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?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This service was previously inspected in August 2015 when we found five breaches of legislation, relating to premises and equipment, safe care and treatment, safeguarding people from abuse, good governance and staff training and support. We were so concerned about the service and the people living at the home that we imposed a condition which prevented them from admitting new people until such time as the service had improved.

We returned in March 2016 and found that although there had been some improvements, the service continued to breach legislation which related to good governance and staff support. We issued two warning notices) that required the provider to make the relevant improvements within a set time period and maintained the condition the service could not admit any new people into the home.

In August 2016, we carried out a focused inspection and found the service had improved sufficiently to meet the remaining two breaches of legislation and we therefore removed the condition which had previously restricted new residents. The services' rating remained at 'requires improvement' as we needed to see consistent progress over time.

This inspection took place on the 10 March 2017 and was unannounced. Alexander House is a care home that provides personal care for up to 20 older people, some of whom maybe living with dementia. At the time of the inspection, there were 16 people living at the home and one person was temporarily receiving respite care at the home.

The service did not have a registered manager in post, although it is legally required to do so. 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 regional manager told us the registered manager had recently resigned and the provider was seeking to recruit a new manager as soon as possible. At the time of the inspection the deputy manager was acting up as the manager.

At this inspection we found areas of concern, namely in respect of the storage and the recording of medicines. With regard to the storage, the provider had identified the issue and was awaiting a new metal cabinet but in the meantime, medicines were not stored as securely as they should have been. The recording of medicines was generally satisfactory; however, we noted a number of omissions over a one week period for a person using the service.

The second issue of concern was regarding the general recording of information about people who used the service. We found some areas where records were not complete and contemporaneous, such as an injury to someone who used the service which had not been appropriately recorded. In addition, the lack of a complaints log meant the provider could not easily identify what action had been taken or if there were any

patterns or trends.

We identified two breaches of the Health and Social Care (Regulated Activities) Regulations 2014 during our inspection. You can see what action we told the provider to take at the back of the full version of this report.

People told us they felt safe. The provider had completed pre-employment checks, including criminal records checks, to make sure only suitable staff were employed. Staff were knowledgeable about what they needed to do if they considered anyone was at risk of harm.

People received care from staff that were well trained and supported to undertake their roles and responsibilities. There were sufficient staff on duty to meet people's needs.

Staff were kind and compassionate. They knew people well and could deliver care in line with the person's wishes. People could participate in a range of activities dependent upon their wishes and were encouraged to maintain contact with friends and relatives.

The provider supported people's with their health needs. This included their nutritional needs and ensuring they had access to healthcare professionals as and when they needed them. The service was able to provide end of life care to people should it become necessary.

The provider used a variety of methods to seek the views of people who used the service, their representatives or relatives about the quality of service provision to identify if there were any areas that needed to improve. People told us they felt able to raise issues or concerns with the acting manager and felt their views would be taken seriously.

We saw that risk assessments were completed and reviewed regularly. These helped to ensure people maintained their independence as far as possible. Any accidents and incidents were recorded and reviewed by the acting and regional managers to see if any patterns could be identified.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The storage and recording of medicines was not completed in a safe way in line with national guidelines. This meant people were at risk of unsafe care and treatment.

Notwithstanding the above, people told us they felt safe. There were risk assessments to ensure people were kept safe as possible. Accidents and incidents were recorded so any patterns could be identified.

The provider undertook pre-employment checks to help ensure only suitable staff were recruited.

There were enough staff on duty to meet people's needs. There were premises checks to make sure the environment was safe for people to live and work in.

Is the service effective?

Good

The service was effective. New staff had an induction period so they could better understand their roles and responsibilities. Subsequently they received training and support to undertake their role.

Staff had an understanding and working knowledge of the Mental Capacity Act 2005 to help ensure people's rights were protected. Staff sought people's consent prior to providing care.

People received care and support they needed to maintain good health. This included access to healthcare professionals as and when they needed them, and sufficient amounts to eat and drink.

Is the service caring?

Good

The service was caring. Staff were heard and observed to be caring. They ensured people had privacy and dignity.

People were encouraged to maintain relationships with friends, relatives and people that were important to them.

The provider delivered appropriate end of life care to people where they required it.

Is the service responsive?

Good

The service was responsive. People received care that met their needs and reflected their choices.

People were offered a choice of activities dependent upon their interests.

People felt able to raise issues and concerns and knew they would be taken seriously and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led. The recording and maintenance of some records was not always up to date and accurate.

The service did not have a registered manager in post. People felt the acting manager was open and approachable.

People were routinely asked about their views of the quality of care provided, in order to improve the service.

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 took place on 10 March 2017 and was unannounced. The inspection was undertaken by one inspector.

Prior to the inspection we reviewed information about the service such as notifications they are required to submit to CQC. Notifications contain information about significant events the service is required to inform us about. The provider also completed a provider information return (PIR). This is a form that asks the provider for key information about the service, what the service does well and improvements they plan to make. We also looked at previous inspection reports.

On the day of the inspection we spoke with four people who lived at the home and two relatives who were visiting their family members. As some people in the home were not able to fully share their experiences of using the service with us, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk with us.

We looked at records relating to three people who lived at the home, and four staff files. We also considered information which related to the safety and governance of the home. We had tried to contact a number of healthcare professionals, however at the time of writing this report we had not managed to contact any of them.

After the inspection we spoke with another two relatives over the telephone. We also had telephone and email contact with two relatives of a person who had lived at Alexander House, but had moved because of their changing needs and who were able to tell their views about the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe living at Alexander House and a relative went on to say, "I'm so thankful I've found Alexander House. Now I know mum is safe."

Notwithstanding the above we found some areas of concern with the recording and storage of medicines. For most people we saw there were no omissions or errors in the recording of medicines. However, for one person we noted multiple errors regarding one medicine. So over a seven day period there were gaps in the Medicines Administration Records (MAR) for three separate days. In addition, the medicine prescribed varied in dose as either one or two tablets. Where the MAR had been completed it did not record the dose administered. This meant we could not be assured people were receiving the medicines as prescribed and if they were, what dose they were given.

Medicines were stored in a locked medicines trolley which was secured to the wall, in line with the Royal Pharmaceutical Society's guidelines regarding the storage of medicines. However, a door of the trolley had been damaged and could potentially be forced open. Additionally, items stored on the inside of the door had fallen to the bottom of the cabinet, meaning they could be damaged if stored in glass bottles or not easily located. The provider had identified this issue themselves and had ordered a replacement but this had been pending for some time. This meant people were not appropriately protected against the risks that can arise if medicines were not being stored safely.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider completed risk assessments to ensure risks were minimised as far as possible. We saw there were general risk assessments which included people's risks of falls, developing pressure ulcers and in relation to moving and handling. Additionally, there were risk assessments that were specific to people. For example staff completed a Malnutrition Universal Screening Tool (MUST) for those people who were at risk of not eating or drinking enough. In each assessment there was an outline to establish the measures that had been taken to minimise the risk to the person to the lowest reasonable level. We saw these risks assessments were adequate for their intended purpose and had all been reviewed in January 2017.

We saw the provider kept a record of all incidents and accidents. This meant the acting manager could monitor any trends or patterns to help prevent reoccurrences. This included if incidents were occurring to particular people, for example if someone was falling at a certain time of the day. The acting manager told us the new electronic system would allow senior managers to access this information more easily.

Staff received annual training so they knew how to keep people as safe as possible. Staff we spoke with were clear about how to safeguard adults safety and what action they should take if they had any concerns or issues.

The provider completed various checks prior to employing new staff to help ensure suitable staff were

recruited. From the records we looked at there were a range of records and checks, including completed application forms, proof of identity and address, references and criminal records checks. We saw the criminal records checks had been completed for volunteers, and were renewed every three years for all staff to help ensure they continued to be suitable to work within the home.

We reviewed staffing levels to ensure they were sufficient to meet people's needs. We saw there were three staff on duty during the day and two at night. The acting manager told us there were vacancies for three care staff, an activities coordinator and the registered manager's post. We were told the vacancies were being covered by permanent staff and regular agency staff. The activities coordinator and registered manager's post were currently being advertised Feedback about staffing levels and staff was positive. One person we spoke with said, "I get on with all the staff and when I use the call bell they are generally very quick at answering it." From our own observations during the inspection we also noted that there appeared to be enough staff to meet people's needs.

We checked some records to make sure the premises were maintained safely. For example, the lift was serviced regularly and Legionella (bacteria sometimes found in water supplies) and portable appliance tests were completed. However, we did note the gas safety certificate was two weeks out of date. We discussed this with the acting manager who was able to show us evidence the engineers had already been booked to complete the check.

Good

Is the service effective?

Our findings

We saw staff were well trained and supported to undertake their work. Two new members of staff were able to tell us about their induction which included shadowing more experienced staff and completing certain mandatory online training. Staff understanding of the training was verified through competency questionnaires post-training. Once induction was completed staff were required to regularly refresh certain training such as fire safety, first aid, dementia awareness and moving and handling. The records we checked confirmed training was undertaken in a timely manner. Staff confirmed they had the opportunity to undertake additional training if it was considered relevant to their role, for example caring for a person with arthritis or sensory loss.

Staff told us they were supported by their managers. Staff had a supervision meeting with their line manager once every six to eight weeks, this was confirmed by the records we looked at and by staff themselves. Staff also had an annual appraisal to reflect on their work and their professional development.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff had received training in MCA and DoLS and they were aware of people who had restrictions on their liberty and those that did not. Alexander House catered for people with a range of needs, which included people who were able to go out independently and those who were reliant on staff support if they were leaving the building. If there were restrictions on people's liberty, appropriate authorisations had been gained from the local authority.

People were encouraged to eat and drink sufficiently to meet their needs. People were positive about the food and one person said, "You won't believe the amount of food I'm now eating." We saw in the lounge area there was a range of cold drinks and fruit available for people to help themselves. There was also confectionary available on request for people and their visitors. People's weight was monitored monthly and any significant changes in their weight was identified quickly and action taken accordingly. We spoke with the chef who told us they could cater for special diets where people had individual preferences or specific health needs.

People were supported to have access to healthcare services dependent upon their needs. This included a

community GP, although people could choose to remain with their own GP if they wished. Alexander House also had links with a range of other healthcare professionals which included opticians, dietitians, district nurses and the challenging behaviour team.

Good

Is the service caring?

Our findings

People were positive about the care they or their relatives received. Comments included, "It's a cracking place" and "So pleased with the care". A relative said, "I have no concerns, they recognise and respect her ability. They do things like matching her clothes because that's who she was."

We saw and heard many examples of staff being caring towards people. In one example, we saw a member of staff walk carefully behind someone who had a mobility impairment to ensure they did not fall. Once the person had chosen where to sit, the member of staff checked they were settled and were heard to ask, "Do you want your cardigan on, you feel a bit cool?" and "Let me move the table nearer so you can get to your crossword." We spoke with the person afterwards who said, "I've got my confidence back since I've been here."

Staff were able to support people in a way that maintained their privacy and dignity. Staff were able to tell us how they practically supported people. This included talking to people when providing personal care and telling them what they were doing. We heard a member of staff discreetly guiding someone to their bedroom and explaining what they were about to do to help the person with personal care.

The home had measures in place to assist people some of whom were living with dementia to be as independent as they could be. This included handrails along corridors and mobility equipment so people could move freely. One person told us, "Got my independence now and move around using a frame." There was also signage on doors such as toilets and bathrooms, and clocks and calendars to help people orientate themselves. We saw the home used pictures of food items to show people what was on the menu that day, but also to help them choose what they wanted to eat.

People were able to maintain relationships that were important to them. A number of relatives visited the home throughout the day and told us they were always made to feel welcome. There were no restrictions on visits to the home and whilst some relatives told us they telephoned beforehand others tended to drop in. We saw there was a range of information readily available to people and their relatives in the foyer area. This included the service users' guide which gave information about the home and leaflets from other relevant organisations.

The home provided end of life care to people should it become necessary. Some people had recorded their wishes for end of life care which included a 'Do not attempt resuscitation' form should they become unwell and stop breathing. We were also told the home would be able to accommodate relatives who wished to be near their relatives at the end of their life. Additionally, the provider had a range of training available to staff to help them understand how to care for people who were dying.

Throughout the day we heard staff adapt their language and the way they communicated with people, dependent upon on the person they were talking with. For example, we heard an exchange between a staff member and someone living with dementia. The member of staff often repeated the person's name to help them understand the questions were being directed at them. The staff member then used a variety of ways

to gently coax the person into the lounge. When it became clear the person did not want to move, the member of staff said, "Shall I come back for you later?" In this exchange, it was clear the member of staff knew the person well and could tailor their communication methods accordingly, as well as ensuring they sought consent from the person.

Good

Is the service responsive?

Our findings

People living at Alexander House received personalised care which met their current and changing needs. One relative told us, "My [family member] has deteriorated and so her needs have changed." They went on to tell us how the home had accommodated their relative by adapting their care package to meet their changing needs.

The provider ensured they could meet people's needs before they were admitted to the home. The acting manager told us they would meet people and their relatives, and then gather information from healthcare professionals before completing their own assessment. We saw that once the assessment was completed, people or their representatives were asked to sign their care plan as a way of indicating their agreement with it. We saw these care plans were regularly reviewed to reflect changing needs.

We saw each person had care plans which outlined their assessed needs and how they should be supported. For example, for communication with a particular person it suggested staff should use 'simple words, speak calmly and in an environment that avoided distractions'. There were other care plans which included people's level of understanding, how they expressed their sexuality and information written in the first person about 'what a good day looks like for me' and 'if I am having a bad day.' This information helped staff to provide care that was personalised.

Throughout the day we heard staff giving people choices about what they wanted to eat and where they wanted to be. One person said, "We get good choice about everything, today we have fish and chips but I wanted poached fish in a nice sauce and they get it sorted." Staff were also heard to ask people what they wanted to drink and where they wanted to sit. In this way people could make decisions for themselves and maintain some control in day to day aspects of their care. Another person summed it up when they told us, "I've been here six years and if I didn't like it – I'd leave."

The acting manager told us since January, there had been a vacancy for a part-time activities coordinator, although the post was currently being advertised. In the meantime staff and volunteers arranged activities for people. We saw on the day of the inspection a volunteer conducted a religious service for people who wanted to participate. One person told us how they "enjoyed reading and a game of scrabble." A relative told us, "They [family member] won't do quizzes but joins in with the art classes and gardening." The acting manager told us about their links to the local school which included regular contact with some students, and visits from the school's choir and string quartet. This meant people had an opportunity to participate in a range of social and recreational activities which met their interests.

We saw that people could complain if they were unhappy with the service. The provider had a complaints policy which had been adapted into a simplified procedure contained in the service user guide which was freely available. We were told by a relative about an issue which had been raised with a member of staff but had not been adequately dealt with. We raised this with the acting manager who took immediate and prompt action.

We noted that the acting manager dealt with complaints which they were able to evidence by producing emails they had sent or received in response to a complaint being made. However, the provider could not produce a complaints log which gave an overview of the complaints made and what action had been taken. We discussed this with the acting manager who told us they did have a complaints log, but it could not be located and had not been used for several months.

Requires Improvement

Is the service well-led?

Our findings

We found a number of shortcomings within the service which related to record keeping. There were omissions in the Medicines Administration Records and the provider had not maintained a complaints log. We also found an occurrence where a person who used the service had injured their hand which had resulted in a bruise, but the injury had not been appropriately recorded. This meant accurate, complete and contemporaneous records were not being maintained for each person using the service, which could lead to people receiving unsafe or unsuitable care to meet their needs.

The quality assurance systems of the provider had also not been very effective as they had not identified the concerns we found at this inspection. For example the provider had not identified concerns with the medicines records and the fact that incidents had not been appropriately recorded for these to be reviewed at a later date and to monitor for trends and patterns to prevent recurrence.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We noted the service was in the process of introducing an electronic recording system, which was based on members of staff using an electronic tablet to record all information relating to people which would include risk assessments. The provider hoped this would help to prevent records not being updated in a timely manner

The service did not have a registered manager in post. The regional manager told us they had very recently resigned their post and had informed CQC of their intention to resign as the registered manager of the service. We discussed this with the regional manager who informed us the post had already been advertised and hopefully they would be in a position to recruit in the near future. The deputy manager who had been in post for a number of years, had taken up the acting manager role.
People said the acting manager was open and approachable. One person told us, "If I had a problem, I'd talk to [acting manager]. She's very friendly," and another person said "Normally its [acting manager's name] always phones me. She sorts it out."

We noted the operations manager visited the home monthly to support the acting manager and to review the quality of the service provided. The operations manager reviewed key information regarding the performance of the service to drive towards continuous improvements. There were also a number of checks and audits completed by the acting manager. These included checks on personal bedroom alarm calls and how quickly they were responded to, and fire alarms drills and staff response time to the drills. If any issues were found as a result of the checks and audits, action was taken to address them.

We saw the provider actively and frequently sought the views of people of people who used the service and their relatives. There was a monthly satisfaction survey of people who lived at Alexander House and a six monthly relative's survey. Both surveys had been completed recently and the results were available for us to view. We saw action had been taken as a result of the findings. There were also other opportunities for

people to express their views, including a suggestion box where people could comment anonymously and monthly residents' meetings held at the home.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that people were always protected against the risk of poor care because the recording and storage of medicines was not always complete or safe. Regulation 12 (1) (2) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective quality assurance systems to assess, monitor and improve the quality of services people received. Records for each service user and for the running of the service were not always complete and contemporaneous. Regulation 17 (2) (a)(c)