The Keepings Limited

Birkdale Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Birkdale Residential Home provides accommodation and personal care to up to 29 people. At the time of this inspection there were 26 people using the service. Some of whom were living with dementia.

People's experience of using this service and what we found
People were at the risk of harm from preventable injury as the provider failed to ensure risks had been identified and mitigated.

People were at risk of exposure to infectious illness as the provider failed to ensure appropriate infection prevention and control practices were being followed.

The physical environment within which people lived did not support effective cleaning as equipment, fixtures and fittings were damaged, rusted or unprotected. Food items were not safely stored.

People did not always receive their medicines as prescribed.

The provider did not have effective systems in place to review incidents, accidents, or significant events to see if something could be done differently to keep people safe.

The provider did not have effective systems in place to identify improvements and drive good care. The management team and provider failed to keep themselves up to date with best practice in health and social care.

People were protected from the risks of ill-treatment and abuse as staff had been trained to recognise potential signs of abuse and understood what to do if they suspected harm or abuse.

People were supported to have maximum choice and control of their lives and the provider supported them in the least restrictive way possible and in their best interests; the application of the policies and systems supported good practice.

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

Rating at last inspection.
The last rating for the service was good, published on 11 July 2019.

Why we inspected
The inspection was prompted in part due to concerns received about the management of risk within the building. A decision was made for us to inspect and examine those risks.

This report only covers our findings in relation to the key questions safe and well led.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.

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

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 that the service can respond to COVID-19 and other infection outbreaks effectively.

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

Enforcement and Recommendations
We have identified breaches in relation to keeping people safe and with the overall management of the care provision at this inspection.

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.

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
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect

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 well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Birkdale Residential 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 carried out by 1 inspector.

Service and service type
Birkdale Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Birkdale Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

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
We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We asked the local authority and Healthwatch for any information they had which would aid our inspection. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 2 people who used the service about their experience of the care provided and 2 relatives. We spoke with 6 staff including carers, domestic support, administration staff, maintenance staff and the registered manager. We spoke with the nominated individual on the phone. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included 2 person's care plans and records of medicines administration. We looked at a variety of documents relating to the management of the service, including quality monitoring checks. We confirmed the safe recruitment of 2 staff members.

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 good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

● People were at the risk of harm as the provider failed to ensure the physical environment was safe for people to live in. Some wardrobes had not been secured to a fixed point and freely moved. They were a risk of toppling over. Heavy items were stored off the ground and at the risk of toppling. These issues put people at the risk of harm from crushing injuries.

● Substances hazardous to health were not stored securely and were accessible to people, some of whom were living with dementia. There were cleaning chemicals decanted into unlabeled bottles, nail varnishes and items marked as harmful, flammable and/or corrosive left accessible in communal areas. This put people at the risk of harm from accidental or intentional ingestion.

● The provider had failed to commission a legionella risk assessment. There were several "dead legs" in the water piping. These are locations in the pipework where water can become stagnant. The registered manager did not know these were a potential risk to health and had failed to take remedial action. Legionnaires' disease is a potentially fatal form of pneumonia caused by the inhalation of small droplets of contaminated water containing Legionella. This put people at the risk of harm from infection. However, the provider did complete yearly water testing.

● Hot pipe work to radiators and taps had not been covered. Some radiators did not have covers on them. These issues put people at the risk of burns. Some radiators had broken covers putting people at the risk of entrapment. Several radiators had missing thermostats which created a sharp point putting people at the risk of penetrative injury. People had unrestricted access to the hot water storage systems and to the heating boilers putting them at the risk of scalds or burns.

● The provider failed to complete adequate checks of the location to ensure fire safety was assured. There was a small door leading from the laundry area. This was not included on any fire risk assessment and presented a risk of breaching the fire protection compartments meaning fire could potentially spread.

● There were holes in fire doors compromising the structural integrity of the doors and 2 fire exits had additional locks which were not part of the fire risk assessment. Not all extractor fans were regularly cleaned meaning there was a build-up of debris in them. These issues put people at the risk of harm in the event of a fire. There was worn, and in places torn, floor coverings in communal area and exposed capped pipe work at floor level in corridors. These issues put people at the risk of harm from trips and falls.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We saw visible dirt and debris on kitchen equipment, there was sticky substances on multiple doors and walls where posters and information boards had been removed, there was rust on radiators and radiator covers, there were broken tiles and evidence of water damage on walls. An over chair table was showing signs of fluid ingress and was visibly dirty with evidence of dried fluids on the underside. These

issues hampered effective cleaning practices and put people at the risk of infection.
● There was food items and debris under the radiator covers and other evidence of poor cleaning. Radiators, electric fans and door closures were visibly dirty and handrails and other high frequency touch points were worn exposing unprotected wood beneath. These issues put people at the risk of infection.
● Food items were stored on the floor in the kitchen alongside mop buckets. The dishwasher had been repaired with a sealant which allowed gaps in the surface and there was food debris on the floor alongside visible dirt and other debris. The flooring in this area was torn with gaps allowing fluid and debris into the below surface area. These issues put people at the risk of harm from infection.
● We were not assured the provider was preventing visitors from catching and spreading infections. Visitors were not checked at the point of entering the building if they were well or displaying any symptoms of infection.
● We were not assured the provider was supporting people living at the service to minimise the spread of infection as there was not a programme of cleaning the high frequency touch points throughout the building.
● We were not assured the provider was making sure infection outbreaks can be effectively prevented or managed as the physical environment did not support effective cleaning practices.
● We were not assured the provider's infection prevention and control policy was up to date as the practical application of effective cleaning practices and checks was not being followed.

Using medicines safely
● Medicines were not safely managed. The provider did not have effective oversite to ensure people who were prescribed medicated creams received these as instructed. Two peoples' records of medicine administration (MAR) showed their medicated creams were not given as prescribed. Neither the registered manager nor staff had identified these creams had been omitted. This meant people were at risk of skin breakdown by unsafe and inconsistent support with their medicines.
● Not all medicines were safely stored. We saw drinks thickener had been left in a communal area cupboard. This put people at the risk of harm from choking.
● The provider did not have guidelines in place for staff to safely support people with 'when required' medicines. For example, where medicines were prescribed to assist people to manage their anxieties there were no guidelines for staff on when to administer these medicines.
● There was no guidance on what could be done to support them in other ways without the need for medicine intervention. The provider did not have systems in place to review the effective use of such medicines and could not be assured these were administered appropriately. This meant people were at risk of receiving inconsistent and potentially inappropriate support with their medicines.

Learning lessons when things go wrong
● The provider did not effectively review all incidents, accidents or near misses to see what could be done differently to minimise the risk of reoccurrence. For example, following the identified concern where a person had come into contact with potentially harmful substances the provider failed to secure substances hazardous to health.
● There were multiple locations throughout Birkdale Residential Home where toiletries had been left accessible to people, cleaning products had been decantated into unmarked bottles, medicines left in communal cupboard and cleaning products left on windowsills all of which was accessible to people living with dementia. People remained at the risk of harm from cleaning chemicals as the provider failed to action learning from specific incidents.

We found no evidence people had been harmed. However, 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.

Following our inspection, we passed our concerns to Shropshire and Fire and Rescue for their attention. Additionally, we passed information to Telford and Wrekin's Environmental Health services for their information and consideration.

We have received assurances from third parties that actions are underway to address the most serious of our concerns.

- We were assured the provider was admitting people safely to the service.
- We were assured the provider was using PPE effectively and safely.
- We were assured the provider was responding effectively to risks and signs of infection.

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 support them without any unreasonable delay. One relative said, "Staff are always there if you need them and are free to have a chat when you want."
- The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). Disclosure and Barring Service (DBS) checks and provides information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
- The provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.
- The provider had measures in place to mitigate the risks associated with COVID-19 related staff pressures.

Systems and processes to safeguard people from the risk of abuse
- People were safe from the risks of abuse and ill treatment. One relative told us, "I don't have any concerns about anything here. The staff are lovely and if I was worried, I would say something."
- Staff members had received training on how to recognise and respond to concerns.
- Information was available to people, staff and relatives on how to report any concerns.
- The provider had systems in place to share information about any concerns with the appropriate agency. For example, the local authority, to keep people safe.

Ensuring consent to care and treatment in line with law and guidance
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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. One person said, "I decide when I go outside. They [staff] come with me if I want. I make the decisions myself."
● Staff, and the management team, followed best practice when assessing people's capacity to make decisions and knew what to do to ensure any decisions made were in the best interests of the person concerned.

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 our last inspection we rated this key question requires improvement. At this inspection the rating 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.

Continuous learning and improving care

- The nominated individual told us they weren't concerned about keeping themselves up to date with best practice in health and social care. They didn't attend any training or education programmes to upskill themselves in the safe provision of care. The provider failed to direct a suitably qualified person with the skills and knowledge to identify and manage the risks associated with the health and safety associated with safe accommodation and care. The provider failed to have effective oversite of the delivery of regulated activities within the home.
- The registered manager told us they kept themselves up to date with developments and best practice in health and social care. This included regular attendance and participated in a local providers group. However, the registered manager had failed to keep themselves up to date with health and safety in care homes or the potential risks from known infections. As a result, they failed to ensure appropriate action had been taken to keep people safe.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider did not have effective quality monitoring systems to ensure people received good care. The providers checks did not identify or mitigate the risks from unsafe furniture or fixtures. They failed to check fire exits remained clear, they failed to check food items were safely stored, they failed to ensure the risks from trips or falls had been reasonably preventable. These issues put people at the risk of harm from injury.
- The provider failed to check people had received their prescribed medicines as directed and they failed to ensure protocols for the safe administration of "when required" medicines were completed. This put people at the risk of harm from inconsistent medicine administration. The provider failed to check people's medicines were safely stored. This put people at the risk of choking.
- The provider failed to complete effective infection prevention and control checks on the building, equipment and the practices of staff. They failed to identify or mitigate risks from poor practices which put people at the risk of harm from infection.
- The provider failed to ensure the learning from significant incidents were put into practice. For example, following an internal investigation into the storage of potentially harmful substances the provider failed to ensure all other substances were safely secured.
- The provider failed to demonstrate they understood legal requirements for appropriate environmental assessment or checks. The registered manager did not know about the risks resulting from legionella bacteria and had failed to ensure potential risks had been mitigated. The provider could not demonstrate they had commissioned a legionella risk assessment and could not demonstrate they had taken action to

mitigate any potential for harm. This put people at the risk of infection.

We found no evidence people had been harmed. However, 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● All those we spoke with found they had a positive relationship with the management team who they found to be accessible and engaging. One relative told us they are asked if there is anything which could be done to improve the experience of their family member. They could not think of anything and believed the home was well run.

● Staff told us they thought the registered manager was supportive and their opinions were welcomed and valued.

● Staff understood what whistleblowing procedures were and felt they could raise concerns openly and their views would be valued.

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 management team 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.

● One relative told us they understood things could go wrong and as long as they [management] said "sorry" and put things right that is all they could expect of them.

Working in partnership with others

● The management team had established and maintained good links with the local communities within which people lived. This included regular contact with local healthcare professionals which people benefited from. For example, GP practices and district nurse 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 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure people were kept safe from preventable harm.

The enforcement action we took:

We imposed a condition on the providers registration.

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 systems in place to identify and drive good care.

The enforcement action we took:

We imposed a condition on the providers registration.