Kevindale Residential Care Home

Keegan's Court Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

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, 16 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.

People were not protected by the provider's staff recruitment procedures. The provider failed to ensure staff received the required support to meet people's needs safely.

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

People were at risk of not receiving a service which met their needs and preferences.

The service was not effectively managed and there were no systems in place to monitor the quality and safety of the service provided. The provider had failed to act on the breaches of regulations identified at our last inspection.

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 two ratings for this service was requires improvement. (Report published February 2020) 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 not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This was a planned inspection based on the previous rating.

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.

Ratings from the previous comprehensive inspection for those key questions we did not look at were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

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 breaches in relation to safe care and treatment, person-centred care and good governance 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
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 to varying the conditions the 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? The service was not safe	**Inadequate**
Is the service responsive? The service was not always responsive	**Requires Improvement**
Is the service well-led? The service was not well-led	**Inadequate**

Keegan's Court 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 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. 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
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. 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 four people who used the service about their experience of the care provided. We spoke with four members of staff which included the provider, who is also the registered manager, a senior carer, carer and the cook.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files 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 used our enforcement powers which required the provider to provide assurances that action had been taken to address our immediate concerns relating to the safety of people who lived at the home.

Inadequate

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 now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

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

- The provider had failed to protect people against the risks associated with equipment servicing, fire safety, scalding and legionella. Environmental audits were not being carried out to ensure that risks to people were minimised.
- The provider was unable to produce evidence that the shaft lift was safe to be used.
- Monthly checks on bath hot water outlets were 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.
- There were no records to confirm people were protected against the risks associated with legionella. Appropriate risk assessments had not been completed and routine testing certificates could not be provided.
- Stairgates at the bottom of both staircases were secured with combination locks. A member of staff we spoke to was unaware of the combination to one of the locks. This meant people could not be safely and promptly evacuated in the event of an emergency.
- Personal Emergency Evacuation Plans (PEEPS) had only been completed for five of the 16 people who were living 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.
- 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.

Preventing and controlling infection

- The provider failed to assess and manage risks associated with the control and spread of infection.
- Cleaning schedules had not been reviewed or updated since the COVID-19 pandemic. There was no regular wiping down of touch points to reduce the spread of infection. Cleaning schedules had failed to identify that one bedroom required cleaning.

● 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.

Learning lessons when things go wrong
● Records of any accidents or incidents were maintained however, no action had been taken to reduce the risk of the accident happening again.
● The provider had failed to take appropriate action to address the breaches identified at the last two inspections which demonstrated they did not learn lessons when things went wrong.

Using medicines safely
● The provider had taken some action to address the issues we raised at the last inspection however further improvements were needed.
● Protocols for the administration of as required medicines had been implemented to ensure staff followed a consistent approach.
● There were no protocols or systems to record the administration of topical medicines. This meant there was a risk that staff would 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.

Staffing and recruitment
● The provider failed to ensure people were protected by their procedures for staff recruitment.
● In one of the staff files we looked at the provider had failed to obtain a reference from the staff members last employer. This meant they could not be sure of their previous conduct or suitability to work at the home.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were protected by the provider's recruitment procedures. This is a breach of regulation 19 (fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider failed to ensure that staff were skilled and competent in their role. Staff did not receive regular supervisions to discuss their performance and the provider was not carrying out competency assessments on staff to monitor their skills.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people were supported by staff who were skilled and competent in their role. This is a breach of regulation 18(2) (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living at the home and with the staff who supported them. One person said, "The carers are fantastic. I am happy living here and feel safe."

● Staff knew how to recognise and report any signs of abuse and they told us they would not hesitate in reporting concerns to ensure people were safe.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

At our last inspection the provider had failed to ensure people received care and support which was personal to them. This was a breach of regulation 9 (person-centred care) 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 9.

- No action had been taken since the last inspection to ensure people were involved in the planning and review of the care and support they received.
- None of the care plans we looked at contained evidence that people had been consulted about their plan of care.
- The people we spoke with were unaware that they had a plan of care. One person said, "A care plan? I don't know anything about that."
- Care plans had not been regularly reviewed to ensure they were reflective of people's needs and preferences.
- Important information about people's religious preferences, preferred daily routine and hobbies and interests had not always been completed.
- People's preferences during their final days and following death had not always been recorded. This put people at risk of not receiving personalised care and support as they neared the end of their life.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate people's preferences were considered or met. This placed people at risk of receiving care and support which was not personal to them. This was a continued breach of regulation 9 (person centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans were in place which provided staff with information about any communication or hearing difficulties people may have. However, care plans had not been regularly reviewed.

● A member of staff explained how they had developed communication cards to assist a person who had recently moved to the home.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● During the current pandemic external entertainers have not been able to attend the home however, staff told us they tried to engage people in various activities each day. These included singing, crafts and baking. We observed some people enjoying a sing-a-long during the inspection.

● People have been supported to maintain contact with their loved ones through video and telephone calls and window visits.

Improving care quality in response to complaints or concerns

● People told us they would feel comfortable to raise any concerns they had. One person told us, "No complaints at the moment. I am happy with everything. I would tell the staff if I was not happy about something."

● The provider told us they had not received any formal complaints but would ensure any concerns brought to their attention would be investigated.

Inadequate

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 now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last two inspections the provider was unable to demonstrate safety, or the quality of the service provided was effectively managed. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improvements had not been made and the provider is still in breach of regulation 17.

Continuous learning and improving care

- The provider had failed to assess and monitor the quality and safety of the service and failed to make improvements to the service provided.
- The provider was not carrying out any audits on staff or service user records or audits on medicines, the environment or equipment. Accidents were not being reviewed which meant risks to service users were not considered or mitigated.
- Accurate and complete records in respect of service users were not maintained. Risks had not been considered and care plans had not been raised to mitigate risks.
- The provider failed to follow safe recruitment procedures by not obtaining references from a previous employer to confirm their conduct and suitability to work at the home.
- Policies and procedures in place had not always been updated to reflect changes in legislation. For example, the Infection Prevention Control policy (IPC) had not been updated to reflect the COVID-19 Government guidelines.

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

- The provider was also the registered manager. The provider was not operating effective systems or processes to ensure compliance with the requirements of the regulations. This was the third consecutive inspection where they had not addressed breaches of regulations.
- The provider spent limited time at the home and they failed to ensure that the home was effectively managed in their absence.
- Staff were not provided with opportunities to discuss their role or performance through regular supervision sessions.
- The provider failed to ensure staff were appropriately trained or skilled in their role as they did not complete assessments of their competency.

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

- The provider failed to ensure service users were involved in planning and reviewing the care they received.
- People were not provided with opportunities to express their views on the service they received through meetings and surveys.

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

- There were no effective systems in place to investigate, feedback or learn when things go wrong.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety or the quality of the service provided was effectively managed. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- Staff told us they had good support from visiting professionals such as doctors and district nurses.
- Care plans showed that people saw other healthcare professionals to meet their specific needs. These included speech and language therapists and mental health professionals.

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 9 HSCA RA Regulations 2014 Person-centred care People were at risk of receiving a service which was not personal to them. People were not consulted about the care and support they wanted or received.