Kevindale Residential Care Home

Keegan's Court Residential 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?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Keegan's Court Residential Care Home accommodates up to 19 older people who require support with their personal care needs. Some of whom are living with dementia. At the time of this 14 people were living there.

People's experience of using this service and what we found
The providers quality monitoring procedures were effective in identifying the improvements which were needed to drive good care and support.

People were not always safe as the systems and procedures at Keegan's Court Residential Care Home were ineffective in identifying improvements needed to keep people safe. Risks associated with people's care were not always accurately identified. People were not safe from infectious illnesses as the infection prevention and control measures at Keegan's Court Residential Care Home were not always effective. People's 'As required' medicine protocols were incomplete and in some instances missing.

People were not always supported to have maximum choice and control of their lives and they were not always supported in the least restrictive way possible or in their best interests; the policies and systems in the service did not always support good practice. People were not always treated with dignity and respect and information personal and confidential, to them, was not always kept secure.

People did not always have personalised care and support plans which reflected their individual preferences. People were not consistently provided with information in a way they could easily access or understand as their communication styles had not been effectively assessed.

People did not always receive effective support with their eating and drinking as there was no oversight of records detailing people's intake.

People were protected from harm and abuse as the staff team had been trained to recognise potential signs of abuse and understood what to do.
People had access to additional healthcare services when required.

People received help and support from a kind and compassionate staff team with whom they had developed positive relationships. The provider had systems in place to encourage and respond to any complaints or compliments from people or those close to them.

Rating at last inspection
The last rating for this service was 'Requires Improvement' (published 27 February 2019). At that inspection we identified breaches in the law regarding the notification of incidents, safe care and treatment and quality assurance systems.

Why we inspected
This was a planned inspection based on the previous rating.
The overall rating for the service has remained the same, requires improvement. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement in all key questions inspected. Please see the Safe, Effective, Caring, Responsive and Well-led sections of this full report.

Enforcement:
We have identified breaches in relation to the safe care and treatment of people, person-centred care planning and how the location is managed.

You can see what action we have asked the provider to take at the end of this full report.

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 continue to monitor information we receive about the service until we return to visit as per our reinspection programme. If we receive any concerning information we may inspect sooner.

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

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always 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 Care Act 2014.

Inspection team
One inspector and an assistant inspector carried out this inspection.

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 single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. They were also the registered provider. This means they are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was supported in the day to day running of Keegan's Court Residential Care Home by a home manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to 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 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 of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. 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 spoke with five members of staff including two carers, the home manager and registered manager and maintenance person.

We reviewed a range of records. This included four people's care records including the records of medicine administration. We confirmed the safe recruitment of staff and looked at a variety of records relating to the management of the service, including any quality monitoring checks.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to protect people against the risks associated with the management of their medicines because of inadequate recording. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had failed to make enough improvement, so they continued to breach in breach of this regulation.

Using medicines safely
• People did not always receive safe support with their medicines. Guidelines for 'when required' medicines were incomplete and, in some instances, missing. This put people at risk of receiving inconsistent support with their 'when required' medicines.
• We saw some medicines had been opened but the date of opening had not been recorded. The provider could not be assured the medicine was still viable and safe to use. Staff members told us they had been trained and assessed as competent to support people. However, the assessments of competency, we saw, did not detail what the person had been observed doing only that they were competent. The provider could not be assured staff member's practice had been accurately assessed using recognised best practice. In addition, the medicine storage trolley was left unsecured throughout our inspection in an area accessible to people and visitors.
• The registered manager did not complete checks to ensure people received the right medicine at the right time and could not assure us people received safe support. They did not have effective systems in place to identify any potential medicine errors. Despite our finding people told us they received their medicines when they needed them and in a way, they preferred.

Assessing risk, safety monitoring and management
• People did not always receive safe care and support. For example, the provider showed us their fire risk assessment which they had commissioned in 2017. All the 'to do' actions had been left blank and not completed.
• The registered manager did not complete checks to ensure emergency warning systems or emergency lighting was safe and operated as expected. We saw one fire exit was blocked by a trolley; one fire door was missing, and two fire door self-closure mechanisms were extensively damaged.
• Not everyone had a personal emergency evacuation plan in place. These were plans which would indicate to staff members, and the emergency services, the support people would need at such a time.
• These issues put people at the risk of injury in the event of a fire. Following our inspection site visit we passed our concerns to Shropshire Fire and Rescue Service.
• Not all areas of Keegan's Court Residential Care Home were safely maintained. For example, we saw

several radiator valves were missing exposing sharp points, exposed hot water pipes and open access to boiler and central heating systems. We saw people had access to hazardous substances. For example, corrosive oxidising peroxide and nail varnishes. These issues put people at risk of harm.
• We saw, within the ground of Keegan's Court Residential Care Home, the registered manager had created a pond area. The area contained trip hazards as the surface was uneven and there were no railings preventing people from falling into this pond. The registered manager told us they did not consider this as an issue and therefore had not completed a risk assessment. This put people at risk of injury.
• The registered manager failed to ensure the hot water in taps were at a safe temperature for people to use. There wasn't a thermometer available to check water temperatures. This put people at risk of scalds.

Preventing and controlling infection
• The infection prevention and control processes at Keegan's Court Residential Care Home were ineffective. The registered manager had not completed a legionella risk assessment or done any testing of the water. Consequently, they failed to complete any preventative measures to minimise the risk of legionella disease. For example, water flush throughs of rarely used water outlets.
• Cleaning practices were ineffective. For example, we saw rust on rails in the communal bathrooms and mould on the wall, over chair tables were engrained with an unidentifiable substance, the stair lift was stained and heavily soiled with an unidentified powder and doors were not finished with a wipeable surface. These issues prevented effective cleaning and put people at risk of contracting communicable illnesses.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
• The home manager and registered manager told us they analysed incidents to identify if anything else could be done differently in the future to minimise the risks of harm to people. However, the forms they used did not record they had looked at them or whether any additional action was required. We could not be assured they had effective oversight to learn from incidents of significant events.
• The provider had systems in place to address any unsafe staff behaviour including disciplinary processes and re-training if needed.

Systems and processes to safeguard people from the risk of abuse
• All those we spoke with told us they felt protected and free from abuse at Keegan's Court Residential Care Home. People were protected from the risks of ill-treatment and abuse as staff members had received training and knew how to recognise and respond to concerns.
• Information was available to on how to report any concerns. The provider had systems in place to make appropriate notifications to the local authority to keep people safe.

Staffing and recruitment
• People were supported by enough staff who were available to safely support them. We saw people were promptly supported when needed or requested. The provider followed safe recruitment processes when employing new staff members.

Requires Improvement

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• People's needs were not assessed or regularly reviewed in line with recognised best practice. People's physical, mental health and social needs were not accurately recorded and there were significant gaps in people's care planning. For example, breathing, base line recordings (weight, height), maintaining a safe environment or controlling body temperatures. This put people at risk of not having their care and supports needs met by those supporting them.
• People had assessments regarding their oral health. However, these assessments did not result in a care and support plan designed to promote good practice and the maintenance of well-being. When people were recorded as having no dentist there was no evidence this had been followed up to enable them to receive appropriate treatment.
• When people's needs changed their care and support plans were not updated. For example, one person admitted for end of life care improved and they were able to spend time in communal areas. The care and support plan was not effectively reviewed to account for these changes.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us they had a choice of meals and we saw people making decisions about what they wanted to eat and when. Staff members told us they were required to record the diet and fluid consumption for people they believed to be at risk of dehydration. However, these records were not consistently filled in. Neither the registered manager nor the home manager could tell us what the safe daily targets were or at what point they would be concerned for someone's welfare. This meant there was a risk people may not receive enough food or fluids in order to keep them healthy.

Supporting people to live healthier lives, access healthcare services and support. Staff working with other agencies to provide consistent, effective, timely care
• People told us they had access to additional healthcare professionals including GP's, and district nurses. However, the management team did not ensure information provided by healthcare professionals was forwarded to staff members or updated in people's records. For example, any recommendations for regular turns to maintain healthy skin condition. We saw gaps in the recording of people's regular turns and could not be assured they happened as advised. This meant there was a risk professional advice may not be followed.
• The management team did not always have effective and efficient, communication systems in place. For example, people's care and support plans were not routinely updated or amended when there was a change in people's health or welfare needs. This meant staff members did not always have access to up to

date information directing their care of people.

Adapting service, design, decoration to meet people's needs
• We saw people confidently moving around Keegan's Court Residential Care Home. However, there was a lack of appropriate signage to help people orientate themselves. We saw some bedroom door numbers were missing and bathrooms and toilets were not clearly identified to support people living with dementia.

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 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. 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 saw the provider had made appropriate DoLS applications in line with the MCA and had systems in place to ensure any expired applications were reapplied for in a timely way to ensure people's rights were maintained.
• However, we asked to see one person's assessment of capacity, but this could not be located. The home manager told us they believed this had been archived. This meant staff members did not always have the correct information to effectively support people to make decisions.
• People were not always supported to have maximum choice and control of their lives or in the least restrictive way possible as they had not always been involved in assessments of their care and support.

Staff support: induction, training, skills and experience
• People were supported by a staff team who had received appropriate training and who felt supported by the provider and the management team. Staff members we spoke with told us they received regular support and supervision sessions. These were individual sessions where they could discuss aspects of their work and training.
• New staff members completed a structured introduction to their role. In addition, new staff members worked alongside experienced staff members until they felt confident to support people safely and effectively.

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 the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. 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
• People were not always treated with dignity and respect. For example, we saw people were expected to eat their meals from dirty over chair tables, use a toilet with a missing toilet seat and complete their personal care in areas with rusted fixtures and mould on the walls. These issues did not promote a dignified and respectful setting for people to live in.
• Despite what we found people told us they felt well treated by a kind and respectful staff team. We saw people sharing jokes with staff and happily engaging with them. This indicated to us the staff members treated people well on a personal level. One person told us, "I feel that living here has enabled me to live my life, grab my life back and to be as independent as I could."

Ensuring people are well treated and supported; respecting equality and diversity.
• Information which was personal and confidential to the person was not always securely stored. We found one person's personal records was stored in a shared bathroom along with some personal possessions and medical equipment. In addition, we saw records of people's medicines were kept in a communal area which was accessed by people and visitors.
• However, people were supported by staff members they described as, "Funny", "Lovely," and "Kind." One person said, "The care staff are lovely, and they have become my friends."

Supporting people to express their views and be involved in making decisions about their care
• People consistently told us they didn't know they had a care and support plan and they could not recall being consulted on the contents. None of the care plans we saw had any signatures indicating people had been consulted or if they were in agreement with the content of them.
• However, throughout this inspection we saw people were asked how they wished to be supported and what they wanted to do by the staff members supporting them.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

• People were not routinely involved in their care and support planning. None of those we spoke with could recall being asked what they wanted or how they wished to be supported as part of the care planning process. We saw significant sections of people's care plans which were blank. For example, one person's care plan did not record any information in the section identified as 'working and playing.' This section remained blank despite the person living at Keegan's Court Residential Care Home for two years. We saw other people's care plans with blank sections for over twelve months despite the providers documentation indicating they were reviewed every month. However, those we spoke with told us they believed they received the care and support they needed.

• Neither the registered manager nor the home manager recorded people's life histories, people and places which mattered to them or significant times in their lives. This meant staff may not be able to easily build a rapport and get to know people well.

• People's protected characteristics under the Equalities Act 2010 were not effectively identified as part of their need's assessment. For example, the care records had a section to record people's sexuality. Sexual orientation is identified as a protected characteristic which means it is a legally defined group with legal protections. In addition, people's faiths were not routinely recorded and there was a lack of information on how to effectively meet these needs. This put people at risk of losing their personal identities.

End of life care and support

• People did not have their end of life wishes recorded. Despite Keegan's Court Residential Care Home supporting people at the end of their lives their spiritual wishes and personal preferences were not recorded or known by those supporting them.

• There was a specific section in people's care plans for recording such wishes but the only example we found was when someone had moved into Keegan's Court Residential Care Home for end of life care. However, it did not specify how this care was to be delivered or how it met the person's individual preferences. It did not detail any conversations with families or those close to the person to understand what they would have liked. This put people at risk of not receiving personalised care and support as they moved to this time of their life.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

• The service had not implemented the AIS to identify, record, flag, share and meet the information and communication needs of people. We asked the registered manager and home manager about this. Neither had a working knowledge of AIS and had not individually assessed people in accordance with the guidance. We saw Keegan's Court Residential Care Home supported people with sensory loss and dementia. However, we did not see any examples on how information was presented in a way which met people's individual needs.

These issues put people at risk of not receiving care and support which was personalised them. These issues were a breach of regulation 9 (Person-centered care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to develop and maintain relationships to avoid social isolation
• People did tell us they were involved in activities they enjoyed. We saw one staff member completing nail care with someone as part of a mini pamper session. They were chatting and laughing with the person they supported making this an enjoyable experience for them. People told us they were able to go into their local town for shopping and take part in arranged activities and outings in the summer.
• People told us relatives and friends were able to visit freely and private areas were available if they required them.

Improving care quality in response to complaints or concerns
• People knew how to make a complaint and were confident they would be listened to. One person told us they had raised an issue with the home manager and they were now just waiting for the outcome. The provider had systems in place to record, investigate and to respond to any complaints raised with them.

Requires Improvement

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 remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

At our last inspection the provider's quality assurance procedures were not effective in identifying shortfalls. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found insufficient improvement had been made and we have found additional concerns.

Also, at our last inspection we found the provider had failed to notify us of specific events and were in breach of Regulation 16 and 18 of the Registration Regulations 2009 (Notifications of other incidents). At this inspection we found improvements had been made and they were no longer in breach of this specific regulation.

Continuous learning and improving care

• The provider had a poor track record for identifying improvements and driving good care to achieve positive outcomes for people. At our last inspection we identified three breaches of the health and Social Care Act and the provider had made improvements in only one area identified to them. At this inspection we found additional concerns and a deterioration in the rating for three other key questions we assessed.

•The provider had ineffective systems in place to monitor the quality of the service that they provided. For example, their systems had failed to ensure environmental checks were completed, they failed to identify short falls in the care planning, they failed to check medicines were used within their use by dates or ensure the environment was clean or if staff followed effective infection prevention and control practices.

• The registered manager oversaw a total of three residential homes and spent a limited amount of time at Keegan's Court Residential Care Home. However, they failed to ensure processes were in place to drive good care when they were absent from the location.

• We asked the registered manager what they did to ensure the service they provided was safe and personalised for those living at Keegan's Court Residential Care Home. They told us they did not complete any assurance checks.

• The registered manager could not demonstrate they had effective oversight of incidents, concerns or significant events. They could not evidence they understood risk and there were breaches in legal requirements.

• The registered manager did not provide staff members with the necessary information they needed to effectively and safely support people or to meet their needs.

• The registered manager did not understand the principles of good quality assurance and the service lacked drivers for improvement.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• A registered manager was in post and was present throughout this inspection. They were supported in the day to running of the service by a home manager.
•The manager and provider had appropriately submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a reasonable timescale.

These issues put people at risk of receiving poor care and support. This was a continued 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
• People told us they had a positive relationship with the management team who they found to be supportive. Staff members we spoke with told us they found the management team helpful and approachable.

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
• We saw the management team and provider did not have effective systems in place to investigate or feedback on any incidents, accidents or significant events. complaints. There was poor oversight of any significant incidents by the registered manager.
• Staff members told us the management team were open and transparent when things needed to be improved or changed. However, we could not find evidence to support this assertion.
•The last rated inspection was not displayed conspicuously as required by law. We asked the registered manager about the rating and they told us they didn't know where it was, and we should ask the home manager. However, we did later see it in displayed on the staff notice board in another part of the home. At the time of this inspection the provider did not own or maintain a designated website on which to display their rating.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• People were involved in decisions about where they lived. One person told us they took part in meetings and they had recently been asked for their opinion as part of a survey. However, the results of this survey were still being compiled and not available at this inspection.
• Staff members told us they found the management team approachable and their opinions were welcomed and valued. Staff members took part in regular staff meetings where they could discuss elements of the work they completed.
• Staff members understood the policies and procedures that informed their practice including the whistleblowing policy. They were confident they would be supported by the provider should they ever need to raise such a concern.

Working in partnership with others
• The management team had established and maintained links with the local communities within which people lived. This included regular contact with local healthcare professionals. For example, GP practices and district nurse teams.

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 9 HSCA RA Regulations 2014 Person-centred care People did not have personalised care and support plans which accounted for their individual needs and preferences.

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 did not complete appropriate checks to ensure the physical environment within which people lived was safe.

The enforcement action we took:

We have issued a warning notice to the provider.

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 adequate quality monitoring systems in place to drive good and safe care.

The enforcement action we took:

We have issued a warning notice to the provider.