

Keepence Homes

Keepence Homes

Inspection report

19 Wilcot Road
Pewsey
Wiltshire
SN9 5EH

Tel: 01672562746

Date of inspection visit:
10 September 2020

Date of publication:
13 October 2020

Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

Inspected but not rated

Is the service effective?

Inspected but not rated

Is the service well-led?

Inspected but not rated

Summary of findings

Overall summary

About the service

Keepence Homes is a care home providing accommodation and personal care for up to four people that may have a learning disability or an autistic spectrum disorder. Four people were living in the home at the time of this inspection.

People's experience of using this service and what we found

The service didn't always consistently apply the principles and values of Registering the Right Support and other best practice guidance. These ensure that people who use the service can live as full a life as possible and achieve the best possible outcomes that include control, choice and independence. The outcomes for people did not fully reflect the principles and values of Registering the Right Support, because people's capacity had not been assessed appropriately in line with the Mental Capacity Act. Some choices around accessing the community, visiting relatives and access to pain relief were at times restricted.

People were not always supported to have maximum choice and control of their lives. Mental capacity assessments were not in place or reviewed in order to ensure that staff supported people in the least restrictive way possible and in their best interests. The policies and systems in the service did not support this practice.

Risk assessments were not in place for people at risk of self-harm. Important information was not recorded on people's hospital transfer documents. Actions and investigations from incidents were not recorded to ensure lessons were learnt and actions could be reviewed. Medicine management still needed improvement to be safe. The service was not following department of health guidelines for working safely in care homes during the coronavirus pandemic. This was a continued breach of Regulation 12 Safe care and treatment.

Recruitment checks were still not always thoroughly completed before staff started working for the service. Staffing levels continued to negatively impact on people's involvement in external activities and support. This was a continued breach of Regulation 18 Staffing.

The service was not always working within the principles of the Mental Capacity Act and assessments had not always been completed. This was a continued breach of Regulation 11 Consent.

The provider had failed to implement a robust system to action and drive improvement within the service. There was a lack of oversight and good governance to ensure people received a safe and well managed service that was committed to making the necessary changes. This was a continued breach of Regulation 17 Good Governance.

The provider had failed to submit seven notifications without delay. This was a continued breach of Regulation 18 Notifications of other incidents.

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

Rating at last inspection and update:

The last rating for this service was Requires Improvement (published 29 March 2019) and there were multiple breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had not been made or sustained and the provider continued to be in breach of regulations.

Why we inspected

We undertook this targeted inspection to check if the breaches of Regulations 11, 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, had been met. The overall rating for the service has not changed following this targeted inspection and remains Requires Improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check 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 are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

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 speak with this provider to discuss our proposed actions. We will work alongside the provider and local authority to monitor progress. We will 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?

Inspected but not rated.

Inspected but not rated

Is the service effective?

Inspected but not rated.

Inspected but not rated

Is the service well-led?

Inspected but not rated.

Inspected but not rated

Keepence Homes

Detailed findings

Background to this inspection

The inspection

This was a targeted inspection to check whether the provider had met the requirements of the breaches in relation to Regulation 11 Need for consent, Regulation 12 Safe care and treatment, Regulation 17 Good governance and Regulation 18 Staffing of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009.

Inspection team

The inspection team consisted of two inspectors.

Service and service type

Keepence Homes is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave a short period notice of the inspection. This was due to the current pandemic to allow the service time to implement any additional infection control measures for the visit.

What we did before the inspection

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During the inspection

People in the service had limited verbal communication and expressed themselves mainly through signing, gestures, expressions and sound. We observed two people during our time in the service and spoke with the

registered manager and one member of staff at the service.

We reviewed a range of records. This included three people's care records and all four medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at training data and meeting minutes. We spoke with two relatives and three members of staff away from the service.

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. 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.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly manage risks and incident investigations. This was in a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found these concerns had not been addressed. The provider remains in breach of Regulation 12 Safe care and treatment.

- Risk assessments around self-harm had still not been put in place. The registered manager confirmed this had not been addressed. We saw risk assessments were in place for other risks such as financial support and preparing hot drinks.
- People's hospital passports that transferred with them if they needed to leave the service did not always contain important information for external professionals to be aware of. For example, one person who was at risk of self-harm did not have this on their hospital passport. Another person whose behaviour could at times be aggressive did not have this information included. This meant there was a risk if people transferred into another setting they would not be kept safe as important information had not been shared.
- It was hard to establish what had been reviewed and updated. A front sheet at the start of people's care plans said that all care plans were reviewed in August 2020, however individual care plans had dates ranging from 2016/2017. We saw that information had not been added to people's hospital passports or disability distress plans to reflect a review of these, or updated following recent incidents.
- We reviewed the recording of behaviour incidents and saw these continued to need more detail on outcomes to be an effective review. For example, one outcome was recorded as, 'staff simply told the person to stop'. There was no further information about if this had been effective. In addition, other responses to this person differed from this approach. The consistency of the approaches had not been reviewed to ensure documentation was completed correctly and that this person received support that was appropriate to their needs.
- We could not be assured that people were protected from inappropriate or unsafe care as records were not always up to date or detailed enough. Incidents and accidents that people had experienced were recorded in a folder. We found that there was not always clear information about the incident, or the actions taken.
- For example, a bruise and red marks had been noticed on one person. There was no information about an investigation into how this person may have come by these marks. The registered manager told us they did discuss things verbally as a staff team, but the written review needed to be better. Another person had experienced a seizure, hit their head and had a carpet burn to their face. It did not show that any medical advice had been sought. The registered manager explained they had hit their head on a foam bed but the incident form did not record any details to be a sufficient record of this event.

The shortfalls relating to risk management and learning from incidents was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Improvements had been made to risk assessments to ensure they were clear and contained detail for staff to minimise the risks to people.
- Risk assessments recorded the positive impact of taking the identified risk for that person and the negative impact of not taking it, such as a low self-esteem; or a reliance on others. Risk assessments had a pictorial element which made them accessible for the people living in the service.
- Personal evacuation forms were in place, detailing the support a person would require in the event of an emergency. We saw this had considered people's sensory and communication needs within the plan.
- Care plans contained clear detail for staff to support people at times of heightened behaviours or displays of anxiety. Staff told us they felt confident in managing any aggressive or verbally challenging behaviours that people exhibited at times. One staff member said, "Because we know them well you can see the triggers that can set people off. I feel confident and had training."

Using medicines safely

At our last inspection the provider was not managing medicines safely for people. 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 we found these concerns had not been addressed. The provider remains in breach of Regulation 12 Safe care and treatment.

- People were not protected from unsafe management of medicines. The service did not always have clear guidance or recording for 'when required' (PRN) medicines. We saw two people did not have PRN protocols in place for some prescribed medicines. This meant that there was no clear guidance for staff about when or how to administer these medicines.
- Handwritten medicine administration records (MARs) were not always completed in line with National Institute for Health and Care Excellence (NICE) guidance. Some handwritten MARs did not have the route, form or dose clearly recorded.
- Handwritten MARs had not been signed to indicate it had been checked by another competent person. This meant that there was no system to check for potential errors.
- We requested evidence that staff competency to administer medicines was checked, however the registered manager was not able to provide this. NICE recommend that medicines competency should be assessed annually.
- Regular audits were completed to check that medicines were being administered safely, however these had not identified the above concerns.

The failure to manage medicines safely was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- People were not protected from the risk of infection as the service was not following Department of Health guidelines for working safely in care homes during the coronavirus pandemic. The registered manager informed us that staff were not wearing masks as the staff were in a 'bubble' with people using the service. However, there was no risk assessment in place to support this practice.
- The registered manager told us that people were distressed by staff wearing masks, however masks had been tried for one day only, and supportive tools such as social stories had not been used to support people to adjust to personal protective equipment (PPE).
- Staff had not been trained in 'donning and doffing'. Donning and doffing is the process of putting on and

taking off PPE in a way that minimises risk of infection.

- The registered manager told us that gloves and aprons were worn for personal care, however there were no aprons in stock at the time of our inspection. Current Department of Health guidance states that gloves, aprons and masks should be worn when providing personal care in a care home during the coronavirus pandemic.
- The service had cleaning schedules in place, however there was no evidence to suggest additional cleaning measures had been implemented in response to COVID-19. The registered manager informed us that high touch points, such as door handles, were cleaned two to three times daily, however there was no documentation to support this and this was not observed.
- The home had access to 'whole home' testing. This meant that all staff and people had access to a COVID-19 test, however these had not been completed. The registered manager told us all staff had been tested at least once outside of the home since the beginning of the pandemic.
- The registered manager stated that people living at the service had not been tested as this would be too distressing, however there was no mental capacity assessment to support this decision.
- People had been denied home visits due to the risk of COVID-19, however there was no risk assessment or mental capacity assessment to support this decision.
- The infection control policy in place was written in 2015 and due for review in 2016. This had not been updated in response to the COVID-19 pandemic
- Staff gave mixed feedback on the measures the service was taking. One staff member told us, "I feel it's right for what we are doing and we are in a bubble." Another staff said, "I think that if anyone within the house became infected with COVID-19, we would stand zero chance of not all becoming infected."

These shortfalls are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff recorded people's temperatures twice daily. This meant anyone with a fever could be identified promptly.
- There was a clear visiting policy in place, people were supported to have short visits with their family outside, following social distancing guidelines.
- Following this inspection, the registered manager sent supporting documentation around high touch point cleaning, COVID-19 visitor risk assessment and a COVID-19 contingency plan which would be implemented going forward. The registered manager also informed us the staff had now begun to wear PPE within the service.
- The service is due to receive a visit from the local Public Health team for a further assessment of their infection control measures.

Staffing and recruitment

At our last inspection there were shortfalls identified around staffing. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found these concerns had not been addressed. The provider remains in breach of Regulation 18 Staffing.

- Staff continued to raise concerns about feeling pressured supporting people with very complex needs and having to lone work at times. Staff told us, "One person must be monitored while eating (due to choking) and on occasions will go up and down stairs (has had falls) it can get tricky to monitor another's seizures if you are lone working. I have raised my concerns on occasions to the manager. Another person cannot walk downstairs unaided, this is worrying." The registered manager told us the staffing levels had not improved or changed since the last inspection and there was pressure for staff with people's increasing needs.
- The registered manager spoke to us about the large turnover of staff the service had experienced since the

last inspection and how this has impacted them being able to manage effectively. They commented, "I don't have time to do the management role and the support worker role, I am a support worker by heart." The provider did not have a dependency tool or system in place to effectively calculate staffing. The registered manager told us the rota was worked out according to what was planned in the week.

- People were still experiencing restrictions in being able to access the community and attend activities they chose without advance planning. The registered manager confirmed that activities still had to be scheduled when there was enough staff. One staff member told us, "Sometimes we don't have enough staff. To be able to take them out can be restrictive at times. You have to really plan what you are going to do and who you can take. We used to be able to go out together in a bigger vehicle and now it's more restrictive as we don't have this."

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

- There continued to be areas of improvement needed in the recruitment process. Staff did not always have health declarations completed prior to employment to ensure they were medically fit to undertake their role.
- Staff identification documents were not always signed and dated to show when the original copies had been seen.
- The service did not have a policy for renewing staff's DBS checks. DBS (Disclosure and Barring Service) checks help employers make safer recruitment decisions and prevent unsuitable people working with vulnerable adults. We saw one staff members Criminal record check was last completed in 2012. This meant that the service may not have up to date assurance that staff were of sound character.

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

Ensuring consent to care and treatment in line with law and guidance

At our last inspection the provider was not following the principles of The Mental Capacity Act 2005 appropriately. This was a breach of regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found these concerns had not been addressed. The provider remains in breach of Regulation 11 Need for Consent.

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 found that this was not always appropriately followed.

- People's rights were not always protected as they did not always have mental capacity assessments completed for having 24 hour staff support and for not being able to leave the home without a staff member accompanying them. We saw that the same two people should have had this in place following our last inspection, however the registered manager confirmed that this had not been done.
- Not everyone had clear documentation in place to evidence that a DoLS application had been made or reviewed around the restrictions put in place. Following our inspection, the registered manager sent further documentation which showed one person had an application sent but it expired in 2015. There was no further supporting documentation to show this had been followed up or reviewed during this time to ensure the least restrictive methods were being used.
- Another application was sent for one person but there was no date on this to evidence when this had been applied for. This person also had no documented review completed of the current restrictions in place.

This continues to be a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We saw that some people had mental capacity assessments in place for specific medical decisions undertaken by the learning disability team. For example, the need to have a blood test or to manage their

finances independently. These recorded how the person had been supported to try and understand the information to make the decision and who else had been involved in this process.

- We saw that people's care plans contained information about their ability to make daily decisions and the kinds of decisions they needed more support with. All staff had received training in MCA and DoLS. One staff commented, "My understanding is that all adults are assumed to have capacity unless proven otherwise. Apart from medical interventions my knowledge is that our service users have capacity. To support someone to make a decision, it must be in the individual's best interests."

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

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

At our last inspection the provider was not submitting notifiable events to The Care Quality Commission as per their registration responsibilities. This was a breach of regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009. At this inspection we found these concerns had not been addressed. The provider remains in breach of Regulation 18 Notification of other incidents.

- Seven notifications had not been submitted to CQC in a timely manner. Some were delayed by two months.
- There was no system in place to monitor this to ensure these were sent appropriately.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

At our last inspection the provider had not robustly assessed and monitored the quality and safety of the service. 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 these concerns had not been addressed. The provider remains in breach of Regulation 17 Good Governance.

- The provider had failed to implement a robust system to action and drive improvement within the service. There was a lack of oversight and good governance to ensure people received a safe and well managed service where the leadership team were committed to making the necessary changes. No action plan was in place and there was little or no evidence of any improvements made. The provider continued to be in breach of the Regulations from the last inspection.
- We were unable to review the systems in place to monitor the quality of the service as there was a lack of documented evidence. The registered manager was unable to provide infection control audits, an improvement plan and a business continuity plan. Several policies were either out of date or lacked information to make them effective.
- There was a failure to ensure robust systems were in place to ensure notifications were submitted to CQC in a timely manner.
- Staff told us the registered manager was approachable, but they did not always feel supported by the management team. Comments included, "[Registered manager name] is approachable at a superficial level, will 'say' with much confidence what you want to hear" and "Not always supported, if new things happen and you have not been in for a few days you don't always get informed, we hear from other staff. We don't

see much of the provider in the home."

This was a continued breach of Regulation 17 of the Health and Social Act 2008 (Regulated Activities) Regulations 2014.

- We saw that staff meetings had continued where possible. Staff spoke positively about the staff team commenting, "Members of staff who are kind and caring work well together as a team and provide good support" and "We are a small house and you get used to the staff you work with, we are friendly and support each other and know people well."
- Relatives told us they were kept informed about their relatives care and were happy with the service. They said, "No concerns at all, never have. They keep in touch and ring" and "It is well managed, we get on well with the manager, she's really nice, can ring her for a chat."