Kevindale Residential Care Home

Keegan's Court Residential Care Home

Inspection report

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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
Keegan's Court Residential Care Home is a care home providing support with personal care needs to 12 people at the time of this inspection, some of whom were living with dementia. The home can accommodate 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.

People's experience of using this service and what we found
People were not always safe as the infection prevention and control procedures were not effectively implemented.

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 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. The provider followed safe recruitment practices.

The provider had kept us informed about key events and had good working relationships with others involved in peoples care.

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 the provider needed to embed improvements required from the last 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.

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 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.

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 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 one inspector.

Service and service type
Keegan's Court 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 one carer, one senior carer, administrator and registered manager. We spoke with three visiting healthcare professionals and another staff member on the phone. We looked at three peoples care and support plans and several documents relating to the monitoring of the location and health and safety checks. We confirmed the safe recruitment of one staff member.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

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 did not consistently ensure the physical environment was safe for people. For example, we saw exposed hot water pipes leading to an uncovered radiator in one person's shower room. This placed people at the risk of burns should they have contact with the exposed hot piping. One bedroom contained a portable radiator. This piece of electrical equipment did not evidence it had been safety checked as a portable appliance and showed evidence of scorching on the plastic surround. The provider had failed to ensure this piece of equipment was safe for use. They had failed to assess the risks of burns from contact with this piece of heating. The provider failed to assess the risk of trips or falls as this heater was placed in a walkway with an electrical lead trailing across the floor. This put people at the risk of injury.

● The laundry area contained substances hazardous to health. This area was not locked and chemicals, including those identified as corrosive, had been left out. We asked the provider about this and they said it is difficult as they need keys to keep the door locked and these are often lost. People were independently mobile within the home and had unrestricted access to the chemicals in this area putting them at risk of harm from ingestion or contact.

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 two en-suite toilet systems were broken. The provider was seeking professional support for repairing this. However, the provider had not acted to remove the waste from these toilets or to secure the areas preventing people from entering. The provider did not have any timescale for these repairs. The provider failed to ensure people did not have contact with human waste putting them at risk of contracting communicable illnesses.

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

● Although the provider was facilitating visits for people living in the home they failed to complete checks in accordance with the current guidance. For example, they failed to confirm professional visitors had a negative COVID 19 lateral flow test.

Following this inspection site visit we received evidence from the provider confirming they had acted to remove the immediate risks to people. This included the locking of cupboard doors, removing waste from the broken toilets and removing the portable radiator from one person's bedroom.

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.

● We were not assured that the provider was preventing visitors from catching and spreading infections as they had not implemented effective checks on those entering the premises. On arrival the provider failed to confirm our vaccination status, any recent testing or complete any health checks to ensure we were safe to enter the location. We spoke with other visiting healthcare professionals and they told us no one had checked they were safe to enter the location. We asked staff and the provider about such checks and no one knew what was expected. The provider did not have a system in place to check the COVID-19 vaccination status of professional visitors to the home as required since 11 November 2021. The failure to have this system in place meant people living in the home had been put unnecessarily at risk.
● We were not assured that the provider's infection prevention and control policy was up to date as it did not account for changes in legislation. For example, the provider had failed to monitor the vaccination and COVID-19 status of staff. We asked the provider about their understanding of vaccination as a condition of deployment for their staff. They did not have a system in place to confirm whether staff had received their vaccination and were safe to support people.

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 (3): Safe Care and Treatment, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● People had assessments of risk associated with their care and support including the risk of trips and falls and skin integrity. Staff knew how to safely support people. People had individual personal emergency evacuation plans in place.
● The provider completed checks to the water systems to ensure the temperatures were safe and with the fire prevention systems to ensure they worked in the event of an emergency.

Staffing and recruitment
● People were supported by enough staff who were available to safely support them. All those we spoke with told us they were supported when they wanted. However, staff and the provider told us staffing was currently an issue. At this inspection there was no designated cleaner or chef. The cleaning duties were completed by staff when they were able and the cooking was completed by the provider. However, no one told us they went without or their support was delayed. We saw people were promptly supported when they needed assistance.
● The provider followed safe recruitment checks. This included checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with others.

Using medicines safely
● People's medicines continued to be managed safely. People told us they received their medicines as prescribed.

● 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.

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.

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 hot water piping, unsecured cleaning products, the unsafe use of a portable radiator or correct the repairs needed with the waste management system.

Continuous learning and improving care

- The management team at Keegan's Court Residential Care Home failed to evidence they had kept themselves up to date with requirements in legislation. The provider had failed to implement safe working practices when professional visitors attended their premises. 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 did have other checks in place such as medication audits and care and support plan checks.
- 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 Keegan's Court Residential Care Home .

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

- All those we spoke with said the management team was approachable and they felt supported by them. However, some staff we spoke with said they often felt ignored and any concerns were dismissed without being addressed. The provider recognised some communication with staff had been delayed owing to staff pressures but committed to improve this.

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.

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 which was positive.

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 Regulation 12(1) and (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safe care and treatment. The provider did not complete adequate checks to ensure the property was safe for people. The provider failed to check the vaccination status of staff members. The provider failed to check visiting professionals were safe to enter the location.

The enforcement action we took:

We issued a warning notice to the provider giving them a date by which 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.

The enforcement action we took:

We issued a warning notice to the provider giving them a date by which to be compliant with the law.