Kevindale Residential Care Home

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Inspection report

Kevindale
Broome, Aston On Clun
Craven Arms
Shropshire
SY7 0NT

Tel: 01588660323

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Kevindale Residential Care Home is a care home providing support with personal care needs to 13 people at the time of this inspection, some of whom were living with dementia. The home can accommodate a maximum of 14 older people in one adapted building.

People's experience of using this service and what we found
People were not always safe as the physical environment was not effectively or safely maintained. Fire safety systems had not been routinely checked and the provider failed to identify or mitigate compromised fire safety measures.

The provider did not have effective systems in place to identify environmental issues which could put people at the risk of harm.

The provider did not demonstrate effective infection prevention and control procedures were followed.

The provider did not have robust recruiting systems in place when appointing new staff.

The provider did not have effective quality monitoring procedures to drive good care.

People received their medicines as prescribed. Staff understood how to protect people from the risk of abuse and knew what to do if they suspected something was wrong.

People had assessments of risk associated with their care and support. People had individual personal emergency evacuation plans in place.

The provider had kept us informed about key events and had good working relationships with others involved in peoples care. People and staff told us they found the management team to be approachable.

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 Requires Improvement (published 10 September 2021).

At that inspection we found the provider needed to embed improvements required at the previous inspection.

Why we inspected
The inspection was prompted in part due to concerns received about the management of the location. A decision was made for us to inspect and examine those risks.

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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

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

Following our inspection site visit the provider took action to mitigate the immediate risks to people including conformation of the vaccination status of staff members, fire safety checks and removal of items likely to cause harm.

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 breaches in relation to keeping people safe, recruitment and the providers monitoring of the provision of care at this inspection.

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 request an action plan from the provider to understand what they will do to improve the standards of quality and safety. 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Kevindale 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.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 completed by two inspectors.

Service and service type
Kevindale 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. 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. The registered manager 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
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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. Local authorities together with other agencies may have responsibility for funding people who used the service and monitoring its quality.

During the inspection
We spoke with three people who used the service about their experience of the care provided and we spent time in the communal area observing the support people received. We spoke with four staff members including two carers, administrator and registered manager. We looked at four peoples care and support plans and several documents relating to the monitoring of the location and health and safety checks. We checked the recruitment of four staff members.

After the inspection
We continued to seek clarification from the provider to validate evidence found and to confirm the action they had taken to mitigate risks to people.

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.

Assessing risk, safety monitoring and management

● The provider failed to ensure their fire safety systems were safely applied. The fire alarms and emergency lighting had not been checked as working for several months. We saw multiple fire doors wedged open with wood, stones and a bin. There was insufficient signage to direct people in the event of a fire. We saw an emergency exit blocked by bags of washing and the provider had failed to walk the escape routes to ensure they were safe and accessible. The provider failed to secure their liquid petroleum gas cylinders creating a potential risk of fire should they fall. In two locations we saw electrical extension leads were in use. One extension lead was plugged into another extension lead without any evidence the total electrical load had been assessed. This created a risk of fire.

Following our inspection site visit we contacted Shropshire Fire Rescue who attended and provided guidance and advice to the provider.

●The provider did not consistently ensure the physical environment was safe for people. For example, we saw radiators which had not been covered and were very hot to the touch. This placed people at the risk of burns should they have contact with the exposed metal work. There was a large water boiler located on a worktop in a kitchenet area which was accessible to people. This put people at risk of scalds should they have contact with this piece of equipment.

●We saw carpets leading from the conservatory into the lounge were wrinkled and coming away from their grippers. This presented a risk of trips and falls to people with impaired mobility. Lighting on one corridor was broken and created a dim and unlit area for people to travel. This increased the risk of trips or falls.

● We saw multiple locations throughout the building where cleaning products had been left out and were accessible to people living at Kevindale Residential Care Home. This put people at the risk of harm from accidental ingestion.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. We saw one wall where the plaster was coming away and peeling the paint hampering effective cleaning practices. We saw over chair tables which were showing surface bubbling indicating water ingress and hampered effective cleaning. We saw high frequency touch points, including light switches, which has sticky tape applied which hampered effective cleaning.

● We were not assured that the provider was making sure infection outbreaks could be effectively prevented or managed as their, procedures and understanding of changes did not match current best practice in this area.

● We were not assured that the provider's infection prevention and control policy was up to date as they did not have a designated IPC lead.
● We were not assured that the provider was using PPE effectively and safely. For example, we saw one staff member going into people's rooms administering medicines and distributing newspapers without wearing any PPE.
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. We found the service did not have effective measures in place to make sure this requirement was being met.
● The provider had only confirmed the vaccination status of two staff members but was in the process of contacting all other staff to gather this information.

Following this inspection site visit we received evidence from the provider confirming they had acted to remove the immediate risks to people. Including, but not limited to, removing the hot water boiler, removing door wedges, a check to the fire systems and engagement with Fire Rescue professionals.

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. These issues constitute a breach of Regulation 12: Safe Care and Treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to follow safe procedures for preventing the spread of infectious and communicable illnesses. For example, the provider had failed to monitor the vaccination and COVID-19 status of staff. We asked the registered manager about their understanding of vaccination as a condition of deployment for their staff. They had only just introduced a system for checking and to date had confirmed the vaccination status for two staff members. However, they could not confirm whether all staff had received their vaccination and were safe to support people.

Staffing and recruitment
● The provider did not follow robust or safe recruitment checks. For example, the majority of staff files we saw had DBS checks originating from Scotland. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with others. We asked the provider about this and they could not assure us these checks extended to England or other areas within the UK. The checks did not specify whether a person had been barred from work as the check only confirmed "The applicant has no unspent convictions." The provider failed to check people's right to work and failed to retain copies of original documents seen. We saw one staff member was appointed without an application form, checks to their identity, confirmation of right to work or any DBS check. The provider could not demonstrate this person was a fit and proper person to work with others.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate staff employed were fit and proper persons. This placed people at risk of harm. These issues constitute a breach of Regulation 19: Fit and proper persons employed, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Although people continued to receive their medicines as prescribed the provider failed to complete checks to assure themselves this was safely completed. For example, the provider had not completed a check of the medicines for several months. We saw the medicines trolley was not secured when not in use

and unattended. We raised this with staff members on multiple occasions and at no point was this corrected. We saw the securing point for the trolley was blocked by a dining table. We saw some people's topical creams were stored in a kitchenet area when they should have been returned to a secured area.
● Some people took medicines only when they needed them, such as pain relief. There was appropriate information available to staff on the administration of this medicine including the time between doses and the maximum to be taken in a 24-hour period.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse and ill treatment as staff members had received training on how to recognise and respond to concerns. We saw information was available to people, staff and visitors on how to report any concerns.
● Despite the provider expressing struggles with recruitment and retention of staff during the pandemic we saw people were supported by enough staff who were available to safely and promptly assist them. Those we spoke with told us they were helped when they needed it and there were no delays in the support delivered.

● We were assured the provider was preventing visitors from catching and spreading infections as the they had implemented effective checks on those entering the premises.
● The provider was facilitating visits for people living in the home and completed checks in accordance with the current guidance.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.

Visiting in care homes
● The provider was supporting visits to Kevindale Residential Care Home in line with the Governments guidance.

Learning lessons when things go wrong
● The provider looked at incidents which affected the safety of people. For example, the provider reviewed incidents or accidents to ensure appropriate action was completed.
● People had assessments of risk associated with their care and support including the risk of trips, falls and skin integrity. Staff knew how to safely support people. People had individual personal emergency evacuation plans in place.

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.

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

- The provider had ineffective systems to monitor the quality of the service they provided. For example, their checks had failed to identify or rectify exposed radiators, impeded fire protection systems, unsecured cleaning products, unsafe flooring, they failed to complete medicines checks and failed to address unsafe staff recruitment procedures.

Continuous learning and improving care

- The management team at Kevindale Residential Care Home failed to evidence they had kept themselves up to date with requirements in legislation. They failed to implement safe systems for staff to maintain an up-to-date vaccination status (by providing guidance and assistance for staff to get vaccinated) and ensure staff maintain up-to-date best infection prevention and control (IPC) practice.

We found no evidence that people had been harmed however, managerial oversite and environmental assessments were either not in place or robust enough to demonstrate their quality monitoring was effective. These issues constitute a breach of Regulation 17: Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The 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 required timescale.
- We saw the last rated inspection was displayed in accordance with the law at Kevindale Residential Care Home .

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people. Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People told us they felt involved in decisions about where they lived including what to do and what to eat. The provider had systems in place to receive feedback from people and relatives.
- All those we spoke with said the management team was approachable and they felt supported by them. Staff members told us they found the management team supportive and could go to them at any time.

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.

● The provider was aware of their responsibilities under the Duty of Candour. The Duty of Candour is a regulation which all providers must adhere to. Under the Duty of Candour, providers must be open and transparent, and it sets out specific guidelines' providers must follow if things go wrong with care and treatment.

Working in partnership with others

● The management team had established and maintained links with the local communities within which people lived. For example, GP practices, district nurses and social work teams.

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 the physical environment within which people lived was safe. The provider failed to follow effective infection prevention and control practices including failing to have a system to monitor staff members vaccination status.

The enforcement action we took:

We have issued the provider with a warning notice instructing them of a date by which they are to be compliant with the law.

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 effective quality monitoring systems in place to drive good care.

The enforcement action we took:

We have issued the provider with a warning notice instructing them of a date by which they are to be compliant with the law.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider did not complete robust checks when employing staff members.

The enforcement action we took:

We have issued the provider with a warning notice instructing them of a date by which they are to be compliant with the law.