Solehawk Limited

Kenton Manor

Inspection report

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

Tel: 01912715263

Date of inspection visit:
06 October 2016

Date of publication:
08 December 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of this service on 4 and 11 May 2016. One breach of legal requirements was found at that time. This related to a breach of regulation regarding safe care and treatment, specifically in relation to the safe management of medicines. We also made a recommendation about staffing levels.

We undertook this focused inspection on 6 October 2016 to confirm that they now met legal requirements. We also examined staffing levels as a recommendation had been made previously, and personal care, as this was raised as an area of concern by a relative and dealt with by the local safeguarding adult's team. This report only covers our findings in relation to the legal requirement, the recommendation and areas raised as being of potential concern. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Kenton Manor on our website at www.cqc.org.uk.

Kenton Manor provides accommodation, nursing and personal care for up to 65 people, including people living with dementia. There were 64 people accommodated there on the day of our inspection.

The service had a registered manager in post. 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.

We found the provider had complied with the legal requirement in relation to the safe management of medicines. We found the provider was in breach with the regulation relating to the safe use of the premises.

The registered manager and staff had taken steps to ensure that medicines required on a weekly basis and before food were administered as prescribed.

People and staff said staffing levels were sufficient to ensure people's needs were met safely. Staff were busy but not rushed. We found some people could not use their call bells, so required staff to monitor their wellbeing. Guidance to staff to ensure those individuals were kept safe was not clear.

The home was mostly clean and hazardous areas controlled. However kitchenette areas required refurbishment or replacement to ensure they could be kept clean and corrosive dish washer liquid stored securely. A large number of cartons containing dietary supplements were out of date.

Risks in relation to poor nutrition and hydration were assessed and monitored. We highlighted the need for nursing staff to more consistently guide care workers on target fluid intakes and on what to do should these not be achieved.

Staff helped people with their hygiene and personal care. People were well groomed and appropriately

dressed in clean clothing. Some records relating to the support staff provided were inconsistently completed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to the safe care and treatment and ensuring good hydration. You can see what action we told the provider to take at the back of the full version of this report.

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 consistently safe.

We found action had been taken to improve the safety of the service.

Staff ensured that medicines required on a weekly basis were administered as prescribed.

Some kitchenette areas of the home required refurbishment or replacement.

The stock control of dietary supplements did not safeguard people from the risk of consuming out of date supplies.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Risks in relation to poor nutrition and hydration were assessed and monitored. Guidance on dealing with poor hydration required improvement.

Staff helped people with their hygiene and personal care. People were well groomed and appropriately dressed in clean clothing.

Kenton Manor

Detailed findings

Background to this inspection

We undertook an unannounced focused inspection of Kenton Manor on 6 October 2016. This inspection was done to check that improvements to meet legal requirements planned by the provider had been made after our comprehensive inspection on 4 and 11 May 2016. We inspected the service against two of the five questions we ask about services: 'Is the service safe?' and 'Is the service effective?' This was because the service was not meeting one legal requirement at the time of our initial inspection and we received some information of concern.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This inspection was undertaken by one adult social care inspector. During the inspection we spoke with three people who used the service, although due to their needs we were unable to gain a clear understanding of some people's views on the service. We spoke with six staff members and the registered manager. We looked around the communal areas of the home and with permission looked in a sample of people's own rooms. We looked at three people's care plans, their progress notes, risk assessments and care review records. We examined audit records relating to medicines, the building and infection control. We looked at medicine administration records for six people, medicine stock records, medicine storage areas, and other associated records. We made general observations of how people were supported throughout the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in May 2016 a breach of legal requirements was found. This breach related to the safe management of medicines. At the time of our last inspection we found medicines people required on a weekly basis were not consistently administered. Records for four people who received a specific medicine on a weekly basis before food showed all of them had missed doses during the previous month. In addition we saw multiple missed doses over previous monthly cycles. The registered manager's expectation that staff inform them of any errors, that they should be documented, the person's GP contacted for advice and the person or their family, along with the local safeguarding adults team also be informed, had not been followed.

We requested an action plan from the provider to detail how they would meet legal requirements. This was not received.

During this inspection we found improvements had been made. Staff had ensured people who required medicines before food on a weekly basis received these medicines as prescribed. A prominent reminder had been posted on the medicines cupboard. The administration of these medicines was also monitored as part of the registered manager's medicines audit process. Medicine Administration Records (MARs) completed by staff had recorded these medicines were administered as prescribed, and these records corresponded to the medicine stocks held in the home. We found staff had ensured people received their medicines as prescribed.

At our last inspection we heard mixed views about access to call bells and the adequacy of staff numbers. At that time some staff told us they felt staffing levels were not sufficient to respond to people's needs safely and in a timely manner. We also found some people did not have access to their call bell. We recommended the provider review the dependency tool used and how it was applied at the home.

At this inspection when asked about access to their call bell and the responsiveness of staff, one person told us, "I do know how to use it [the call bell]. They [staff] do come quick; they have to." Other people responded with more general comments about the approach of staff, saying, "I'm well looked after; I'd give it a mark of 500 or 600" and "It's nice here the staff are good. You cannot beat the staff."

Some people had call bells in their room, whilst others did not, or they were out of reach. Due to their communication needs, one person we asked about this was unable to describe how they would summon help. The registered manager told us some people were unable to use their call bells and one person would pull this out of the wall and shout for assistance instead. They told us one person was assessed to receive 15 minute observations to check on their whereabouts and wellbeing. We found there was no process to assess how people might summon help, and if they were unable to, guidance on how frequently they should be checked. We highlighted this to the registered manager who assured us people who could not use a call bell were checked on regularly. The registered manager forwarded a completed risk assessment shortly after this inspection.

Staff we spoke with told us their view was that staffing levels were sufficient to meet people's needs and to keep them safe. We observed staff had a visible presence in the home. A staffing rota was developed to plan staffing cover. For the 64 people living at the home we found there were between 10 to 12 care staff and two nurses employed during the day and six care staff and two nurses at night. Domestic, catering and maintenance staff were also employed above these numbers. The registered manager told us the dependency tool used to calculate safe staff levels was being reviewed by the provider.

Prior to the inspection we received information of concern alleging that some self-service catering areas of the home and crockery were not always clean. We found cups in the first and second floor kitchenettes were clean and free from stains, but on the ground floor and in a conservatory where visitors could help themselves to drinks, many of the cups were stained. We found all of the serveries were showing signs of wear and tear and were unclean. Because of its poor state of repair, one of the locked units which contained corrosive industrial dish washing chemicals was easily accessible. We also found items inappropriately stored, including a cup containing hot water, out of date boxes of dietary supplements and items, such as butter, which required cold storage. Some items, with a limited shelf life once opened, had not been dated to indicate when they would need to be disposed of. We found out of date nutritional supplements and yogurts requiring cold storage, stored at room temperature in one of the treatment rooms.

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

Requires Improvement

Is the service effective?

Our findings

Prior to the inspection we received information of concern in relation to a person's health, possibly linked to poor nutrition and hydration. This also alleged that support to attend to a person's hygiene was not effective.

We observed people were offered drinks at meal times and staff brought round a drinks trolley in between meal times. Risks in relation to malnutrition and de-hydration were assessed and plans of care drawn up to provide staff with suitable guidance. Staff weighed people, either monthly or weekly dependent upon the risk of unintentional weight loss. When they were concerned about peoples' wellbeing, records confirmed that staff had sought the advice of other healthcare professionals such as the General Practitioner or dietitian. Staff recorded the support offered and each person's progress in their daily notes. These were reviewed monthly.

We saw a person at risk of developing urinary tract infections (UTIs) frequently had a low fluid intake; on one occasion as low as 120ml and 200ml the following day. Staff had noted in the person's progress notes that they had encouraged the person to drink, but they had drunk little. There was no evidence that this had been escalated to more senior staff for further advice or action. Poor fluid intake can be a contributory factor to developing UTI's and can lead to other health complications and dehydration. Staff recorded how much fluid the person consumed and whether they had been reluctant to drink. Staff had also sought the input of the GP where they suspected an infection had developed. However, nursing staff had not calculated a target fluid intake or provided guidance to staff in the care plan about what to do if this intake was not achieved. The registered manager acknowledged our concern and undertook to update guidance to staff. They provided this to us shortly after the inspection in the form of a care plan. This advised staff of the target fluid intake for the person concerned and also guided them to raise any concerns with the nurse in charge.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed during the inspection that people were smartly dressed in clean clothing. People appeared well groomed. Staff told us they were required to complete records of personal care interventions. We were informed about the frequency people preferred to receive a bath or shower; at least twice a week and people would be supported to wash daily. Those records we looked at showed people received support at this level, The record for support with oral hygiene record was often omitted. We highlighted this to the registered manager to ensure this was addressed with staff or to indicate if people were independent in this area.

Staff completed care plans relating to personal care. Although these described the support people needed with personal care they did not always describe the frequency that people would prefer or require a bath or shower. We raised these record keeping issues with the registered manager who confirmed this had been addressed shortly after the inspection. The care plan they sent us was person centred and described support specific to that person.

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person had not provided care and treatment in a safe way. The registered person had not ensured the premises were safe to use for their intended purpose and had been maintained to control the spread of infections. The registered person had not done all that was reasonably practicable to mitigate such risks. 12(1) (2)(b)(d)&(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The hydration needs of a service user had not been consistently met. 14(1).