Solehawk Limited

Kenton Manor

Inspection report

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

Tel: 01912715263

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 September 2018 and was unannounced.

We inspected the service to follow up on the breaches and to carry out a comprehensive inspection.

At the last inspection in September 2017 the service was not meeting all of the legal requirements with regard to regulations 9, person-centred care and regulation 12, safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found some improvements had been made but there were continued breaches of regulations 12, safe care and treatment and regulation 9, person-centred care as further improvements were required with regard to aspects of people's care. At this inspection we found two other breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to regulation 18, staffing levels and regulation17, good governance.

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

Kenton Manor is a care home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the premises and the care provided, and both were looked at during this inspection.

Kenton Manor accommodates a maximum of 65 older people, including people who live with dementia or a dementia related condition, in one adapted building. At the time of inspection 64 people were using the service.

A registered manager was in place. 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 provider had a quality assurance programme to check the quality of care provided. However, the systems used to assess the quality of the service had not identified some of the issues that we found during the inspection and those that had been identified were not actioned in a timely way.

People said they felt safe and they could speak to staff as they were approachable. However, we had concerns that staffing levels were not sufficient or that staff were appropriately deployed to ensure people received person-centred care. People said staff were kind and caring. However, we saw staff did not always interact and talk with people. Limited activities and entertainment were available to keep people engaged on the middle and top floor of the home. In some parts of the home there was an emphasis from staff on task-centred care.

Improvements were required to the management of medicines. People were not always supported to have maximum choice and control of their lives with staff supporting them in the least restrictive way possible, the policies and systems in the service did not always support this practice. We have made a recommendation about the management of medicines.

Record keeping was inconsistent. Detailed guidance was not available for staff to minimise or appropriately manage risks to all people. Written information was not available to ensure all people were supported safely and in a person-centred way. There were some opportunities for staff to receive training to meet people's care needs. A system was in place for staff to receive supervision and appraisal. However, we have made a recommendation about staff training

Changes had been made to the environment. Some areas had been refurbished. However, not all areas of the home were clean and well-maintained for the comfort of people who used the service. Further improvements were required to ensure the environment was designed to promote the orientation and independence of people who lived with dementia. We have made a recommendation that the environment should be designed according to best practice guidelines for people who live with dementia.

People were protected, as staff had received training about safeguarding and knew how to respond to any allegation of abuse. When new staff were appointed, thorough vetting checks were carried out to make sure they were suitable to work with people who needed care and support.

People had access to health care professionals to make sure they received appropriate care and treatment. People received a varied and balanced diet to meet their nutritional needs. However, improvements were required to people's dining experience.

Staff followed advice given by professionals to make sure people received the care they needed. Communication was effective to ensure staff and relatives were kept up-to-date about any changes in people's care and support needs and the running of the service.

A complaints procedure was available. People told us they would feel confident to speak to staff about any concerns if they needed to. People had access to an advocate if required.

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 told us they felt safe. However staffing levels were not sufficient or staff appropriately deployed to ensure people were looked after in an effective and person-centred way. Staff were appropriately recruited. Staff were aware of different forms of abuse and said they would report any concerns they may have to ensure people were protected.

Checks were carried out regularly to ensure the building was safe and fit for purpose. However, some areas of the home required attention as they were not clean and they were showing signs of wear and tear.

Risk assessments did not all provide guidance about how to reduce risk to people's health and safety. Improvements were required to medicines management to ensure people received their medicines in a safe way.

Is the service effective?

Requires Improvement

The service was effective.

Staff received supervision and training to support them to carry out their role.

People's rights were not always protected. Records did not show that all best interest decisions were made appropriately involving all the relevant people, when people were unable to give consent to their care and treatment. We have made a recommendation about medicines management.

People received a varied and balanced diet.

Further improvements were needed to ensure the environment was designed to promote the orientation of people who lived with dementia.

Is the service caring?

Requires Improvement

The service was not always caring.

There was an emphasis on task-centred care as there was limited interaction with people by staff. Staff did not spend time talking with people or engaging with them.

People were encouraged to express their views and make decisions about their care. People were supported to maintain contact with their friends and relatives. Staff supported people to access an advocate if required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place, but they were not detailed to meet people's care and support requirements.

There were activities and entertainment available for some people but people were not all provided with opportunities to be engaged when the activities person was not available.

People had information to help them complain. Complaints and any action taken were recorded.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and staff told us the registered manager was approachable.

Although some work had been done to achieve compliance with the breaches made at the last inspection. We considered further improvements were required to ensure people received person-centred care.

The registered manager and provider monitored the quality of the service provided and introduced improvements. However, the systems used to assess the quality of the service had not identified the issues that we found during the inspection. Those that had been identified were not actioned in a timely way to ensure people received safe care that met their needs.

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.

The inspection took place on 19 September 2018 and was unannounced.

The inspection team consisted of one adult social care inspector, a specialist professional nursing advisor and an expert by experience. An expert-by-experience is a person who has personal experience of caring for someone who uses this type of care service for people who live with dementia.

Before the inspection, we had received a completed Provider Information Return (PIR). The PIR asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service as part of our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send CQC within required timescales. We also contacted commissioners from the Local Authorities who contracted people's care and the local authority safeguarding team.

During this inspection we carried out observations using the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not communicate with us. We observed care and support in communal areas and looked around the kitchen.

During the inspection we spoke with 15 people who lived at Kenton Manor, six relatives, the provider, the registered manager, six support workers including one senior support worker, two registered nurses, two members of catering staff, the activities co-ordinator and one visiting professional.

We reviewed a range of records about people's care and how the home was managed. We looked at care records for eight people, five people's medicines records, recruitment, training and induction records for five

staff, staffing rosters, staff meeting minutes, meeting minutes for people who used the service and relatives, the maintenance book, maintenance contracts and quality assurance audits the registered manager had completed.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in September 2017 we made a breach of regulation 12, safe care and treatment as guidance was not available to reduce the risk to people, to ensure they received their medicines safely. At this inspection we found although some improvements had been to aspects of medicines management further improvements were required to ensure people received safe care and treatment. We have made a continuing breach of regulation 12, safe care and treatment as further improvements were required to medicines management.

Some improvements were required to show all people were receiving their administered medicines as prescribed. The medicines administration record (MAR) is a document showing the medicines a person has been prescribed and staff use it to record when the medicines have been administered. The MARs we looked at did not all show they had been completed appropriately. The MARs for two people did not state the specific times to administer their medicines in terms of other drug or food interactions. For another person, although they received their medicines at the correct times, the timings stated on the MAR chart did not correspond to the timings recorded in their care plan. For another person there were two gaps in the recordings on the MAR chart over two days, so it was unclear if the person had received their medicines. For another two people, who had a handwritten MAR in place, a second member of staff had countersigned the record to confirm it was accurate. However, the records showed the medicines timings had been handwritten over the pre-printed timings. For the discontinued medicines specified on the MARs, the reasons for discontinuation were not consistently stated and it was unclear who had authorised the discontinuation. This was discussed with the registered nurse and registered manager at the time of inspection who told us the issues would be addressed.

Some people received support with medicinal creams and improvements were required to show and ensure that people received such support. Body maps were in place to show where the creams should be applied and the medicines listed on the body map were also listed on the MAR. However, for one person the body map and MAR related to two medicinal creams. It did not outline the frequency of usage, the body map did not show where the cream should be applied and the MAR showed there were seven gaps in recording the medicinal cream's usage. For another person although the medicinal cream was listed on the body map, the medicine was not listed on the MAR and there was no confirmation that the medicinal spray had been administered. For a third person a medicinal cream was listed on the MAR but a body map was not in place to show where the cream should be applied and there was no confirmation that the cream had been applied. We were informed this person self-administered their cream, however there was no supporting documentation that stated this.

Clear guidance was available for staff that detailed when some people may need 'when required' medicines, for example, for pain relief but these protocols were not in place for all people who needed such medicines.

Medicines were stored securely within the medicines trollies and treatment rooms. Medicines which required cool storage were stored appropriately in a fridge. Maximum and minimum temperatures were recorded on a daily basis and were between the required two and eight degrees centigrade. However, on

several occasions the recorded temperatures were below the two degrees centigrade. This was lower than the recommended temperature for the cool storage of some medicines and action had not been taken by staff to ensure medicines were still safe to use. As the quality of medicines may have been compromised as they had not been stored under required conditions.

Appropriate arrangements were in place for the disposal of medicines but we observed a Sharps bin was not available on the top floor for the disposal of a used insulin injection.

Appropriate arrangements were in place for the administration, storage and disposal of controlled drugs, which are medicines which may be at risk of misuse. However, records showed that stock balances were not checked and recorded on a weekly basis.

Care plans were not in place for all people that provided detailed guidance for staff for the management of behaviours that challenged when a person may become agitated or distressed. Some care plans were vague and did not document what staff needed to do, to recognise triggers or de-escalate the situation to calm and reassure the person when they were agitated or upset. For example, several care plans labelled people as challenging when assisted with their personal care but no guidance was provided about how staff should work with the person to support them when they became distressed and embarrassed at personal care intervention. One personal hygiene care plan recorded, "[Name] requires full assistance with all hygiene and dressing. [Name] is resistive to interventions due to dementia two people required. [Name] is resistive to interventions and will often lash out."

Risk assessments were in place and they were recorded in people's care records. The documents provided staff with a description of any identified risk. However, they did not provide specific guidance to mitigate risk or how people should be supported in relation to the identified risk. For example, the risk of falling. One care record stated the person was at high risk of falls but written guidance was not available to show how to reduce the risk the of falling to keep the person safe but rather recorded the action to take after the fall.

A personal emergency evacuation plan (PEEP) was put into place for each person when they started to use the service, taking into account their mobility and moving and assisting needs. However, it was not evaluated monthly to ensure it was up-to-date and accurately reflected any risk. This was for if the building needed to be evacuated in an emergency. Other risk assessments were in place with a system of review to ensure they remained relevant, reduced risk and kept people safe.

At the time of inspection not all areas of the home were clean and there was a mal-odour in areas identified at inspection. Carpets in some lounges and hallways were stained and marked and showing signs of wear and tear. The registered manager told us that this had been identified and when they checked the registered manager was told lounge carpets would be replaced within two weeks. Dining room floors were not well-cleaned as some chairs were difficult to move as people sat down. Not all place mats and chairs were clean as they felt sticky to the touch and place mats were worn and some contained food particles.

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

Staff received training about infection control and they had access to protective equipment to help reduce the spread of infection.

Most people who used the service and relatives said that they and their relatives were safe at the home. A person told us, "I'm doing very nicely here, I love it." One relative told us, "I think [Name] is kept safe here."

However, we received mixed comments about staffing levels and the availability of staff. One person told us, "Staff are always around." Another person commented, "Staff sometimes can sit but sometimes there is no-one around." A relative said, "The staff work hard, they could do with more staff." Another relative said, "I think there is a problem with staffing, particularly when someone is off sick." Other relative's comments included, "There are not enough staff to have time to care for [Name]", "Staff have no time to talk to people they are always busy or doing paperwork", "The staff are busy, they don't have much time to talk to people" and "We have sometimes seen people on their own in the lounge and they couldn't access the buzzers if they needed help."

Our observations during the inspection showed staff were busy, staffing numbers were insufficient and staff deployment was ineffective to ensure person-centred care to people in all parts of the home. There were 64 people living at the home at the time of inspection. The registered manager told us 22 people on the top floor were supported by one registered nurse and three support workers. On the middle floor 25 people were supported by one nurse and three support workers and on the ground floor 18 people were supported by three support workers including a senior support worker. However, the staffing rosters and our observations showed the numbers of staff were not consistently maintained on all floors each day. Staff members' comments included, "There are usually four support workers on the floor but not today", "Mornings are busiest" and "Sometimes I am the only qualified staff and it is difficult when we have had PEG feeding and we have insulin/blood monitoring."

On the day of inspection people on the ground floor were supported by two staff members until an additional member of staff from the adjoining home came over to assist after the evening meal. We discussed this with the registered manager who told us they had been unable to arrange staff cover as a staff member was off. During the course of the day we observed support staff carrying out domestic tasks such as washing dishes after the lunch time and evening meal and cleaning the dining rooms. We were told support staff were also responsible for tidying people's bedrooms. We observed because staff were busy some bedrooms were not tidy, with beds unmade, curtains not open and items of clothing left on the floor. Due to the amount of tasks staff had to complete this reduced the amount of direct care time with people as support staff were carrying out ancillary tasks. During the day we observed care was task-centred and staff did not have any meaningful interaction or engagement with people as they were busy, although a member of staff was usually available to supervise people in the lounges on the middle and top floor of the home.

Overnight staffing levels included two registered nurses and six support workers including a senior support worker.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had receiving training about safeguarding, they had an understanding of safeguarding and knew how to report any concerns. Staff were able to describe various types of abuse and tell us how they would respond to any allegations or incidents of abuse. One staff member told us, "I'd report it to the nurse or registered manager." The safeguarding log showed 27 alerts had been raised by the home or received between January 2018 and September 2018. However, there was no evidence to show they were analysed for any themes and trends. The service was currently placed in organisational safeguarding by the safeguarding team, as the number was over the threshold and had triggered the process with the local authority. Meetings were to take place to investigate with the provider and registered manager the numbers of referrals and how they were being managed.

Regular analysis of incidents and accidents took place. The registered manager told us learning took place

from identified incidents and action was taken to reduce the likelihood of them recurring. For example, with regard to falls and distressed behaviours. Records showed if there were any concerns about a change in a person's behaviour a referral would be made to the positive behaviour team and new care plans were implemented. A falls protocol had also been introduced for when a person fell more than three times. However, there was no overall analysis of incidents to identify any patterns or trends to reduce any apparent risk. The registered manager told us they would discuss this with the management team at head office as they had an imminent managers meeting.

Recruitment of staff was 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 DBS 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.

Arrangements were in place for the on-going maintenance of the building. Regular checks were carried out and contracts were in place to make sure the building was maintained and equipment was safe and fit for purpose. Appropriate emergency evacuation procedures were in place, regular fire drills had been completed and all fire extinguishers had been regularly serviced.

Requires Improvement

Is the service effective?

Our findings

Staff had some opportunities for training to understand people's care and support needs and they were supported in their role. A staff member commented, "I have just done training about special diets and the presentation of pureed foods. It is being rolled out to all kitchen staff by the middle of October 2018." Another staff member said, "I do on-line training." Other staff comments included, "Supervisions do happen. I had one last week, it was about communication", "The nurse or manager does my supervision every three months and appraisals happen every year", "There are training opportunities", "I have done heaps of training", "They [management] are going to set up some training on line for me" and "I had an appraisal not long ago."

Staff members were able to describe their role and responsibilities. They told us when they began working at the home they had completed an induction programme which included a week at headquarters and they had the opportunity to shadow a more experienced member of staff when they came into the home. This was needed to ensure they had the basic knowledge needed to begin work. New staff studied for the Care Certificate as part of staff induction to increase their skills and knowledge in how to support people with their care needs. (The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care.)

The staff training records showed staff were kept up-to-date with safe working practices and they had opportunities for other training to understand people's care and support needs. Staff training courses included dementia awareness, dignity, equality and diversity, mental capacity and deprivation of liberty safeguards, positive behaviours, person-centred care, fluids and nutrition, risk assessments and records and reporting. Staff told us and the staff training matrix showed all training was provided by e-learning. We had been told that the e learning pass rate bar to pass the course was set at less than 75%. This level would not show that staff had understood all elements of the training. Staff did not receive face-to-face training for courses with a practical element such as for fire training and moving and assisting. We discussed this with the registered manager who told us it was being addressed and a new training provider was to be used.

We recommend that staff receive a mixture of e-learning and face-to-face training to ensure their understanding and competence.

People's needs were assessed before they started to use the service. This ensured that staff could meet their needs and the service had the necessary equipment for their safety and comfort. Assessments were carried out to identify people's support needs and they included information about their medical conditions, dietary requirements and their daily lives.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had submitted DoLS applications appropriately.

Records contained information about people's capacity to make decisions and their levels of understanding. However, they showed that where people lacked mental capacity to be involved in their own decision making, the correct process had not always been followed. Records did not show evidence of a best interests meeting taking place with the involvement of people, or their relatives, where people did not have capacity to consent to some restrictions. Best interest decision information was not available to detail why bedroom doors were locked or people's consent to having their bedroom door locked. We observed people's bedroom doors were locked and people did not have a key. Some decisions were not specific such as close observation of people and the use of bed rails and lap belts. With regard to the use of covert medicines (covert medicine refers to medicine which is hidden in food or drink). There was a covert medicine administration form for use for one person, it had not been reviewed since April 2017 and there was no record of the best interest decision making and how it had been decided. The registered manager told us the GP, nurse and pharmacist had been involved in the decision making. However, the 'best interest' decision making did not adhere to the National Institute for Health and Care Excellence (NICE) guidelines as the best interest decision had not involved the relevant people.

We recommend the manager considered the National Institute for Health and Clinical Excellence guidelines on managing medicines in care homes.

The home was spacious, bright and airy. An enclosed garden was available with a sitting area. Recent resident and relative meeting minutes showed areas of the home were being refurbished and decoration had taken place in some communal areas and bedrooms. However, the environment was showing signs of wear and tear in some areas. Walls, doorways, some bedroom walls and communal areas needed re-decoration. The flooring leading to the kitchen was damaged and required attention and the part of the kitchen flooring was also damaged and showing signs of wear and tear. We observed inappropriate storage in some people's bedrooms. There were large boxes of continence aids in people's bedrooms, in some bedrooms we saw three or four large boxes stacked against the wall which restricted mobility for the person around their bedroom and also did not provide a comfortable living environment. For another person, we observed with a relative, two hoists that were not used by the person but were locked in their bedroom. A member of staff told us they were there so they did not block the corridor. This was inappropriate storage as the equipment belonging to the home was stored in an individual's bedroom. We checked later in the day and saw this had been addressed in one of the bedrooms.

The communal areas and hallways of the home had decorations and pictures of interest. Corridors were bright and themed in some areas. There was a display at the end of the corridor on the middle and top floor with a seating area for people as they moved around. There was appropriate signage around most of the building to help maintain people's orientation. Lavatories and bathrooms were signed for people to identify the room to help maintain their independence. However, we considered some improvements could be made to ensure people were kept orientated in other areas of the home. People's bedroom doors did not all provide signage to help them identify their bedroom. Memory boxes were not available that contained items and information about people's previous interests to help them identify their room. They would also give staff some insight into the person's previous interests and life when the person could no longer communicate this information themselves.

We recommend the service finds out more about current best practice regarding the design of

accommodation for people who live with dementia.

People were supported to access community health services to have their healthcare needs met. Their care records showed they had input from different health professionals. For example, the GP, district nurse, tissue viability nurse and the behavioural team. One relative told us, "A chiropodist and dentist visit [Name] regularly." Another relative said, "Name has recently had their eyes tested and they see the GP on Wednesdays." A GP led clinic assisted by a specialist community nurse and nurse from the home was held at the service one afternoon each week, we saw it took place on the day of our inspection. The clinic was held to review people's health needs and to make sure they were treated promptly. It was also to help prevent people's unnecessary admission to hospital.

Systems were in place to ensure people received varied meals at regular times. We spoke with the cook who was aware of people's different nutritional needs and special diets were catered for. They told us people's dietary requirements such as if they were vegetarian or required a culturally specific diet were checked before admission to ensure they were catered for appropriately. One person told us, "The food is okay. Plenty to eat and drink." Another person commented, "Food has its ups and downs." A relative said, "There are always lovely meals, Sunday lunch is very good."

People who were at risk of poor nutrition were supported to maintain their nutritional needs. This included monitoring people's weight and recording any incidence of weight loss. Referrals were also made to relevant health care professionals, such as dieticians and speech and language therapists for advice and guidance to help identify the cause. Records were up-to-date and showed people with nursing needs were routinely assessed monthly against the risk of poor nutrition using a recognised nutritional screening tool. Food and fluid charts recorded people's nutritional and fluid intake. However, food charts did not record portion size. For one person's fluid chart goal it did not correspond with what was documented in the person's care plan. Charts were fully completed, however they were not analysed, thereby effectively monitoring people's intake and taking action as required. We discussed this with the registered manager who told us it would be addressed.

We observed the lunch time dining experience in two of the three dining rooms and a luncheon club also took place for six people in the bar. Food was well-presented and looked appetising. People were offered a choice of meal. Tables were set with tablecloths, condiments, menus and napkins. People who lived with dementia were encouraged to make a choice or be involved in decision making with regard to their food. Juice and hot drinks were served with the meal. However, we considered some improvements were required to the organisation of people's dining experience. Relaxing, tranquil music was not available to entertain people as they waited or to encourage people to eat their meal in dining rooms. On the top floor the meal time took from 12.30pm until 2.30pm as people waited some time for staff to serve their food. Two staff members were available in the dining room to assist 11 people whilst one staff member assisted people in their rooms with their meal and delivered meals to people, from the top floor, dining in the lunch club on the ground floor. The hot trollies were in the dining room from 12.15pm, but during the meal the chef delivered some softened vegetables for people as part of their specialist food requirements.

In the top floor dining room people were seated at tables from 12.30pm but at 1.00pm only three people in the dining room had been served their meal. Due to the length of time waiting for their meal and to be served their next course some people with distressed behaviours became agitated as they waited. One person was given biscuits as they waited for their meal. Staff did not observe when a person left the table and helped themselves to a cup of sugar which they ate. Another person placed table decorations in their food and another person poured their juice back into the jug in the serving area. Staff did not during the meal provide support and encouragement to some people to eat their meal whilst it was still hot. One

person did receive full assistance to eat their food from the nurse who came to assist the person. The meal time organisation on the top floor was discussed with the registered manager who told us it would be addressed.

Requires Improvement

Is the service caring?

Our findings

At the last inspection we had made a breach of regulation 9, person-centred care. At this inspection we were told staff had received training about person-centred care in order to help ensure people received person-centred care. However, we considered further improvements were required to records and staffing levels and deployment to ensure the person was at the centre of their care.

Some people's care records contained information about people's likes, dislikes and preferred routines. However, this information was limited or not available for all people. Social histories or pen pictures were not available for people. In some records the social information forms that captured such information about people's previous hobbies and interests was limited or not available to help ensure staff provided person-centred care when the person was unable to tell staff about their routines and how they wanted their care to be delivered.

Communication care plans were in place for some people that provided information about how a person communicated. Examples included, "[Name] will put their thumb up and nod their head to state they have understood" and "Requires time to understand what has been said, staff to approach [Name] in a calm manner and try to keep eye level allowing them time to respond." However, record keeping was inconsistent as communication care plans were not always in place where required and did not always reflect the person's current needs. For example, a communication care plan stated, "If the person is having particular trouble picture cards can be used such as for food and drink." When we spoke with the nurse they told us the relative had taken the picture cards home as they were no longer required

People who were able to express their views told us they made their own choices over their daily lifestyle. They told us they were able to decide for example, what to eat, when to get up and go to bed and what they might like to do. For some people who needed encouragement to be involved in decision making some care plans detailed how a person may be encouraged and involved in decision making. For example, one care plan stated, "[Name] has difficulty making choices about food so staff should physically show them choices." Menus and activities although available in written and pictorial format were small and difficult to read, and accessible information advertising activities and days of the week and other information to keep people informed and involved was not available.

Care was task-centred rather than person-centred. We noted staff were visible in communal areas but throughout our observations in the morning they were engaged in completing paperwork when sitting with people whilst people sat silently and were not engaged or stimulated. People sat sleeping or were unoccupied and dis-engaged apart from at meal times or when care was provided. In some lounges the television was turned on but it was not loud enough if people wanted to watch and listen to a programme and there did not appear to be any interest or recognition from people to show it was appropriate and people were listening and engaging with it. In another lounge there was silence, no music, television or any interactions taking place as people sat as a staff member wrote records until we intervened. During our observations after lunch the same routine continued apart from when people were assisted to see the GP at the clinic.

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

Staff engaged with people in a calm and quiet way when they engaged with them. When they carried out tasks with the person they bent down as they talked to them so they were at eye level. People were positive about the support provided by staff. Their comments included, "I am doing very nicely here, I love it", "I can't grumble my family visit often", "The staff are okay, very nice", "They [staff] are a nice crowd, the staff are good" and "The staff are very good with me." People's privacy and dignity were respected. People told us staff were respectful.

We observed that people looked clean, tidy and well-presented. One relative told us, "[Name] always looks clean and tidy." Staff knocked on people's doors before entering their rooms. Bedroom doors were closed when staff assisted people in their bedroom to protect their dignity. Records were held securely and policies were available for staff to make them aware of the need to handle information confidentially.

Written information was available that showed people of importance in a person's life. Relatives were involved in discussions about their family member's care and support needs and they could approach staff at any time. One relative told us, "Staff always contact me if they have any concerns about [Name]."

There was information displayed in the home about advocacy services and how to contact them. The registered manager told us people had the involvement of an advocate, where there was no relative involvement. Advocates can represent the views for people who are not able to express their wishes.

Requires Improvement

Is the service responsive?

Our findings

We had concerns records did not include details with regard to how people liked and needed their support from staff. It is important information to help ensure people receive person centred care and necessary for when a person can no longer tell staff themselves about their preferences. Care plans did not include details about peoples' choices to encourage the person to maintain some involvement and control in their care.

Care plans were developed from assessments that outlined how people's needs were to be met. For example, with regard to nutrition, personal care, medicines, pressure area care, communication and moving and assisting needs. Records showed that monthly assessments of peoples' needs took place with evidence of evaluation that reflected any changes that had taken place. Evaluations included information about people's progress and well-being, however they did not all provide an account of the person's progress or deterioration over the month. Records did not show that reviews of peoples' care and support needs took place with relevant people at regular intervals. A relative commented when asked if they had attended any reviews, "I am not sure about the care plan, is it six monthly?"

Care plans were in place that provided some details for staff about how the person's care needs were to be met. However, care plans did not provide guidance to staff to ensure consistent care was provided to people detailing what the person could do to be involved and to maintain some independence. Care plans did not give instructions for frequency of interventions and what staff needed to do to deliver the care in the way the person wanted. For example, a personal hygiene care plan stated, "[Name] requires assistance of one-two members of staff to assist their personal hygiene/dressing needs." Other care plans for personal hygiene which stated the person became distressed did not document what staff needed to do to de-escalate the situation when a person became agitated because of personal care interventions. Limited care plans were in place for other some other assessed needs such as continence and mobility.

Records showed the relevant people were involved in decisions about a person's end of life care choices when they could no longer make the decision for themselves. People's care plans detailed the 'do not attempt cardio pulmonary resuscitation' (DNACPR) directive that was in place for some people with regard to their health care needs. However, information was not available with regard to people's spiritual and cultural preferences at this important time and for their wishes after death to ensure their final wishes could be met. Examples of information that was available included, "[Name] has not stated or expressed any spiritual wishes at present" and "[Name] has not expressed any preference or wishes about their end of life care." We discussed this with the registered manager that written information should be available, as the service provided end of life care, so staff knew how to care for the person at the end of their life following any cultural or religious wishes of the person.

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

Staff completed a daily accountability record for each person and recorded their daily routine and progress in order to monitor their health and well-being. This information was then transferred to people's support

plans. Charts were also completed to record any staff intervention with a person. For example, when personal hygiene was attended to and other interventions to ensure peoples' daily routines were met. These records were used to make sure staff had information that was accurate so people could be supported in line with their up-to-date needs.

Some people confirmed they had a choice about getting involved in activities. One person told us, "The odd time there is bingo but it doesn't suit me." Another person commented, "I like it here in the summer you can go in the garden." Other peoples' comments included, "I just sit around there is nothing to do, they sometimes leave a quiz for me", "The only way I can go out is with my friends" and "There's nothing to do all day." Records were not available which showed when people were offered an activity or if they refused or took part. The record would be useful to monitor people's engagement and participation and to prevent their social isolation.

An activities person was employed over 40 hours of the week. On the day of inspection on the ground floor we observed a movie afternoon taking place that was attended by five people. Activities were not observed taking place on the middle or top floor of the home during the day. The activities person told us they had been providing one-to-one activities using sensory equipment with some people and they had assisted a person to shower. We observed they ran the luncheon club that took place in the bar. An activities programme however, advertised individual activities, men's club, coffee morning, arts and crafts, movies, pamper sessions, sensory sessions and music club.

Entertainment and organised social events took place on a regular basis. These included cheese and wine evenings and craft events and singers. Seasonal entertainment also took place. The activities coordinator was enthusiastic about their role. They told us preparations were in hand for Christmas events such as a pantomime, carol service and Christmas fayre that was being organised. They told us links were being made with the local community with a nearby school where some pupils were to do chair aerobics with people. A mini bus was available to take people on trips but it was not available currently as it required repair.

People knew how to complain. The complaints procedure was on display in the entrance to the home. A record of complaints was maintained and five had been received since the last inspection. A complaints procedure was in place to ensure they were appropriately investigated.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in post. They had registered with the Care Quality Commission in 2013 to be the registered manager of Kenton Manor. They were fully aware of their registration requirements and had ensured that the CQC was notified of any events which affected the service.

Some improvements had been made to service provision. However, further improvements were required in the identified areas such as staffing levels and staff deployment and systems to ensure person-centred care, record keeping, staff training and governance which were discussed at the inspection.

We had concerns audits were not all effective to ensure the well-being at all times of people who used the service.

Auditing and governance processes were in place to check the quality of care provided and to keep people safe. A quality assurance programme included daily, weekly, monthly and quarterly audits. They included checks on staff training, medicines management, dining experience, accidents and incidents, infection control, nutrition, skin integrity, falls and mobility, health and safety, accidents and incidents, home presentation and complaints and safeguarding management. Audits showed the action that had been taken as a result of previous audits. However, the audit and governance processes had either failed to identify or they had not been actioned in a timely way issues identified at inspection including the environment, medicines management, accident and incident analysis, record keeping, staffing levels and staff deployment, activities provision and people's dining experience.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us monthly visits were carried out by the regional manager to speak to people and the staff regarding the standards in the home. They also audited a sample of records, such as care plans, complaints, accidents and incidents, medicines records, risk assessments, safeguarding and staff files. These audits were carried out to ensure the care and safety of people who used the service and to check that appropriate action was taken as required. We noted that identified actions in audits were not always actioned in a timely way. We noted some areas for improvement that we identified at inspection had been identified at the regional manager's audits in July and August 2018.

The registered manager assisted us with the inspection. Records we requested were produced promptly and we were able to access the care records we required. The registered manager was able to highlight their priorities for the future of the service and were open to working with us in a co-operative and transparent way.

Staff, people and relatives said they felt well-supported. Staff were positive about the management of the service and had respect for them. Several staff members said, "The manager is approachable."

Staff told us communication was effective. People's needs were discussed and communicated at staff handover when staff changed duty, at the beginning and end of each shift. This was so staff were aware of the current state of health and well-being of people. There was also a handover record that provided information about people, as well as the daily care entries in people's individual records. One staff member told us, "Handovers do happen between staff at the beginning of each shift." Another staff member said, "Communication is effective." Other staff comments included, "The nurse will keep us up-to-date about any change in people's support needs", "Communication isn't always effective", "We have a daily handover sheet", "We have a handover sheet it gives all the information we need and we can refer to progress notes as well" and "All support staff attend the handover when you come on duty."

People and their relatives were kept involved and consulted about the running of the service. A variety of information with regard to the running of the service was displayed to keep people informed and aware and this included the complaints procedure, safeguarding, survey results, advocacy and forthcoming events. Meetings took place with them and minutes were available for people who were unable to attend. Meeting minutes showed items discussed related to the running of the home, the environment, menus and activities.

Staff told us monthly department staff meetings took place and minutes of meetings were available for staff who were unable to attend. One staff member commented, "Staff meetings happen monthly." Staff meeting minutes showed topics discussed included training, hygiene, nutrition, person centred care, care planning, staff performance, complaints and incident reporting. Staff meetings kept staff updated with any changes in the service and to discuss any issues. Meeting minutes also referred to the 'resident of the day scheme' where aspects of a person's care was checked.

The provider monitored the quality of service provision through information collected from comments, compliments/complaints and survey questionnaires that were sent out annually to people who used the service, relatives and staff. Results were available from a survey in 2018 that were mainly positive and showed where comments were made and where suggestions had been made for improvements, for example to menus and the environment these had been actioned and the results advertised showing what people had said and the action taken.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that records and systems were in place so that people received person-centred care that met their needs and preferences. Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People did not all receive safe care and treatment. Systems were not all in place to mitigate all risks to ensure people received safe care and treatment. Regulation 12(1)(a)(b)(d)(g)(h)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance People were not protected from the risk of inappropriate care and treatment due to a lack of information or failure to maintain accurate records. Robust systems were not in place to monitor the quality of care provided. Regulation 17(1)(2)(a)(b)(c)(d)(e)(f)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation 18 HSCA RA Regulations 2014 Staffing

The registered person had not ensured staffing levels were sufficient and staff were appropriately deployed to provide timely, effective and person-centred care to people at all times.

Regulation 18 (1)