Kevindale Residential Care Home

Keegan's Court Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inspected but not rated**
Is the service caring?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Keegan's Court Residential Care Home is a care home providing support with personal care to 15 people at the time of this inspection, some of whom were living with dementia. The home can accommodate a maximum of 19 older people. Accommodation is provided in an adapted building providing 15 beds in the main building and two bungalows, each providing two beds.

People's experience of using this service and what we found
People were not always treated with dignity or respect. Confidential information was not secured and was accessible to those without authority.

People were not safe as the provider failed to ensure the physical environment was safely maintained and systems and processes were not effectively followed. Including, but not limited to, ineffective fire safety systems, unsafe storage of chemicals and lack of identification of risks with associated with windows and the pond area.

People were not always protected from the risks of abuse. People did not always receive their medicines safely or as prescribed.

The provider did not effectively analyse significant incidents to learn from them and to make changes to improve people's safety. The providers infection prevention and control procedures were not effectively followed.

The provider did not have effective quality monitoring procedures in place to drive improvements in the care they provided. The management team did not have clearly defined roles and responsibilities.

People were not always supported to have maximum choice and control of their lives. Staff did not always support them in the least restrictive way possible or in their best interests; the application of policies and systems in the service did not always support best practice.

The provider followed safe recruitment practices.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 25 February 2022).

At that inspection there were breaches of regulation regarding safe care and treatment and how the location was managed. Following that inspection, the provider was issued with warning notices.

We undertook a targeted inspection on 12 April 2022 to check they had complied with the warning notice. We use targeted inspections to follow up on Warning Notices or to check concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question. Following the targeted inspection, we confirmed the provider was meeting the legal requirements and the conditions of the warning notice.

Why we inspected
The inspection was prompted by concerns about the management of the location. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence the provider needs to make improvements. Please see the safe, effective, caring and well-led sections of this report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Keegan's Court Residential Care Home on our website at www.cqc.org.uk

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to keeping people safe, dignity and overall governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service effective?

Inspected but not rated

At our last inspection we rated this key question requires improvement. We have not reviewed the rating as we have not looked at all of the key question at this inspection.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our well-Led findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Keegan's Court Residential Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 [the Act] as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was completed by one inspector.

Service and service type
Keegan's Court Residential Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. In this instance the registered manager was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

During the inspection
We spoke with four people who used the service about their experience of the care provided and we spent time in the communal area observing the support people received. We spoke with six staff members including two carers, one senior carer, provider, operations manager and maintenance manager. We looked at three peoples care and support plans and several documents relating to the monitoring of the location and health and safety checks. In addition, we looked at three staff files.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. The rating for this key question has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The physical environment was not safe for people. For example, we saw fire exits were blocked by furniture and used pieces of equipment. The cellar was heavily cluttered with combustible material. These issues put people at the risk of harm in the event of an emergency.
- The laundry area contained substances hazardous to health. This area was not locked and chemicals, including those identified as corrosive, had been left out. People were independently mobile within the home and had unrestricted access to the chemicals in this area putting them at risk of harm from ingestion or contact.
- Not all heavy wardrobes, or large pieces of equipment, were safely secured putting people at the risk of crushing. Window restrictors were not in place on all windows or secured using tamper proof fixings. This put people at the risk of a fall from heights.
- The pond area was not safe for people to access. This area contained tripping hazards and an unsuitable cover over the water. This put people at the risk of drowning.
- The provider failed to ensure people were protected from ill health during a significant period of hot weather. We saw one person sat outside, without their shirt on. The provider had failed to ensure the person was in a shaded area or had the options of sun cream being applied. This put the person at risk of ill health as a result of exposure to extreme temperatures.
- People were sleeping next to makeshift bed bumpers. One was made from what appeared to be a folded crash mat in a duvet cover, and another was a large mattress bag which had been attached to the ends of the bed. The use of unsuitable materials put people at the risk of entrapment and strangulation.
- Although people had personal emergency evacuation plans in place these did not account for changes in risk. For example, one person was at risk of going missing this had not been updated in their evacuation plan putting them at risk of harm in the event of an emergency.

Using medicines safely

- People did not receive their medicines safely or as prescribed. The provider failed to monitor the safe temperature ranges for the storage of medicines. Staff did not have instructions on what to do if the readings deviated from the safe ranges. This put people at risk of receiving ineffective or compromised medicines.
- People did not have appropriate medication care plans in place for "as required" (PRN) medicine. For example, one person was prescribed medicine to support their anxiety. There was no instruction for staff on how to support them instead of relying on medicine or how to recognise any signs which would indicate they may need their medicine. This put people at risk of receiving inappropriate amounts of medicine.
- The managerial oversite of the use of PRN medicines was ineffective. We saw one person was being given

their PRN medicine every morning. One staff member told us they thought they needed this every day and didn't understand it should only be administered when required. This staff member believed they were administering the medicine in order to control and manage this person. This put people at the risk of over medication. Following identification of this issue we raised a safeguarding alert to ensure the safety of this person.

Preventing and controlling infection

● The provider was not promoting safety through the layout and hygiene practices of the premises. We saw over chair tables which showed evidence of fluid ingress, damaged toilet surrounds and human waste left in one person's room for an extended period.

● The provider was not using PPE effectively or safely. We saw several staff members supporting people with their face masks below their noses or their chin. We saw the provider enter one part of the building with no face mask on. This was in proximity of staff and people. This was not challenged by any of the staff members present. These issues put people at the risk of harm from communicable infections.

Learning lessons when things go wrong

● The provider did not have effective systems in place to learn when things went wrong. For example, following a recent incident when someone went missing, they failed to review their systems or response to see if anything could be done differently.

● Following another incident, in one of the providers other homes, concerns were raised when someone went missing. The staff involved had since been redeployed at Keegan's Court residential care home. The provider had not completed an investigation into the circumstances or appropriately engaged staff to see if lessons had been learnt.

● We asked where the providers missing persons policy was. After some time, the operations manager found it and told us everyone had read and signed to say they understood it. We noted only one staff member in the building had signed this policy, but this was in 2017. Neither the provider, operations manager, cook, maintenance person or other care staff had read this policy. This demonstrated the provider failed to learn from significant incidents.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. These issues constitute a breach of Regulation 12 (Safe Care and Treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Despite our findings people told us they felt safe and well cared for at Keegan's Court Residential Care Home. One person said, "I quite like it here. I feel it is secure and I have no issues. It's all quite ok."

Systems and processes to safeguard people from the risk of abuse

● People were not effectively protected from the risk of abuse and ill treatment. During our inspection we raised three separate safeguarding alerts with the local authority. This was in relation to staff interactions, lack of dignity and suspected inappropriate use of medication. These issues had not been identified by staff or the management team and as such had failed to act to safeguard people from suspected abuse.

● People's personal property was not accounted for or accurately recorded. We saw a bank card, cheque book and what appeared to be a yellow metal wedding band stored in the providers safe. None of these items were recorded in people's personal property inventory or recorded elsewhere in the property. This put people at the risk of financial and material abuse.

● In other areas of the home we saw people's personal property, including clothing, was stored in unused rooms and storage areas. For example, the cellar. Neither staff nor the provider could identify who owned these items which put people at risk of losing their personal property.

● We saw one bedroom was being used by a member of staff to sleep in. This room contained personal items of property belonging to someone else. These items were mixed in with the staff members items. No one could tell us who these items belonged to or how long they had been in the room. The operations manager could not assure us they could identify the owner to ensure they were appropriately returned putting them at risk of material loss.

Systems were not robust enough to safeguard people from abuse and improper treatment. This placed people at risk of harm. These issues constitute a breach of Regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When these issues were identified we contacted Shropshire Fire and Rescue, Shropshire Local Authority Commissioners and the adult safeguarding team to raise our concerns in order to keep people safe.

● We were assured the provider's infection prevention and control policy was up to date although staff and the management team did not always follow this effectively.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.

Visiting in care homes
● The provider was supporting visits in line with the Governments guidance.

Staffing and recruitment
● People were supported by enough staff who were available to safely assist them. All those we spoke with told us they were supported when they wanted. However, at this inspection there was no designated cleaner. The cleaning duties were completed by staff when they were able. However, those we spoke with told us they were supported when needed and without any unnecessary delay.
● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with others.

Inspected but not rated

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection this key question was rated requires improvement. We have not changed the rating as we have not looked at all of the effective key question at this inspection.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was not working within the principles of the MCA. We witnessed a staff member enforcing unreasonable and potentially unlawful restrictions on one person as they attempted to stand and move. We immediately passed our concerns to the operations manager and to adult safeguarding.
● We spoke with two staff members who did not know what DoLSs was. Additionally, they could not explain to us what the MCA was. They did not know who was currently subjected to a DoLSs and did not know what authority they had should someone attempt to leave the building. This put people at the risk of having their liberty unlawfully restricted.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained the same. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence. Ensuring people are well treated and supported; respecting equality and diversity.

- People were not always treated dignity and respect. We saw one person had not been provided with toilet paper in their room. They had to use the torn pages of a magazine to clean themselves. Human waste was then left in the room for a period of at least 90 minutes.
- Another person's toilet seat was missing. The provider had not replaced this once it had been identified as missing, yet they had spares available.
- We witnessed one person, with capacity to make decisions for themselves, attempt to stand from their chair. A staff member instructed them, "You are not going anywhere." This was then repeated to the person until we made our presence known. At this point the staff member sought to see how they could assist the person. This interaction demonstrated a complete lack of respect for the person and was undignified.
- Peoples personal belongings were treated with disrespect. There was a lack of safe storage or inventory to ensure peoples belongings remained with them or followed them once they no longer resided at Keegan's Court Residential Care Home.
- People's communal areas were used to store used equipment. For example, in the bungalow we saw one person's dining and living area was used to store a used mattress which was leaning against their lounge chair. This item also prevented safe access to their dining area. This showed us people and their environment were treated with a lack of respect by the provider and management team.
- People did not have their confidential information secured safely. We saw personal information left in communal areas where those without authority had access to it. We also saw information from one of the providers other homes was left in a corridor with no attempt to secure any sensitive information.

This was degrading to people and who were not treated with dignity or respect. These issues constitute a breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We passed our concerns to the local authority and the adult safeguarding team.

- People's protected characteristics under the Equalities Act 2010 were known by staff members. These included gender, sexuality, disability, ethnic origin etc. We saw one person expressing themselves in the language of their origin. Staff members had attempted to learn certain common phrases and used technology to translate when it was needed. They supported what they were saying with gestures and physical prompts.

Supporting people to express their views and be involved in making decisions about their care

● Despite our findings people felt they were generally well cared for and looked after. One person said, "I have absolutely no concerns about how I am cared for. They [staff] are all lovely to me." Another person told us, "No complaints. I get what I need. If I want to choose then I can."

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements. Continuous learning and improving care.

- This location was first registered with the CQC in November 2017. We first inspected in January 2019. Since the time the location has been registered, they have been inspected on seven occasions where we have provided them with a rating. They have consistently failed to reach an overall rating of good at any inspection. Out of the seven inspections the provider has been in breach of regulation on six occasions.
- At our last rated inspection, published February 2022, we identified breaches of regulations. This was in relation to unsafe management of the physical environment and poor infection prevention and control practice. In addition, we found the management did not have effective quality monitoring in place and had not kept themselves up to date with changes in legislation. Despite initial improvements the provider had failed to sustain improvements and they are once more in breach of regulations.
- Neither the provider nor the operations manager had a clear role within Keegan's Court Residential Care Home. When asked neither knew who was responsible for key elements like quality monitoring or notifications. There was not a clear understanding of management roles or responsibilities.
- We asked to see the providers continuous service improvement plan. The operations manager told us they had made some notes when they were first employed but this was not formalised with the provider and they could not find it at the time of the inspection. This demonstrated neither they, nor the provider, had a clear understanding who was taking the lead on improving people's experiences of care or what improvements needed to be made.
- Neither the provider nor the operations manager knew the relevant health and safety legislation on how to maintain a safe care environment. This lack of knowledge meant they could not effectively check risks were being identified or mitigated.
- The provider failed to act when risks were identified to them. For example, the maintenance person and operations manager told us they highlighted the risks of fire in the cellar area. They went on to say this had been ignored by the provider and nothing had happened as a result putting people at continued risk.
- The quality monitoring systems were inadequate in identifying and mitigating risks to people. For example, they failed to ensure window openings were restricted or fire exits were cleared.
- The provider failed to provide a positive example of quality and risk management. For example, we instructed the provider to remove items from blocking fire exits on the first day of our inspection. On day two we saw these items had been returned blocking one of the exits. We saw the provider entering peoples living areas without wearing a face mask creating a potential risk of infection. They failed to announce themselves to the person in the area demonstrating a lack of respect towards them.
- The providers quality systems had failed to identify or mitigate fire risk, risk of falls from height, risk of

drowning, risk of chemical ingestion or the risk to people's property.
● The operations manager told us they completed regular quality checks as part of a walk around the building. These checks failed to identify poor staff behaviour and risks associated with people's dignity or risks from exceptionally hot weather.
● The provider completed regular checks on people's medicines. These checks were ineffective as they failed to identify fridge temperatures were not being checked, potential over medication was being administered or specific medicine care plans were missing.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong.
● The provider was aware of their responsibilities under the duty of candour. The duty of candour is a regulation which all providers must adhere to. Under the Duty of candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment. However, they failed to complete investigations into significant events. They did not have systems in place to identify learning or what could be done differently.

Managerial oversite and environmental assessments were not robust enough to demonstrate their quality monitoring was effective. These issues constitute a breach of Regulation 17 (Good governance), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We saw the last rated inspection was displayed in accordance with the law at Keegan's Court Residential Care Home .

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● All those we spoke with said the management team was approachable and they felt supported by them. However, some staff we spoke with said they often felt their concerns were ignored and dismissed without being addressed.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People told us they felt involved in decisions about where they lived. We saw examples of recent resident surveys completed where all the responses were positive.

Working in partnership with others
● The management team had established and maintained links with the local communities within which people lived. For example, GP practices, district nurses and social work teams.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People were not treated with dignity by those supporting them.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the physical environment was safe for people to receive safe care and treatment.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

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 The provider had failed to ensure safeguarding systems were effectively followed.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers quality monitoring systems were ineffective.

The enforcement action we took:

We have taken action to remove this location from the providers registration. Meaning they are no longer able to provide a regulated activity from this location.