Kevindale Residential Care Home

Keegan's Court Residential Care Home

Inspection report

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Tel: 01588638898

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**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 needs to a maximum of 19 older people. Accommodation is provided in an adapted building providing 15 beds and two bungalows in the grounds, each providing two beds. At the time of the inspection, 14 people were using the service.

People's experience of using this service and what we found
Risks to people's safety and well-being were not always considered and plans to mitigate risks were not in place or had not been reviewed.

Action had not been taken to reduce the risk of scalding from hot water outlets. Information about how people should be safely evacuated in the event of an emergency was not available for each person who lived at the home.

People were not protected by the procedures for the management and administration of medicines.

Infection, prevention and control procedures did not protect people from the risk of infection.

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

Rating at last inspection. The last rating for this service was inadequate (report published February 2021)

Why we inspected
We undertook this targeted inspection to check whether the provider had taken action to address the more serious concerns in relation to Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 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.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

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.

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.

We have identified continued breaches in relation to safe care and treatment. 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
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or varying the conditions 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.

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

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.

We will assess all of the key question at the next comprehensive inspection of the service.

Keegan's Court Residential Care Home

Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check whether the provider had taken action to address the more serious concerns identified at the last inspection in relation to Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The concerns related to assessing and monitoring risks, fire safety and risks associated with hot water.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by two inspectors.

Service and service type
Keegan's Court 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 who was also the provider. This means that they are legally responsible for how the service is run and for the quality and safety of the care provided.

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. This included information received from the provider. We sought feedback from the local authority and professionals who work with the service. 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. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with four members of staff which included a senior carer, two carers and an administrator.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at one staff file in relation to recruitment, supervision and training. A variety of records relating to the management of the service, including policies and procedures and quality monitoring were reviewed.

After the inspection
We met with the provider to discuss our findings and to seek assurances about the action they would take to ensure people were safe.

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. 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 follow up on the specific concerns we had about Keegan's Court Residential Care Home. We will assess all of the key question at the next comprehensive inspection of the service.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to robustly assess the risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12

- At our last inspection we found risk assessments associated with people's health, well-being and personal care needs had not always been considered or regularly reviewed. Care plans were not always developed to manage known risks. This meant people could be at risk of receiving unsafe or inappropriate care.
- Following our last inspection, the provider gave reassurances that this had been addressed however, we found that this was not the case. Risk assessments and care plans had not always been completed to mitigate and manage risks.
- Despite reassurances from the provider we found checks on bath hot water outlets were still not being carried out to ensure temperatures remained within safe limits. The temperatures of hot water outlets in wash hand basins were well in excess of safe limits and there was no warning signage in place. The only signage we saw was to remind staff of the safe temperature when assisting people to have a bath. This placed people at risk of scalding.
- Personal Emergency Evacuation Plans (PEEPS) had still not been completed for all the people who lived at the home. This meant staff and the emergency services would not have access to important information to enable them to evacuate people safely in the event of an emergency.
- Environmental audits were not being carried out to ensure that risks to people were minimised. Therefore, people could not be confident the environment would be safe and conducive to their needs.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety or risks were 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.

● Following our last inspection, the provider had removed the combination locks from stairgates and replaced with a sliding bolt which meant people could be evacuated promptly in the event of an emergency.
● The provider had taken action to ensure the shaft lift had been serviced and was safe to use and that risks associated with legionella had been addressed.

Preventing and controlling infection
● Despite reassurances from the provider following the last inspection, they had continued to fail to assess and manage risks associated with the control and spread of infection.
● Cleaning schedules had not been reviewed or updated since the corona virus pandemic which began in March 2020. There was no regular wiping down of touch points to reduce the spread of infection.
● The infection prevention control policy (IPC) in place had not been reviewed or updated to reflect the COVID-19 pandemic. This meant staff did not have access to up to date information about how to reduce the risk of infection. This placed both people who use the service and staff at risk of harm.
● Bins provided for the disposal of personal protective equipment (PPE) were not foot operated. This increased the risk of the spread of infection.
● The walls in the laundry were not fitted with impermeable coverings which meant they could not be easily cleaned. The cupboard doors under the sink were damaged and the sink was dirty. This meant there was an increased risk of the spread of infection.

Using medicines safely
● Following our last inspection, the provider told us they had implemented systems to record the administration of topical medicines. At this inspection, records could not be located, and staff told us they didn't know anything about forms to record the administration of creams. This meant there was a risk that staff would not know how, when and where the prescribed creams should be applied.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety or risks were 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.