Care Quality Commission

Kevindale Residential Care Home

Keegan's Court Residential Care Home

Inspection report

The Grange
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Shropshire
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Tel: 01588638898

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13 June 2023

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service well-led?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Keegan's Court Residential Care Home is a care home providing support with personal care to 2 people at the time of this inspection. The home can accommodate a maximum of 19 older people. Accommodation is provided in an adapted building providing 15 beds and 2 bungalows, each providing 2 beds.

People's experience of using this service and what we found
This was a targeted inspection that considered whether or not people were safely supported by enough staff who had sufficient training, information and managerial direction to minimise the potential for harm.

People were at the risk of harm as the provider had failed to provide sufficient staff to safely support them at certain times of the day and night. Staff were not provided with clear instructions on what to do in the event of an emergency.

People were not safeguarded from the risk of abuse as the provider failed to assess the risks to people from a known individual entering the building.

The provider did not have effective oversite to ensure people received safe care.

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 inadequate (published 30 March 2023). At our last inspection the provider was in breach of regulations regarding keeping people safe, dignity and respect, safeguarding people from abuse, staffing and the overall management. At this inspection concerns remained regarding the safe provision of care, safeguarding people from abuse and managerial oversite.

Why we inspected
The inspection was prompted due to concerns received about unsafe staffing levels in the home. A decision was made for us to inspect and examine those risks. We found continued breaches regarding keeping people safe, safeguarding people from abuse and governance of the home. Following the inspection site visit the provider told us they had employed the services of a managerial consultancy to support them with restructuring their company.

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

The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on a Warning Notice or other specific 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.

Enforcement
We have identified continued breaches in keeping people safe, safeguarding people from abuse and how the home was managed.

Please see the action we have told the provider to take at the end 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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. We will assess all of the key question at the next comprehensive inspection of the service.	**Inspected but not rated**
Is the service well-led? We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about. We will assess all of the key question at the next comprehensive inspection of the service.	**Inspected but not rated**

Care Quality Commission

Keegan's Court Residential Care Home

Detailed findings

Background to this inspection

Why we inspected
This was a targeted inspection to follow up on concerns received regarding unsafe staffing levels and the management of the home.

Inspection team
This inspection was completed by 2 inspectors.

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. Keegan's Court 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 not a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection and had contact with

the local authority. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

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 used all this information to plan our inspection.

During the inspection
We spoke with 2 people about the support they received. Additionally, we spoke with 2 staff members including a carer and a cook. Following the inspection site visit we spoke on the phone with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We looked at documents relating to fire safety including the providers evacuation strategy.

Inspected but not rated

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 inadequate. This meant people were not safe and were at risk of avoidable harm. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns raised with us regarding safe staffing and effective management. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. These issues were 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 remained in breach of regulation 12.

Assessing risk, safety monitoring and management
●People were not safe as the provider had failed to review their fire evacuations strategy to account for reduced staff in the building. They failed to provide instructions to staff on how to summon support from staff sleeping-in or those on-call and not in the building. Staff did not know where the fire evacuations strategy was or what it contained. The providers evacuation strategy was not updated to include staff roles. For example, the strategy referred to the "Nurse in charge" when there were no nurses and to the "Home Manager and Deputy" when there was no home manager or deputy. The information in the strategy was inaccurate and did not reflect the staffing in the home at the time of the inspection.
● We asked a staff member what they would do in the event of an emergency where people needed to be evacuated. They told us they would phone the on-call person to get them to return to work. The staff member could not demonstrate who would phone the emergency services or when. They told us the 2 people living in the home would need 2 staff to safely support them but could not tell us how this would be achieved when they were the only staff member in the building. The providers fire evacuation strategy did not account for times when there was only 1 staff member in the building. These issues put people at the risk of harm in the event of an emergency.
● People were at the risk of harm as the provided failed to ensure all staff had received the correct training to safely support people in the event of an emergency. A staff member told us, "If there was a fire here I would help evacuate people. [Person] upstairs cannot walk so I would either lift them or take them in their chair." The lack of appropriate staff knowledge put people at risk from avoidable harm.

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

We passed our concerns to Shropshire Fire and Rescue for their awareness.

At our last inspection systems were not robust enough to safeguard people from abuse and improper treatment. This was 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.

At this inspection the provider remained in breach of regulation 13.

Systems and processes to safeguard people from the risk of abuse
● During this inspection we confirmed with people, staff and the nominated individual an ex-staff member regularly attended the building and spoke with people alone. This ex-staff member was previously dismissed following allegations of abuse. The provider failed to evidence the action they had taken to prevent the potential for further abuse. They could not demonstrate they had assessed any potential risks this ex-staff member may have presented to people.
● We asked staff about the presence of this ex-staff member, and they told us, "They come and go when they want. They have the code for the door so just let themselves in." We spoke with people who told us they often see the ex-staff member alone who often talked about the financial hardship they were going through.
● The nominated individual knew this ex-staff member was entering the building. They were also fully aware of the allegations of abuse and the dismissal of this ex-staff member. However, they failed to identify or mitigate any potential for harm. These concerns put people at the risk of harm from emotional/psychological abuse and financial abuse.

The provider failed to identify, assess or mitigate potential risks of abuse. This was 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.

Following our inspection site visit we raised concerns with the local authorities safeguarding team.

Inspected but not rated

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 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. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns raised with us regarding unsafe staffing and ineffective management. We will assess the whole key question at the next comprehensive inspection of the service.

At our last inspection the provider did not have effective systems in place to monitor and drive good and safe care provision. This was a breach of regulation 17 (Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection the provider remains in breach of regulation 17.

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

- The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of people who may be at risk. The provider failed to review their emergency evacuation plan to account for the reduced staff available to support people. This put people at the risk of harm in the event of an emergency.
- The provider failed to complete checks to ensure any potential risks to people had been identified and mitigated. For example, they failed to identify or monitor the access into the building and presence of an ex-staff member who had been previously dismissed following allegations of abuse.

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

Following our visit, the nominated individual informed us they had commissioned the services of a managerial consultancy to support them with restructuring their company. This would include the provision of an interim manager although no further details were provided.

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 would be safely supported in the event of an emergency.

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 failed to identify, assess or mitigate potential risks to people.

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 provider failed to have effective systems in place to drive good care.

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.