There were no other systems in operation, such as internal checks, or peer reviews which would have identified issues we found at this inspection.

Systems in place to audit care plans, risk assessments, accidents and incidents and to monitor the care people received such as making sure people were not being deprived of their liberty unless DoLS authorisations were in place, were insufficient and had not identified the issues we found at this inspection.

In addition some records relating to the management of the service were not available for inspection and could not be located as several minutes from staff meetings, people using the service and relatives' meetings held over the past year, could not be located.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager in post because they had resigned from the service in May 2015. The service had recruited a new manager who was due to start in September 2015 and who planned to register with CQC as soon as possible as required by law. The deputy manager had been acting up in the absence of a registered manager and they told us they felt well supported by other managers in the organisation and the operations manager.

People using the service, their relatives and staff were regularly updated on issues relating to the service as regular meetings were held for separate groups where managers relayed this information. However, meeting minutes did not always reflect they were used as an opportunity to gather feedback to use to improve the service and staff confirmed this. The deputy told us they would consider encouraging staff to chair the staff meetings as part of encouraging their feedback and involvement in improving the service. People were involved in developing the service in some ways, such as being involved in the recruitment of the new manager.

The service notified the CQC of issues such as applications to authorise deprivation of people's liberty and their outcomes, as required by law.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding service users from improper treatment Systems and processes were not operating effectively to investigate, immediately any allegation or evidence of such abuse. A person was deprived of their liberty without lawful authority. Regulation 13(3)(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **This breach is from our July 2015 inspection. We will inspect it full at our next inspection.** The provider did not ensure that the premises and all equipment used in the carrying on of the regulated activity were adequately maintained to make sure people, staff and visitors were safe. Regulation 15(1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes had not been established and did not operate effectively to ensure compliance with the requirements in this Part. Systems or processes did not enable the registered person to assess, monitor and

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	improve the quality and safety of the service or to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who may be at risk from the operation of the service. Regulation 17(1)(2)(a)(b)
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient numbers of staff deployed at the service. Regulation 18(1)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way for people through assessing the risks to the health and safety of people receiving care, doing all that is reasonably practicable to mitigate any such risks and ensuring that the premises used by the service provider were safe to use for their intended purpose and are used in a safe way. Regulation 12(1)(2)(a)(b)(d)

The enforcement action we took:
CQC imposed the following condition on the providers registration: Keychange Charity must not provide the regulated activity of personal care at or from the location Keychange Charity Alexander House for any new service users from the date on which this condition takes effect. The date from which this condition took effect was 3 February 2016.