Mr & Mrs A J Bradshaw

Keswick House

Inspection report

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Date of inspection visit:
06 November 2018

Date of publication:
20 May 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This unannounced inspection took place on 6 November 2018. It was prompted by the outcome of a safeguarding investigation which had been carried out by the local authority and the allegation had been substantiated.

At our previous inspection in 16 September 2016 we found the service was good. At this inspection we found a significant deterioration in the quality of care and the overall rating for this service is Inadequate which means it will be in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

Keswick House is a residential care home registered to provide accommodation and personal care for up to 14 people with a learning disability. The house is next door to another of the providers services. At the time of the inspection 14 people were living there. We inspected this service within the principles of Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion and promote people with learning disabilities and autism using the service living as ordinary a life as any citizen. We found that the model of care at Keswick House was not supportive of these principles and that people did not have choice and control over their day to day lives.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had not taken action to ensure that people were safeguarded from abuse. They had failed to

respond and learn lessons from an incident that had resulted in psychological abuse of some people who used the service. There were still insufficient safely recruited staff to meet people's assessed needs. The provider could not be sure that staff were trained and safe to fulfil their roles.

The service did not always provide care that promoted people's independence as much as they were able. A lack of staff and resources meant that systems and routines had been put in place which prevented people from living as ordinary a life as possible. People did not always receive care that met their individual assessed needs.

People were able to take assessed risks when accessing the community independently and risks associated with health care conditions were minimised through risk assessment. People's medicines were stored and managed safely. Staff followed safe infection control procedures when supporting people to prevent the spread of infection.

The principles of the Mental Capacity Act 2005 (MCA) were being followed to ensure that people who lacked the mental capacity to agree to their care at the service were supported to do so.

People had enough food and drink of their liking to maintain a healthy diet. People had access to a range of health care professionals if they became unwell or their needs changed.

There was a complaints procedure. People we spoke with felt able to speak up about any concerns they had. Some people had plans put in place as to how they wished to be cared for at the end of their life.

Staff told us they felt supported and that the management was approachable.

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.

People were not always safeguarded from the risk of abuse and lessons were not always learned following incidents that had resulted in harm to people.

There were insufficient numbers of staff. Safe recruitment procedures had not been followed to ensure staff were of good character and fit to work with people.

Risks associated with health and community access were assessed and minimised.

Medicines were stored and administered safely.

Control measures were followed by staff to prevent the spread of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's holistic needs were not being met in line with national guidance.

Staff were not trained to support people in a health emergency.

People were supported to eat and drink food of their liking.

The principles of the MCA were being followed.

People had access to a range of health care professionals if their needs changed or they became unwell.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect and their right to privacy was not always upheld.

People told us they were asked about their care and support and that their choices were respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People did not always receive care that met their assessed needs.

People were supported to access the local community and with hobbies and activities of their liking.

The provider had a complaints procedure.

End of life plans were in place for some people who used the service.

Is the service well-led?

Inadequate

The service was not well led.

The culture of the service did not ensure that people were provided care and support with the principles of national guidance. There was no vision or plan for future care provision.

The provider had not taken action to ensure that people were safe from abuse and had sufficient staff.

Staff felt supported and liked the management.

Keswick House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was prompted in part by a notification of a safeguarding incident which had been investigated and substantiated by the local authority.

This inspection took place on 6 November 2018 and was unannounced. It was undertaken by one inspector and an assistant inspector.

We looked at information we held on the service including previous inspection reports. We reviewed notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with four people who used the service and observed others care and support. We spoke with four care staff, one relative who was visiting and the registered manager. We spoke with both of the providers.

We looked at the care files for three people who used the service. We also looked at various records held by the service such as the rotas, medicine administration records, weekly audits, one staff recruitment file and the safety checks the home completed.

Inadequate

Is the service safe?

Our findings

At the last inspection we found that the service was rated good. At this inspection we identified some serious concerns and have rated the safety of the service as Inadequate.

We had received information from the local authority that a safeguarding allegation of psychological abuse towards several people who used the service had been substantiated against a person who worked at the service. On the day of the inspection we found that this person had still been working and visiting Keswick House on a regular basis. The provider had not acted to minimise the risk of abuse occurring again and people were at continued risk of harm.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Prior to this inspection we received information from the commissioners in relation to some people's care, that they raised in connection to the staffing levels in Keswick House and they asked for a breakdown of the staffing hours and this had not been acted upon. The registered manager informed us that they were not aware of what the staffing budget for the home was and they were not able to increase or change staffing levels within the service. This meant that service users were at risk of not having their care needs met by sufficient staff. We found that there was no system in place to determine the required staffing levels to meet people's needs. In addition to this the registered manager did not have the freedom to adjust staffing levels to meet people's needs and tailor them to provide personalised care to people.

People we spoke with told us they thought there was enough staff to support them and on the day of inspection we observed some people going out in to the community on activities. However, we observed some people receiving minimum interaction throughout the day. We found that a lack of available staff meant that staff were not able to deliver care and support to people to live as independently as they were able to. We observed that people had limited involvement in preparing their meals and we saw that staff completed household tasks for people which meant that they were unable to gain the skills they required to move towards more independent living. We discussed with the provider the staffing levels that would be needed to make the service more personalised and they told us due to historically low fees that they would need to have a conversation with the commissioners of the service. This meant that people's care was not personalised to meet their individual needs and preferences due to a lack of sufficient numbers of suitably trained staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at how the provider ensured that new staff were of good character and fit to work with people who used the service. We found that staff members who had a criminal record which the registered manager had known about had not been risk assessed to assess the potential harm to others. This meant that their performance was not being closely monitored to ensure people were kept safe.

This concern constitutes a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People lived in an environment that was clean and in good decorative order. Cleaning schedules were in place and the staff completed infection control audits. Staff had access to personal and protective clothing. Staff undertook the responsibility for completing people's laundry for them and led on the cleaning of bedrooms.

People had risk assessments in place that looked at their individual needs such as fire evacuation, specific health needs and activities undertaken. People's risk assessments were reviewed and staff were asked to sign them to confirm their understanding.

People received their medicine on time from staff trained to administer. People had detailed protocols in place for 'as required' medicines. We reviewed what happened following a medicine error and found that the service had investigated the events which occurred and had taken necessary action. People's medicine were kept secure in a medicine trolley that was fixed to the wall.

Health and safety checks were completed in the service and external contractors brought in to complete tasks such as the buildings fire risk assessment and electrical safety testing. Items in the home were serviced within the required time scales for example the hoists and fire extinguishers. Detailed records were kept around wheelchair maintenance and staff had clear instruction of what they needed to check.

Accidents and incidents were recorded in an accident book. There had been very few accidents since the last inspection. Some people had behaviour monitoring charts in place and these were reviewed by the registered manager and the staff team in order to identify any patterns or trends.

Requires Improvement

Is the service effective?

Our findings

At the last inspection we found that the service was rated good. At this inspection we identified some concerns and have rated the effectiveness of the service as requires improvement.

Staff informed us that they received a range of training to support them in their role. However, we identified that some staff had not completed all the training allocated by the provider. Furthermore, most of the training was completed on line. We discussed first aid training with the registered manager and we were advised that staff had completed this online and therefore they had not participated in any practical learning exercises such as how to perform Cardiac Pulmonary Resuscitation (CPR). This meant that staff were unable to effectively respond in a medical emergency.

Keswick House is a spacious building yet we found that not all the space was used and that the configuration of the building limited people's opportunities. The laundry facilities remain in the basement which meant that people living at Keswick House were not able to participate in this activity. People were observed throughout the inspection congregating around the main kitchen/diner and at times the space was busy with several people doing different things while others sat watching, as opposed to being engaged in something themselves. One person told us, "The area gets crowded so sometimes some of us have to move away." We discussed with the registered manager how some changes to the environment could increase the outcomes for people.

People told us they liked the food the provider offered and that they received sufficient drinks throughout the day. We observed a large accessible menu on the wall which was supported by pictures of meals. One person told us," The food is good and we all get a choice of what we want."

People's care plans contained information that was specific to their needs. People who were new to the service had assessments completed that were then used to inform staff how that person should be supported. People's ongoing needs were reviewed by the provider on a regular basis and amendments were made to the care plan where required.

People had documents within their care plans that enabled staff to manage and respond to identified health needs such as health passports and health action plans. People's specific needs were monitored and records in the daily file were kept up to date. People who required their weight to be monitored were supported to weigh themselves monthly. Actions were followed up as required. We saw in the house diary that the home supported people to attend a range of different appointments, including going for blood tests, dentist appointments and opticians.

Staff worked well together and had systems and processes in place to ensure information was shared within the team. There was a central file that staff used on a daily basis to record key information and handover discussions took place between day and night shifts. Team meetings took place and minutes were made available for staff to read. One staff member told us," We are made aware that there has been changes to someone's support plan and then we read and sign to confirm we have taken on board the information." We

observed that Keswick House maintained a close working relationship with other homes in the community and shared resources as well as organised joint events.

Peoples capacity to consent to their care and support was sourced and we saw that the provider considered best interests when it was deemed that a person lacked capacity. Staff were able to explain their responsibilities under the Mental Capacity Act and one staff member explained, "We breakdown information for people to help them make a decision and when supporting people we explain what we are doing and why." 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 who were subject to a deprivation of liberty had the required paperwork in place indicating that the relevant assessments and safeguards had been considered. Four people were subject to a deprivation of liberty at the time of inspection. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. 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 that the correct documentation was in place and conditions were being met by the staff team.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we found that the service was rated good. At this inspection we identified some concerns and have rated the service as requires improvement.

A recent safeguarding allegation about how some people who used the service were treated had been recently substantiated by the local authority. The provider had not recognised that the way in which some people had been spoken to and about was disrespectful and unkind. This meant that people were at risk of not being cared for in a kind and respectful manner.

Our observations during the inspection were that people interacted with each other in a positive way and that people got on well. One person told us, "We do occasionally fall out but we always sort it out in the end." We heard lots of laughter over the course of the day and a relative told us, "The home is very caring and I never worry about what is happening when I am not here." One staff member told us, "I love it here as there is a real family atmosphere." We spoke with the registered manager about the family atmosphere and they told us that it was one of the homes strengths but that they were aware of the need to ensure that staff understood their professional boundaries and they were working on changing the culture as there had been blurred lines.

The provider had recently extended its registration with CQC to accommodate someone from the local community who had additional needs. Staff told us that they were undertaking additional training to be able to support this person in receiving the correct support. The person told us, "The staff are good to me and they have made me feel very welcome, I've settled in ok".

Peoples files were kept secure and staff signed as part of their daily tasks that information was secured. We did highlight to the registered manager that there was a note on the communal wall planner that someone required cream however as soon as this was identified, this was removed.

The registered manager told us that they were in the middle of organising some joint work with the local college around the subject of dignity and respect to increase staff knowledge and improve on the experiences of people living in the home

People were engaged in conversation about the home and we saw minutes of the monthly house meetings which were chaired by a person living in the service. Minutes of house meetings were taken and they were in an accessible format to ensure people had access to the information recorded. Topics discussed included activities, events and safety issues for example the group talked about fire safety and discussed inviting the fire brigade to the house to talk to everyone.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection we had no concerns in the responsiveness of the service. At this inspection we found this area required improvement.

People did not always have access to person centred activities that enabled them to learn skills in caring for themselves within the home, such as cooking, washing and cleaning and other household tasks. We found that the culture of the home was focused on doing things for people more so than enabling people to progress. We observed that staff led on activities in the kitchen and there was little encouragement to get people to join in the cooking. We saw minutes of house meetings where one person repeated a desire to participate in cooking meals. This meant that people were not being supported to be as independent as they were able to be and their aspirations may not be being met.

We saw that staff were responsive to people's physical wellbeing and saw staff supporting people with physiotherapy exercises. We also observed people engaging in table top type activities as well as a group of people going to a local centre. One staff member told us, "We try to get people involved in activities that they will enjoy and that they choose to do." In one person's care file we noted the home supported them to go fishing which the person later told us they really enjoyed.

We asked the registered manager if anyone who used the service had any specific cultural, spiritual or sexual needs protected under the Equality Act 2010. The registered manager told us they supported one person who originated from another country and we saw that this information had been recorded in their file. We discussed the cultural needs of the others living in the home and how it was important that people could recognise what was important for them for example, celebrating Christmas and Easter.

People had access to an accessible complaints procedure that was displayed on the notice board. People told us that they knew how to raise a concern. One person said, "If I was unhappy about something I would just tell the staff or the boss." We spoke with a relative who told us, "I have never had to raise a complaint but I would speak with the manager if I needed to." We spoke with several staff members who were all able to explain the homes procedure and what they would do should someone raise a compliant with them. We spoke with the registered manager who told us they had not received any recent complaints. On the notice board we observed the outcomes of a survey completed with the people living at Keswick House and the feedback was that people found the service was responsive.

There was no one receiving end of life care at the service. The registered manager told us that some people's relatives had funeral plans in place for their loved ones and these were readily available in their care plans if needed.

Inadequate

Is the service well-led?

Our findings

At our previous inspection we rated well-led as good. At this inspection we found this area was inadequate.

We found that the provider had not taken action to minimise the risk of abuse to people by taking action following a recent safeguarding investigation which had been substantiated. People living in Keswick House were at risk due to the ongoing contact from the person involved with the service. The provider had not learned lessons from the investigation and looked at how the interactions between themselves, staff and people should be based on a professional approach at all times.

The provider had not ensured that staff working at the service were suitable and safe to do so. This meant that people were put at risk as the designated quality checks had not been carried out and any risks identified with individual staff members had not been assessed and minimised prior to them working with people.

The culture of the service was not following the national guidance in how to support people with learning disabilities to live in the community. Some people had resided at the service for many years and they were restricted in their opportunities to learn new skills and work towards independence. Routines and systems had been put in place which restricted people's ability to be as independent as they were able to be. The provider told us that the funding they received was not sufficient to be able to create the environment conducive to meeting the best practise guidance. However, there was no clear strategy or vision for the service of how they should work towards delivering care in line with the national guidance now and in the future.

These issues constitute a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received supervision and completed lots of training however we identified that not all staff had completed their training and that some of the training undertaken was not giving people the full skill set that they required.

Staff told that they felt well supported by the registered manager and that they could get support whenever they needed it. One staff member told us, "The manager's door is always open and they will always come and help with the care if we need some extra support. They have an excellent relationship with the people living here."

Staff completed audits throughout the month that were reviewed by the deputy manager and registered manager. Area's looked at included care planning, medicines, health and safety and the cleanliness in the home. Staff told us, "The manager always sorts things straight away when we identify there is a problem or something needs changing."

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 19 HSCA RA Regulations 2014 Fit and proper persons employed Staff were not always safely recruited as staff with criminal convictions did not always have their suitability to work with vulnerable people who used the service risk assessed.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always being protected from potential abuse following allegations being substantiated.

The enforcement action we took:

Notice of Proposal, followed by Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Lessons were not always learned following safeguarding investigations. The culture of the service was not following the national guidance in how to support people with learning disabilities to live in the community. Governance systems were not effective.

The enforcement action we took:

Notice of Proposal, followed by Notice of Decision

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not always enough staff to support people effectively.

The enforcement action we took:

Notice of Proposal, followed by Notice of Decision