Solehawk Limited

Kenton Manor

Inspection report

Kenton Lane
Gosforth
Newcastle Upon Tyne
Tyne and Wear
NE3 3EE

Tel: 01912715263

Date of inspection visit:
18 September 2017
02 October 2017

Date of publication:
21 November 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 18 September and 2 October 2017. We last inspected the service on 6 October 2016 and found the provider had breached the regulations in relation to infection control and meeting people's nutritional needs. We did not receive an action plan from the provider following the last inspection. We found during this inspection there were no concerns identified with infection control or nutrition.

The home provides accommodation, nursing and personal care for up to 65 people, including people living with dementia. There were 63 people living at the home when we inspected.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the provider had breached the regulations relating to safe management of medicines and person-centred care. People did not have care plans to guide staff as to when to administer when required medicines or covert medicines. Other records were available to confirm regular medicines were administered and stored appropriately. We found people's care was often rushed and there was a lack of stimulation and engagement for people in communal areas.

You can see what action we have told the provider to take at the back of the full version of this report.

People and relatives said the home was safe.

Staff had a good understanding of safeguarding and the provider's whistle blowing procedure. They knew how to report concerns. Safeguarding concerns had been referred to the local authority safeguarding team and fully investigated by the provider.

People, relatives and staff said there were enough staff deployed to meet people's needs in a timely way.

Regular health and safety related checks were carried out, such as checks of fire safety, gas and electrical safety and specialist equipment. The provider had a business continuity plan to deal with unforeseen emergencies. People had personal emergency evacuation plans (PEEPs) which described their support needs in an emergency.

Accidents and incidents at the home had been recorded and investigated. These were monitored to look for trends and patterns.

There were effective recruitment procedures and protocols to ensure staff were recruited safely. This included taking up references and completing Disclosure and Barring Service (DBS) checks.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Although people were supported with eating and drinking as needed, we noted some people were brought to the dining room a long time before their meal arrived.

Staff told us they were well supported and had access to training to enable them to carry out their role effectively.

Staff supported people to access healthcare services when required.

People's needs had been assessed which included identifying their care preferences. Although medicines care plans were not available for most people, other care plans we viewed were personalised. These had been reviewed regularly to help ensure they reflected people's current needs.

There were some opportunities for people to participate in group activities if they wished. This included a coffee morning and arts and crafts sessions.

People and relatives knew how to raise concerns. Previous complaints had been investigated and action taken to resolve the complaint.

Staff had opportunities to give their views and suggestions about the home. For example by attending staff meetings or speaking with the registered manager.

There were regular quality assurance checks. Where improvements had been identified action had been taken to deal with the issue. However, we noted medicines audits were not fully effective as they had not identified people did not have medicines care plans.

There were opportunities for people and relatives to provide feedback about the home. The most recent feedback was positive. Regular residents' meetings were held although these were not always well attended. We have made a recommendation about this.

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.

People did not have care plans to guide staff about the support each person needed with taking their medicines appropriately.

Staff knew how to identify and report whistle blowing and safeguarding concerns.

There were sufficient staff on duty to supervise people's safety.

The provider had effective recruitment procedures.

There were up to date checks, risk assessments and emergency procedures to maintain health and safety in the home.

Accidents and incidents were dealt with effectively.

Is the service effective?

Good

The service was effective.

Staff confirmed they were well supported and received the training they needed.

The provider followed the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS).

People were supported to meet their nutrition and health care needs.

Is the service caring?

Requires Improvement

The service was not always caring.

We observed people's care was often rushed. Relatives provided feedback that staff were busy and this affected people using the service.

Some people did not receive appropriate engagement and stimulation when in communal areas.

People told us they felt they received good care and were treated with dignity and respect.

Is the service responsive?

Good

The rating remains good.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We received mixed feedback from relatives about the management of the home. Although most staff felt the home was well managed.

Medicines audits had not been effective in addressing a lack of guidance available to staff about how to administer people's medicines.

Other quality assurance audits were carried out consistently.

People, relatives and professionals had given positive feedback about the home following consultation.

Kenton Manor

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 18 September and 2 October 2017. The first day of inspection was unannounced. The second day was announced. This meant the provider knew we would be coming.

On 18 September 2017 the inspection was carried out by one inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. On 2 October 2017 the inspection was carried out by one inspector.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also had contact with the local authority commissioners of the service, the clinical commissioning group (CCG) and the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider completed a provider information return (PIR) prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with nine people who used the service and six relatives. We also spoke with the registered manager, one nurse, a senior care assistant and three care assistants. We looked at a range of records which included the care records for five people, medicines records, recruitment records for five staff members and other records relating to the management, quality and safety of the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Staff did not have access to appropriate guidance to enable them to administer people's medicines safely and in the way people wanted. Some people had been prescribed 'when required' medicines. These were medicines the person did not take every day but only when circumstances required, such as medicines to manage pain relief. We saw one person had been prescribed a particular medicine to help with agitation. This medicine was to be administered as a last resort when all other strategies had been exhausted. We found this person did not have a care plan or protocol in place to help guide staff as to when this medicine should be given.

Some other people who lacked capacity often refused their medicines and required their medicines to be given covertly. Covert medicine administration is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. The provider sought the required authorisation from a clinician and had also arranged for a Mental Capacity Act assessment and best interest decision to be carried out. We found people did not have a medicines care plan that described when and how these medicines should be given to ensure they received them safely. We noted one person's care records indicated they had a 'covert medicines' care plan. However, when we checked their care records this plan was not there. The registered manager told us the care plan must have been archived.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives told us medicines were administered in a timely manner. One person said, "I get my medication twice a day, no concerns there." Another person told us, "I get medication usually in the morning and at night, I have no problems with it." A third person commented, "I get it every day the girls keep me right." One relative said, "[Family member] receives their medication morning and evening and everything seems to be working, no complaints." Another relative told us, "My family member's medication is fine, I don't get involved with it as they seem fine." Medicines records we viewed were accurate to confirm medicines were received, stored and administered appropriately.

Most people living at the home and their relatives told us the home was a safe place. One person said, "I do feel safe in here, because there are people around if I need someone." Another person told us, "I feel very safe in here. What makes me feel safe is that I am not on my own and the staff are here." A third person commented, "I feel safe here as I have had no reason not to be." One relative told us, "I feel it is safe here. I feel happy my family member is secure here." Another relative said, "This is a safe place for my family member as they are well looked after and there are staff around if they need anything."

Staff also told us they felt the home was safe. One staff member commented, "It is a locked unit." Another staff member said, "I think it is safe because it is secure."

Staff were aware of the provider's whistle blowing procedure. They told us they had not needed to use it

whilst working at the home. One staff member said, "I have not used it but I have no worries." Another staff member told us, "I would be able to raise views no problem." A third staff member commented, "I am not shy to speak up if something is bothering me. I will speak up."

Staff showed a good understanding of safeguarding and knew how to report concerns. One staff member commented, "I would go straight to the manager." Staff had received appropriate training to keep people safe and had recently completed safeguarding training. A log of safeguarding concerns was maintained which confirmed they had been referred to the local authority safeguarding team and fully investigated in line with the locally agreed policies and procedures.

People and relatives did not raise any concerns with us about staffing levels in the home. Staff members said staffing levels were usually appropriate. One staff member commented, "[Staffing levels are] always at the right level. If someone phones in sick, [registered manager] does her best to cover it." Another staff member told us, "Staffing levels are quite good, I think so." We observed staff were visible and on hand to assist people if required. We observed staff responded to people's needs within a reasonable time frame. For example, when people pressed their nurse call for help and assistance. Although staff responded quickly we saw and relatives commented that some staff appeared to be in a hurry when supporting people.

Health and safety related checks were carried out regularly to keep both the premises and equipment safe for people. These included checks of fire safety, gas and electrical safety as well as specialist equipment used when helping people to mobilise, such as hoists and slings. These checks were up to date when we visited the home. Procedures were in place to help ensure people continued to receive care in emergency situations. For example, a business continuity plan and personal emergency evacuation plans (PEEPs).

Accidents and incidents at the home were appropriately recorded, investigated and monitored. Monitoring included analysing incidents to identify any particular trends and patterns, such as the time, location and reason for incidents occurring. Action taken following incidents included accessing medical assistance, hospital admission and increased observations to keep people safe.

The provider had effective procedures and protocols to ensure staff were recruited safely to the home. This included completing a range of pre-employment checks. Staff files showed evidence of an applications and interview process, references being taken up and Disclosure and Barring Service (DBS) checks being made.

We found the home was maintained in a clean and tidy manner, with no lingering unpleasant odours around the home. Toilets, bathrooms and en-suite facilities were clean and tidy.

Good

Is the service effective?

Our findings

People were happy with the meals they received at the home. One person told us, "I like the food here. There is always plenty to eat and drink." Another person commented, "We are well fed and watered here, I have no complaints with the food or drink we are served." A third person said, "I like my food, no complaints here."

On the first day of our inspection we joined people for lunch to help us assess their lunchtime experience. Staff told us lunch was usually served at 12.30pm. However we noted people were being supported into the dining room before 12 noon. This meant people had to sit and wait for a long time before receiving anything to eat. We saw tables had not been set with tablecloths or condiments. People were given a choice of cheese and tomato sandwiches with chips or sausage roll, chips and beans.

People with specific dietary needs were catered for appropriately. For example, one person required a 'soft diet' due to swallowing difficulties. A friend was helping the person to eat, staff told us this "kept the person calm." Independence was encouraged for those people who were able to eat and drink without support. For example, staff encouraged people to walk to the dining room rather than use a wheelchair of they were able. We saw staff offered assistance to help people sit down safely at the dining table. People were offered a choice of drinks either orange squash, blackcurrant squash, tea or coffee. Some people had chosen to eat lunch in their own room and this was arranged for them. However, most people were encouraged to eat in the dining room to promote inclusion.

Support with eating and drinking was provided in a caring manner whilst maintaining dignity and respect. For example, staff asked each person whether they would like a dignity apron to protect their clothing. Staff provided practical assistance for some people where needed or prompts and encouragement for others. For example, we overheard staff comment: "Would you like some juice?"; "Would you like to try dessert?"; and, "You haven't eaten that much today, do you think you might like to try to eat a little more?" Although staff were busy during the lunchtime they still chatted to people whilst they were having their lunch.

Staff confirmed they were well supported working at the home. One staff member said, "I feel supported. [Registered manager's] door is always open." Another staff member commented, "I am very supported. I have supervision with [registered manager]." A third staff member told us, "I am very supported. We have supervisions when we need them."

Staff completed the training they needed to carry out their role. One staff member said, "Training is no problem. I have done safeguarding, palliative care and food and nutrition. All my mandatory training is up to date." Another staff member told us, "We do get training, there is always on-going training." Essential training for care staff included fire safety, food hygiene, moving and handling, health and safety, equality and diversity and dignity in care. The registered manager told us the provider had recently changed to a new training company. They said the frequency for updating training had also changed from three years to annually. This meant that because of this change the training matrix showed that a significant number of training courses were showing as overdue. A training plan was in place to bring training in line with the new requirement to update training annually.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people lacked capacity, DoLS authorisations had either been applied for or authorised. The registered manager carried out a regular audit of DoLS authorisations to help ensure DoLS authorisations were reviewed when required. Care records included MCA assessments and best interest decision records where people were unable to consent to their placement at the home.

Staff had a good knowledge of the MCA. They had completed specific training on MCA including DoLS. Staff readily described the strategies they used to support with making choices and decisions. For example, showing people limited items based on their preferences to make a choice of clothing to wear. Other strategies included adapting communication methods by using signs or speaking slowly for other people. One staff member said, "Not all people have capacity. There is a lot of involvement from families if they are unable to communicate."

All people we spoke with told us they had access to other care services to meet their health care needs such as dentists, podiatrists and doctors. One staff member said, "We refer to OT (occupational therapy), SALT (speech and language therapy) and GPs regularly. There is a GP round on a Wednesday."

Requires Improvement

Is the service caring?

Our findings

Relatives we spoke with gave us mixed views about the care provided at the home. Relatives felt most care staff were kind but that sometimes their family member's care was rushed. One relative told us, "The staff are nice and my family member is looked after, but the staff always seemed very stressed out. I feel they are understaffed and it does show." Another relative commented, "I think the care here is fine and I am happy with the care my family member receives from the staff. They always do their best but they are always very busy and seem to be running around a lot." A third relative said, "The staff are lovely, they do a great job but they do seem under staffed a lot of the time. It's hard when they have agency staff in as they do not know the residents. The staff rarely have time to have a chat with my family member. They are just busy, they have a tough job." A fourth relative commented, "I feel some of the staff are nice… I don't feel that there is enough staff they seemed stressed most days." A fifth relative said, "Some of the staff are quite caring, others not so much."

Although planned group activities took place regularly, we observed the people who didn't attend the activity were usually not engaged or stimulated. We noted staff were visible in communal areas but throughout our observations they were engaged in completing paperwork. Staff when we spoke with them told us they spent time with people on a one to one basis. One staff member said, "We sit and chat with people." However, during the time we spent at the home we saw staff very rarely sat with people in a meaningful way and chatted with them.

We carried out observations on both inspection days and at various times of the day. We did not see any meaningful engagement with people whilst they were in communal lounges. For example, a number of people congregated in a seating area just outside the nurses' office. We noted there was often no staff in this area and there was very little interaction unless a person shouted out when a staff member walked past. There was no TV or background music in this area.

On another occasion we carried out a specific observation in a first floor communal lounge. When we first arrived at the lounge there were six people sitting without a light on. The lounge did not have a TV and there was no music playing. We noted that a staff member looked into the lounge without interacting with people then left. After five minutes staff supported a person into the lounge. The person was transferred from their wheelchair into a chair. However, we noted this transfer was rushed and staff did not provide any explanation as to what was about to happen or offer any reassurance whilst the transfer took place. There was no interaction with any other people in the lounge. After 20 minutes a domestic member entered the lounge and put the lights on. At this point a staff member entered the lounge with a care file. They sat down and proceeded to complete paperwork. Again there was no interaction with people. After a further two minutes the staff member asked people if they would like any music on. One person commented "aye." The staff member arranged for the radio to be plugged in and tuned into a radio station. We fed back our observations to the registered manager during our inspection.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we discussed the staff team with people they said they found them caring and considerate towards them. One person told us, "Yes I am happy here, the staff are nice and help me." Another person commented, "The staff are kind and lovely." A third person said, "The staff are good and look after me." A fourth person commented, "I like it here, I am happy."

We did observe at times caring interactions between staff and people using the service. For example, we noted a senior care worker checking people were comfortable and had what they needed. For example, they placed a blanket over on person's knees as they were cold. They went and got a pillow for another person who was slumped in their chair.

People told us they felt their privacy and dignity was always respected. They confirmed if they needed any help with personal care they felt very respected. They told us curtains were always pulled across or doors closed for privacy and dignity. Staff described how they aimed to maintain dignity and privacy when providing personal care. This included talking to people, explaining what was happening and keeping doors closed for privacy.

People were able to choose how they spent their day. For example, people told us they were able to go to bed when they wanted and were not told when to go. One person told us, "I like to listen to music and go to bed." Another person commented, "I like to go to bed around 9pm." One staff member said, "We encourage people to participate as much as they can." Relatives told us they felt happy and involved in making choices and decisions about their family member's care.

Staff told us they spent finding out about people's preferences and these were recorded in their care records. One staff member told us this included asking about whether people liked a bath or shower, wanted to use the hairdressing service and preferred activities. Care records contained information about people's likes and dislikes. Each person had a 'one page profile' which included details of their personal qualities, what was important to them and how to support the person. For example, for one person this was to ensure they were always dressed smartly, had cup of tea before bed, visits from family and hug.

Good

Is the service responsive?

Our findings

Care records showed people's needs had been assessed both before after their admission to the home. This included assessing people's needs across a range if areas including considering any cultural or religious needs they had. Where potential risks had been identified corresponding risk assessments were in place. For example, a risk assessment had been carried out as one person was unable to use the nurse call system. The risk assessment was personalised to the person's circumstances. The provider also carried out other general assessments to assess whether people were at risk of poor nutrition, skin damage and falling.

The initial assessments were used to develop individualised care plans for each person. Care plans clearly identified the people's needs, a goal or outcome and the interventions required from care staff. Care plans were supplemented as required with additional care plans where people had specific needs, such as short term illnesses requiring antibiotics. Care plans had been updated to take account of changes in people's circumstances. Regular reviews were carried out to help ensure care plans remained up to date.

The home employed one activities coordinator who provided activities for 40 hours each week, Monday to Friday. They told us they were usually able to focus on activities as they rarely had to double up to help as a care worker. A hairdresser was available at the home once a week as well as a weekly chair aerobics class. The home had access to a minibus which was used to take people on outings.

One the morning of our first visit a coffee morning and chat took place. This usually took place three times a week with different people attending. On this occasion nine people from various parts of the home attended this. A cake decorating session took place on the afternoon with a further eight people attending.

Relatives we spoke with said they did not have reason to make any complaints. If they needed to make a complaint they would have no problem addressing this with staff or the management of the home. One relative told us, "We have never really had any complaints." Another relative commented, "I have never raised a complaint but I would if I needed to no problem." Another relative told us about a complaint they had made. They said, "I spoke to the manager and asked them to lock my family members door …This was respected and they lock it. My family member is much more at ease now."

There had been four complaints received during 2017 mostly in connection with poor communication between staff and relatives. The complaints log showed these had been investigated and a written response sent to the complainant. Records also confirmed action had been taken to address the concerns raised. This included accepting responsibility and a written apology where needed.

The provider held meetings for residents and relatives to share their views about the home. We viewed the minutes from previous meetings and saw these were used as an opportunity to discuss areas of interest such as social events, activities, menus and people's views of living at the home. Feedback from previous meetings was positive about the home. However, we noted these meetings were not usually well attended. For example, there were no attendees for the last meeting in August 2017.

We recommend the provider reviews best practice in engaging people and relatives in development of the home and takes action to update its practice accordingly.

Requires Improvement

Is the service well-led?

Our findings

Relatives gave us mixed views about the management of the home. For instance, one relative commented, "She is nice if I have any problem I would speak to her." However, other relatives gave less positive feedback. Another relative told us, "I have seen [registered manager] but she … doesn't really interact much." A third relative said, "[Registered manager] seems ok, I don't see much of her to be honest."

Most staff we spoke with told us the registered manager was approachable. One staff member commented, "You can approach [registered manager]." Another staff member told us, "[Registered manager] is very approachable, very helpful. We can see her anytime." One staff member said the home was "well managed". They said, "I can approach [registered manager]."

The provider had a structured approach to quality assurance. The registered manager and other senior staff completed a range of weekly and monthly checks to help ensure people were safe and well cared for. This included checks of pressure sores, people's weight, short term medicines like antibiotics, complaints, accidents and health and safety. Where people were affected by these issues the audit provided details of any action taken to address the issue. For example, the pressure area audit gave details of people affected, how they had been affected, details of specialist input and details of any equipment used in their treatment.

Although medicines audits were carried out regularly, they were not always completed accurately. For example, we noted most people receiving covert medicines did not have a relevant care plan in place. The medicines audit pro forma contained a specific prompt regarding covert medicines. This stated 'any resident who is receiving medicines covertly has a care pathway in their care plan.' We saw this was consistently answered 'Y' for all people despite them not having documented care plans. The registered manager told us this would be addressed immediately and care plans would be put in place as soon as possible.

The provider carried out an external quality audit periodically to check on the quality of people's care. Actions had been identified during these audits and were then followed up at subsequent audits. Previous actions included replacing satellite kitchens, a new financial transaction process and providing rest room facilities for staff.

Staff described the home as having a good atmosphere. One staff member said, "Everybody is happy at the moment." Another staff member told us the atmosphere was, "Good, friendly. That is a thing that relatives say." A third staff member said, "There is a good atmosphere, if there wasn't the residents would pick up on that."

There were regular opportunities for staff to meet and share their views about the home. Minutes from meetings were available to view. Topics discussed at meetings included the results of the staff survey, the use of agency staff and training. The provider held different staff meetings for qualified staff, care staff and ancillary staff.

We viewed feedback from people, relatives and professionals following consultation the provider had carried out. This included questions relating to the five key questions CQC inspect against. Namely is the home safe; effective; caring; responsive and well-led. We saw relatives had given very positive feedback across all areas. For example, 100% of people and relatives believed their relative to be either safe or very safe. We also saw 100% of people, relatives and professionals were happy with the care provided at the home.

There had been eight compliments received during 2017 thanking the provider and staff for the care provided to people. These used words including 'kindness'; 'caring'; 'wonderful care' and 'affection' when describing how people had been treated at the home.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not always ensure people received care that met their needs and preferences. Regulation 9(1)(b), 9(1)(c) and 9(3)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to mitigate risks to people using the service as guidance was not available for staff to ensure people received their medicines safely. Regulation 12(2)(a) and 12(2)(b).