Care Quality Commission

Solehawk Limited

# Kenton Hall Nursing Home

## Inspection report

Kenton Lane
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Tyne and Wear
NE3 3EE

Tel: 01912711313

Date of inspection visit:
24 August 2017
25 August 2017
06 September 2017

Date of publication:
24 November 2017

## Ratings

| Overall rating for this service | Requires Improvement |
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| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

We carried out an inspection of Kenton Hall Nursing Home on 24 and 25 August 2017. The inspection was unannounced. We last inspected this service on 8 April 2015 and at that time we rated the service as Good.

At this inspection, due to issues with responsiveness to call bells, food on offer, record keeping and governance we have rated the service as Requires Improvement.

Kenton Hall Nursing Home can accommodate up to 60 people. Accommodation is provided on two floors of en-suite single bedrooms. A passenger lift provides access to both floors. At the time of the inspection there were 59 people using the service.

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.

The systems in place to keep people safe had been maintained. Staff had a good understanding of the safeguarding process. Accidents and incidents were well recorded and monitored to determine if any trends were occurring.  Staffing levels were based on the needs of people who used the service, and were reviewed regularly to ensure safe levels. Safe recruitment processes, including pre-employment checks had been followed.

Medicines were administered by trained staff who had their competencies to administer medicines checked regularly. Medicine administration records were well completed. The home was clean and staff followed infection control procedures. We were able to easily access potentially harmful cleaning products, but the registered manager told us they would ensure these items were securely stored in future. Health and safety checks were completed however we noted fire testing had not been carried out as frequently as detailed in the provider's safety schedule.

Staff training was up to date. Staff received regular supervision and an annual appraisal.

Feedback about the food on offer was negative. It was described as processed and bland. The registered manager explained they were working towards making improvements to the meals provided.

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. Applications had been made for Deprivation of Liberty Safeguards (DoLS), where it was considered that people would be unable to keep themselves safe if they were to leave the home unaccompanied.

People had access to a range of healthcare professionals to maintain their health and wellbeing. The service

had very good links with the local GP practice and was part of an initiative to reduce hospital admissions. A GP and a specialist nurse visited the service at least weekly to carry out 'ward' rounds. Healthcare professionals we spoke with, who visited the home regularly, were very positive about the care provided at the service.

People told us staff were warm and caring. We observed that staff knew people, their needs, and their relatives well. Relatives popped in and out of the home during our inspection and were made to feel welcome by staff.

Some people who used the service did not have English as a first language. Staff had sourced translation aids, bought DVDs filmed in their first language, and held parties and special meals in the home to celebrate events which were important within their culture. People's privacy, independence and right to a private life was promoted. The service had bought a double bed for one person so their partner could stay overnight in the home.

People and relatives told us the call bell was not always responded to in a timely way. We monitored the call bell during our visit and found most calls were answered within five minutes, but that some did take longer than this. People's needs were assessed and care plans were in place describing to staff how those needs should be met. However we found care planning and record keeping in relation to people's fluid intake was poor.

People were very positive about the range of activities on offer in the home, and the registered manager told us they had worked hard to introduce more varied activities to the home such as electronic reading devices, virtual reality and arts and crafts. These were well received.

Complaints had been responded to in line with the provider's policy, however we found assurances provided within responses to complaints had not always been well monitored. The registered manager carried out a scheduled of audits, and completed regular reports to the provider. However the quality assurance system had not been robust enough to identify and address the shortfalls which we found during the inspection. The provider had also failed to record evidence of their own quality visits to the home.

Feedback about the registered manager from staff and healthcare professionals was very good. They described the home as having strong leadership. The registered manager and staff had worked hard to maintain strong links with the local community and businesses.

We found one breach of the Health and Social Care Act 2008. This related to good governance. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br><br>The service remained safe. | **Good** |
| **Is the service effective?**<br><br>The service remained effective. | **Good** |
| **Is the service caring?**<br><br>The service remained caring. | **Good** |
| **Is the service responsive?**<br><br>The service was not always responsive.<br><br>People and relatives told us they felt it took staff too long to respond to call bells.<br><br>Care plans were in place and were detailed. However care planning to mitigate risks of dehydration were not specific, and records relating to people's fluid intake were poor.<br><br>People spoke very highly of the activities on offer in the home.<br><br>Processes were in place to manage and respond to complaints and concerns. People were aware of how to make a complaint should they need to. | **Requires Improvement** |
| **Is the service well-led?**<br><br>The service was not always well-led.<br><br>Some of the concerns found during our inspection had been raised in the past through satisfaction surveys and resident committee meetings, but had not yet been fully addressed. The provider's quality assurance system had not highlighted some of the shortfalls which we had found.<br><br>Whilst feedback about the registered manager from people and relatives was mixed, staff and healthcare professionals were very positive about their leadership qualities.<br><br>The home maintained good links with the local community. | **Requires Improvement** |

Care Quality Commission

# Kenton Hall Nursing Home

**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 was planned to check 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 24 and 25 August 2017. Our visit on 24 August 2017 was unannounced. This meant the provider and staff did not know we would be visiting. The inspection was carried out by two inspectors 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. The expert-by-experience who was part of this inspection team had expertise in older people.

Before the inspection we reviewed all of the information we held about the service including statutory notifications the provider had sent us. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We contacted the local authority commissioning and safeguarding teams and the local Healthwatch. Healthwatch are a consumer champion in health and care. They ensure the voice of the consumer is heard by those who commission, deliver and regulate health and care services.

We reviewed the Provider Information Return (PIR). 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 five relatives. We also 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. Throughout the inspection we spent time in the communal areas of the home observing how staff interacted with people and supported them. We spoke with the registered manager, deputy manager, eight care workers, activity coordinator, two domestic staff, the cook, laundry assistant and the maintenance worker. We reviewed seven people's care records. We looked at four staff personnel files, in addition to a range of records in relation to the safety and management of the service. We also spoke with three healthcare professionals who visited the home regularly. After the inspection the registered manager sent us some further information to help us with our

inspection, we also contacted two relatives by telephone. We concluded these inspection activities on 6 September 2017.

Good

# Is the service safe?

## Our findings

One person we spoke with said, "I feel safe here." Relatives said they felt their family members were well looked after. One relative said, "I'm happy with [person's name] here. It feels like the right place for them." Staff had been provided with training about how to recognise and respond to any safeguarding concerns. The staff we spoke with were able to clearly describe the appropriate steps they would take if they had any concerns about people's safety or wellbeing.

People, relatives and staff told us the home employed enough staff to keep people safe. Staffing was determined using an assessment tool which took into account people's assessed needs. The registered manager told us this tool detailed the minimum number of staff the home could operate on, but that actual staffing within the home was over this number, to ensure that people's needs were met in a timely way. New roles of breakfast coordinators had recently been introduced who worked on mornings during the busy times in the home, they helped set out breakfasts and provided support with eating and drinking. This allowed care staff to concentrate on helping people to get up and to get dressed. During the inspection we noted staff appeared busy but that people's needs were met.

Recruitment of staff remained robust and thorough. Appropriate checks had been undertaken before staff began working for the service, including written references, and a satisfactory Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions. Registration of nursing staff was checked on a regular basis, to ensure it was up to date. All nursing staff are required to be registered with the Nursing and Midwifery Council (NMC).

Systems were in place to manage medicines safely. Staff who administered medicines had undertaken training and were subject to yearly competency checks to ensure their skills and knowledge remained up to date. Steps were taken to ensure any specific instructions related to medicines were met. For example, night staff gave some people their medicines first thing in a morning, as it was important it was given as a certain time every day. We checked a random sample of medicines and found stocks corresponded accurately to medicines administration records.

There were emergency plans in place to ensure people's safety in the event of a fire or other emergency at the home. We saw care records included assessments of potential risks such as falling, pressure damage or dehydration. Where possible steps had been taken to reduce identified risks, including the use of equipment such as bed rails to prevent falls from bed. Accidents and incidents were well monitored and reviewed regularly by the registered manager to determine if any trends could be identified or if any further steps could be taken to reduce the risk of accidents reoccurring.

During a walk around of the home, we were able to easily access a cupboard which stored some cleaning materials which could be harmful to people. This cupboard was locked, but the key was hanging close by on a hook. After securing the room we discussed the access with the registered manager. She informed us she would arrange for the lock to be replaced with a keypad entry system.

The home continued to be in a good state of repair. At our last inspection some window restrictors could be undone, we saw this risk had now been addressed and that they were secure. A range of audits, safety checks and service records were in place, which included gas safety, electrical and water system checks carried out by external contractors. However we noted fire alarm checks were not carried out as regularly as stated within the provider's safety schedule. We fed this back the registered manager who told us they would address this.

The home was clean and tidy, with no unpleasant odours. We observed staff follow infection control procedures in washing their hands before providing personal care and wearing protective clothing such as aprons and gloves when appropriate.

Good

# Is the service effective?

## Our findings

People and relatives told us they believed staff had the skills and experience to provide the support required. Staff were trained to help them meet people's needs effectively. The induction process continued to incorporate opportunities for new staff to shadow experienced staff, read company policies and work towards the Care Certificate. The Care Certificate is a set of minimum standards for care workers.

The provider had identified a schedule of training which they considered mandatory. Training was monitored to ensure it remained up to date and we saw a high level of completion. Staff undertook specialist training on caring for people living with a dementia, nutrition and end of life care. We spoke with several staff about the support they received. They confirmed they had had regular opportunities for formal supervision, yearly appraisal and had also attended staff meetings. They said they felt supported by the registered manager and felt that their concerns were listened to. One staff member told us they were encouraged to give their opinions and suggestions and they felt part of a team.

We found staff communicated with people whose first language was not English by using translated phrase cards. Family members were also encouraged to assist with communication barriers by speaking to their loved ones in their given language. Staff told us that they had learned a few words to understand the person's wishes and beliefs.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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. Some people who used the service did not have capacity to leave the home unaccompanied, as it was considered that they would be unable to keep themselves safe. We saw applications had been made to the local authority for assessment regarding DoLS authorisations. The registered manager told us that at that point no decisions had been made in people's 'best interests', but was able to talk us through the process they would follow if there were any doubts over people's capacity to make specific decisions.

We looked at the care records for four people who used the service and there was evidence that people were consulted about how they wanted to receive their care. Consent was gained for things related to their care. For example, we saw people had consented to the use of photographs on care plans and medical records. People who used the services told us the food served at the home was unappetising. People's comments included; "The food is very processed, very poor quality and needs to be improved" and "The food is rubbish, there's nothing healthy, everything is bland and over-cooked." Staff also told us the food could be

improved. One staff member said, "It's not good. It's not what I would want to be eating."

We spent time observing lunch on the first day of the inspection. There were no menus displayed. People ordered their meals in advance, and the people we spoke with were unable to tell us what meal they had ordered. One person said, "I never know what we are getting and to be honest you are not missing very much because it's never very nice." The meal was pasties, small cubed potatoes and spaghetti hoops or soup and sandwiches. Staff told us that other meals could be provided on request such as a salad or jacket potatoes, people confirmed they could request these meals if they preferred.

We shared feedback about meals with the registered manager who told us they were working with the cook to make improvement. A new cook had recently been employed who specialised in homemade cakes and pastries. People had shared that they would like different type of cheeses and the registered manager had arranged regular cheese and wine evenings. The provider had facilitated a shared learning experience for the cooks from the home with chefs from a restaurant the provider also owned. The restaurant chefs prepared a three course meal for people alongside the cooks from the home. The registered manager told us the dining rooms had been set up like a bistro with candles and table clothes.

We spoke to the cook who was knowledgeable about people's likes and dislikes and people who required special diets such as gluten free, diabetes soft diets and fortified meals. We asked the cook if they catered for people from different cultures and backgrounds. He told us that stir fries and curries were available for those who wanted them and they had halal meat delivered for some people.

The two dining rooms were not large enough to accommodate everyone living on each of the floor. The registered manager told us lots of people preferred to eat in the lounge or in their bedrooms, but if everyone chose to eat in the dining room they would consider splitting the meal into two sittings. There was a warm atmosphere in the dining rooms over lunchtime, and we saw staff offered support with meals in a sensitive way.

People could choose to spend their time in a number of communal areas of the home, including lounges, a conservatory and large landscaped gardens. We discussed increasing signage in the home to assist people to find their way around with the registered manager, who told us they would look at sourcing more.

People's health needs were well met. The home had very good links to health and social care professionals to help maintain their health and wellbeing. A specialist nurse visited the home on a weekly basis as part of a project to reduce admissions to hospitals. A GP also visited at least once a week to carry out a GP round. These links with healthcare professionals meant nurses and care staff could communicate any concerns promptly, and seek advice and guidance about meeting people's healthcare needs in the home. We saw prompt referrals had been made to dietitians, speech and language therapists and other professionals where changes had been noted in people's health.

We spoke with three health and social care professionals who all gave very positive views on the service. We spoke with a social worker for one person. They told us that the person had increased their weight and their general health and wellbeing had improved since their admission into the home. Other comments included, "The staff provide good quality care and make appropriate referrals if they require advice and support with the health care of any individual" and "This is one of the best homes I visit."

Good

# Is the service caring?

## Our findings

People using the service told us they were treated with kindness and compassion. One person said, "They're a lovely bunch of carers." Another person commented, "Staff are good and I'm very happy here." A relative told us, "It's fantastic here. The family are so happy with the care."

Staff we spoke with told us with pride that they thought the home was very caring. A theme which came from conversations with staff was describing Kenton Hall Nursing Home as a 'home from home'.

Throughout our inspection we observed staff interacting positively with people who used the service. Staff continued to be knowledgeable about people's individual needs, backgrounds and personalities. They gave each person appropriate care and respect while taking into account the person's wishes. We saw staff enabled people to be as independent as possible while providing support and assistance where required. Daily records made by staff described how the person had been throughout the day, tasks or activities they had taken part in and how their mood had been. During our observations we saw staff were patient and took opportunities to chat with people. However two people we spoke with did describe staff as 'rushed' and therefore had to focus on carrying out their tasks with little time to sit and talk with people. One person said, "The staff are nice, quite helpful but they're too busy to talk." We shared these comments with the registered manager.

We found that staff spoke to people with understanding, warmth and respect, and took into account people's privacy and dignity. In conversations with staff they were able to describe the ways in which they promoted people's privacy and independence when they provided personal care. We saw staff knocking on a people's bedroom doors before entering. Policies and procedures were in place which provided guidance on respecting privacy and promoting dignity.

Relatives visited throughout our inspection; they were warmly greeted and made welcome by staff. The registered manager told us they had strong links with many of the families of people who used the service. One relative still regularly visited to have lunch in the home even though their family member no longer received care at Kenton Hall Nursing Home.

Throughout conversations with the registered manager and with staff, it was clear that people's right to private life was respected. The registered manager told us that parts of the home were used to host parties, and relatives could choose to hold a wake at the home if they wished. A double bed had been bought to facilitate one person's partner to stay overnight at the home with them.

Care records prompted staff to consider whether any arrangements needed to be made to ensure people's cultural and diverse needs were taken into account. Some people who used the service did not have English as a first language. We saw events such as the Chinese New Year had been celebrated in the home, and staff had sourced DVDs in people's first language to watch. Staff had devised communication aids, but some important documentation, such as the service user guide had not yet been translated. The service user guide sets out what people should expect from the home, including how to make a complaint. We discussed

this with the registered manager who told us she would look into a translation service.

The activities coordinator facilitated regular 'resident committee meetings' where people could make suggestions or raise questions about any aspect of the service. Records of the meetings recorded that a wide variety of topics had been discussed. People we spoke with confirmed they could discuss any issues of their choice.

There was no one accessing an advocacy service at the time of the inspection, but the registered manager advised us that they would refer to such a service if they felt an individual needed support to make decisions. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions.

Requires Improvement

# Is the service responsive?

## Our findings

People's feedback about whether the service was 'responsive' was mixed. People told us that staff would respond to their requests but that call bells were not always answered in a timely way. Comments from people who used the service included; "They're not quick at answering the call bell" and "It's my only criticism really. It's a good home. But sometimes it's far too long a wait before the staff will come after you've pressed the call bell." We monitored the call bell over a 30 minute period. During this time it rang 13 times. Eight of these calls were responded to in less than two minutes, a further three were answered within five minutes, and two were answered within ten minutes.

Staff continued to identify and plan for people's specific needs using a range of assessments. Individual care plans remained in place to support staff to maintain people's health, well-being and individuality. Most care plans were detailed and provided sufficient information to enable staff to provide consistent care. However we noted some omissions. Where people were assessed as at risk of dehydration their care records stated their fluid intake should be monitored. However these care plans did not recommend daily fluid targets to enable staff to identify when further action should be taken. On checking the fluid charts we found gaps in recording. Staff were not totalling up a daily intake. Three people's fluid charts recorded they had at times consumed less than 500mls in one day. One chart recorded only 200mls in a 24 hour period. We spoke with the registered manager about this issue. She told us she was confident staff were providing adequate fluids, but that recording in these instances did not represent the care provided. She told us some people did not have a clinical need to monitor their fluid intake. We noted however some people were dependent upon staff for assistance with nutrition and hydration. It was not clear therefore, how much fluid some people were taking in or what action staff would take when fluid levels were low.

People's health and care plans were reviewed monthly. Reviews included an update of their weight, skin integrity and other health indicators such as blood pressure. Whilst care plans were reviewed regularly the comments continued to be limited in their usefulness, as phrases such as, "care plan remains relevant" and "no changes" were repeated frequently on review records.

The home continued to offer a range of activities to provide meaningful ways for people to spend their time, maintain their interests and develop new skills. The registered manager told us, "We have moved away from the traditional activities expected in care homes and are embracing technology with the use of kindles, a laptop for designing arts and crafts, virtual reality headsets so residents can have virtual trips anywhere they wish. These have been very popular additions to our activities." Activities records showed people could take part in a variety of arts and crafts such as clay modelling as well as quizzes which were often accompanied by a food theme such as curry or cheeses of the world.

People and their relatives were consistently positive in their comments about the activities on offer in the home. One relative said, "It's fantastic here. The stimulation and interaction is marvellous and the family are so happy with his care." We observed a morning armchair exercise group and an afternoon art activity. We saw people were smiling and chatting with one another. Everyone taking part in the activities told us they enjoyed them. We saw artwork created by people who used the service was displayed on the walls.

All of the people we spoke with told us they would make a complaint if they had any concerns. Complaints were well recorded and the registered manager had followed the provider's complaints policy in response to formal written complaints and any concerns which had been raised verbally. Where necessary the registered manager had carried out investigations in response to complaints including reviewing records and taking statements from staff.

Requires Improvement

# Is the service well-led?

## Our findings

During our inspection we found shortfalls in delivery of the service which had not been identified and addressed by the provider's internal quality assurance systems. People we spoke with told us they felt the call bells went unanswered for too long. One person said, they had raised this issue with the registered manager but they had seen no improvements. We saw it had also been discussed during 'resident committee meetings'. The registered manager told us the call bell rang in their office, so they were aware when it was a busier day and could themselves provide support to people and staff. However they acknowledged that they did not formally monitor the call bell by extracting information about how long each bell had rang for. In discussions they told us they would look into whether they could do this.

The results of a satisfaction survey from November 2016 highlighted issues with the quality of meals served in the home. Whilst the registered manager was able to describe the steps taken to make improvements, it was clear from comments shared with us from with people, relatives and staff that they were still not satisfied with the standard provided nine months after the survey.

When reviewing complaints records we saw two relatives had raised concerns over their family member's hydration levels. In response to these complaints the registered manager had provided assurances that fluid levels were being monitored. However we noted fluid balance charts for both people were poorly completed. We viewed the records at 5pm, and saw one person's record had no entry that day since 9am. The registered manager, and staff we spoke with assured us both people had been provided with adequate drinks but that staff had forgotten to record these fluids. These examples did not evidence that the provider had sought to act on feedback to improve the service.

The registered manager told us they were well supported by the provider. They explained representatives from the provider's organisation visited the home regularly, and provided feedback on the quality of the service through discussions and highlighting areas for improvement which they had noted. The registered manager, explained when asked, that there was no formal process of feedback from these regular visits. The provider did not complete a report of their visit, or share an audit tool or action plan relating to the checks they carried out on the quality of the service.

The registered manager continued to carry out a range of checks and audits at the home and to report back to the provider organisation monthly detailing complaints, accidents, sickness levels and staff training completed. They also completed a daily walk around of the home, and a monthly health and safety audit. However we saw these checks had not highlighted that fire alarms were not being tested in line with the provider's safety schedule.

We found that the provider's quality monitoring system had failed to identify and address the issues which we found during our inspection. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good Governance.

At the time of our inspection there was a registered manager in place. They had been formally registered

with the Care Quality Commission since February 2015. Feedback about the leadership of the service was mixed. Most of the people and relatives we spoke with told us the registered manager was a visible presence, friendly and approachable. However some expressed frustrations that they had not seen improvements in areas they had raised as requiring attention such as call bell responses and quality of the food. One person said, "[Registered manager] is lovely. Perhaps too laid back though."

The registered manager met with staff regularly during staff meetings. Staff comments about the registered manager and the provider organisation were very positive. They described the registered manager as fair and supportive and told us they thought they had the skills to be able to run the home very well. Feedback from health professionals was that the home had strong leadership. One health professional told us. "[Registered manager] is excellent. They have a grip on what is going on. Always up to speed about what is going on with any of the residents. Staff I speak to are always happy. [Registered manager] is doing a good job."

Good links with the local community and local businesses had been maintained. The activities coordinator had worked with a local garden centre who provided all of the materials and facilitated a workshop for people to make the hanging baskets displayed around the home. The home held Christmas and summer fayres which the local community were invited to. The previous Christmas fayre had raised £1400 which was used to fund activities and other events in 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<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes in place to assess, monitor and improve the quality of the service provided were not robust enough to identify and address shortfalls. Records were not always an accurate account of the care people received. Regulation 17.2 (a)(b)(c) |