Solehawk Limited

Kenton Manor

Inspection report

Kenton Lane
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Tel: 01912715263

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Kenton Manor is a residential care home providing personal and nursing care to 60 people at the time of inspection, some of whom were living with a dementia. The service can support up to 65 people in one large adapted building.

People's experience of using this service and what we found
The arrangements for medicines management did not keep people safe. People were at risk of serious harm, injury or death due to unsafe management of 'as required' medicines, diabetes management and epilepsy management.

People were also at risk of serious harm as staff did not have clear guidance within care records in relation to risk assessments, care plans or protocols to support people safely. Clinical staff did not always follow the provider's processes, best practice guidance or prescribing instructions.

Clinical staff did not always refer people in a timely way to other health care professionals, for example the GP. People's health needs were not always fully assessed and recorded.

The quality assurance processes were not effective to ensure people were safe from risk of serious harm. The provider did not have oversight of the service and they were not aware of the issues we identified as part of the inspection.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was inadequate (published 4 December 2019) and the service was placed into 'special measures'. At the last inspection there were multiple breaches of regulations. The provider completed an action plan after the last inspection to show what they would do, and by when, to improve.

At this inspection enough improvement had not been made and the provider was still in breach of the regulations.

Why we inspected
We undertook this targeted inspection to make sure all aspects of the provider's action plan had been completed. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC are currently trialling targeted inspections, to measure their effectiveness in following up on a Warning Notice or other specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the

previous inspection. This is because they do not assess all areas of a key question.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report.

Enforcement
We have identified two continued breaches Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This is in relation to safe medicines management, leadership of the service and the quality and assurance systems in place.

Please see the action we have told the provider to take at the end of this report.

Follow up
At the time of the inspection the provider was working towards completing an action plan from our previous inspection which reflects what they are doing to improve the standards of quality and safety, and we are receiving regular assurances of the progress of improvements. We will work with the provider, local authority and Clinical Commissioning Group (CCG) to monitor progress and discuss on-going concerns.

We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration. For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our Safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-led findings below.

Kenton Manor

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. This was a targeted inspection to check on specific concerns we had about staff recruitment and safeguarding processes.

Inspection team
This inspection was carried out by three inspectors.

Service and service type
Kenton Manor is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service. This included any statutory notifications received. Statutory notifications are specific pieces of information about events, which the provider is required to send to us by law.

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 sought feedback from the local authority contracts monitoring and safeguarding adults' teams and

reviewed the information they provided. We contacted the NHS Clinical Commissioning Group (CCG), who commission services from the provider, and the local Healthwatch for their feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We reviewed 14 people's medicine and care records and reviewed policies and procedures relating to governance of the service. We spoke to eight members of staff including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested immediate action be taken with regards to managing people's medicines and reviewed regular updates from the service about this.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check medicines were managed safely.

We will assess all of the key questions at the next comprehensive inspection of the service.

Using medicines safely
At our last four inspections the provider had failed to robustly assess the risks relating to the health safety and welfare of people with regards to medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines continued to not be managed safely. On the first day of inspection we found that five people had not received their morning medicines. We raised this with clinical staff at lunch time, who took action to ensure these medicines were given. Medicine administration records were not fully completed to allow them to be counted to see if they had been administered or not. This meant people were at serious risk of harm due to unsafe administration of medicines.
● Care plans and records did not include all relevant medical information to keep people safe from injury, serious harm or death. For example, one person was receiving a medicine as part of their treatment for epilepsy. The service did not know that the person had a diagnosis of epilepsy and thought they were receiving the medicine for another condition. We asked the service to contact the GP to make sure they understood the person's medical history and create a care plan to reflect this need.
● Protocols for staff to follow for 'as required' medicines continued to be unclear. For example, one person who was using an 'as required' oral spray to reduce chest pain did not have a clear step by step process for staff to follow to use this medicine. This may have resulted in serious harm or death to the person if emergency treatment was required.
● Diabetes management was not always safe. For example, clinical staff did not refer one person who had increasing high blood sugar levels to the GP. We found people's 'as required' protocols for diabetes medicines were not followed safely by clinical staff. We requested an urgent medical review of three people was completed by a doctor on our first day of inspection.
● Clinical staff continued not to follow the prescribing instructions for medicines for the treatment of dementia.

This demonstrates a continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 due to unsafe medicines management and practices,

especially the high risk concerns of the management of people's 'as required' medicines, diabetes treatment and epilepsy treatment.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we have specific concerns about.

The purpose of this inspection was to check whether the leadership and quality assurance systems allowed for improvements to the safety and quality of care provided to people.

We will assess all of the key questions at the next comprehensive inspection of the service.

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

At our last inspection the provider did not have effective quality and assurance systems in place to ensure that people received safe, effective and responsive care. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● After our last inspection we requested the provider made urgent improvements at the service to make sure people received their care and treatment needs in a safe way. After the inspection the provider sent us an action plan stating they had addressed our concerns. However, we identified continuing concerns during this inspection.
● The quality assurance systems at the service did not identify the issues we found during the inspection process. For example, audits did not show errors had occurred with medicine administration. People's care and medicines records were not completed as not all needs had been fully reviewed or documented.
● The provider did not have oversight of the service and had not fully identified where improvement was needed.
● Records relating to the care provided to people and to the governance of the service were not accurate or complete.

This demonstrated a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We are continuing to work with the provider, local authority and CCG to ensure improvements are made to reduce the risks to people.

● After our inspection the provider took action to address our concerns and appointed an external company to improve the service and overall quality of care provided to people.