Review of compliance

Solehawk Limited Kenton Hall Nursing Home	
Region:	North East
Location address:	Kenton Lane Gosforth Newcastle-upon-Tyne Tyne and Wear NE3 3EE
Type of service:	Care home service with nursing
Date of Publication:	February 2012
Overview of the service:	Kenton Hall is a care home providing accommodation for up to 60 persons who require nursing or personal care; treatment of disease, disorder or injury; and diagnostic and screening services.

Summary of our findings
for the essential standards of quality and safety

Our current overall judgement

Kenton Hall Nursing Home was meeting all the essential standards of quality and safety but, to maintain this, we have suggested that some improvements are made.

The summary below describes why we carried out this review, what we found and any action required.

Why we carried out this review

We carried out this review because concerns were identified in relation to:

Outcome 01 - Respecting and involving people who use services
Outcome 04 - Care and welfare of people who use services

How we carried out this review

We reviewed all the information we hold about this provider, carried out a visit on 6 January 2012, carried out a visit on 29 December 2011, observed how people were being cared for, looked at records of people who use services, talked to staff and talked to people who use services.

What people told us

People told us that the staff were kind, gentle and attentive, and were never rough with them. They said that they were treated with respect, and that their privacy and dignity were protected by the staff.

Comments included, "I'm definitely happy here. The care is second to none, it's absolutely brilliant"; "Staff are very obliging, they'll do anything for you"; and, "I couldn't be happier. You couldn't get better care".

We asked people if they could suggest any necessary improvements to the home: none were able to identify any areas for improvement.

Most told us that they decided when they wanted to get up and go to bed, and no-one told us that staff got them up when they had expressed a wish to stay in bed.

What we found about the standards we reviewed and how well Kenton Hall Nursing Home was meeting them

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

We found that, on balance, people were being given choices as to when they get up in the morning, but that such choices needed to be clearly recorded.

Overall, we found that Kenton Hall was meeting this essential standard, but we have suggested improvements to maintain this.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights

We found that people living in the home were experiencing a good standard of care that met their individual needs and enhanced their quality of life.

Overall, we found that Kenton Hall was meeting this essential outcome.

Actions we have asked the service to take

We have asked the provider to send us a report within 7 days of them receiving this report, setting out the action they will take to improve. We will check to make sure that the improvements have been made.

Where we have concerns we have a range of enforcement powers we can use to protect the safety and welfare of people who use this service. When we propose to take enforcement action, our decision is open to challenge by a registered person through a variety of internal and external appeal processes. We will publish a further report on any action we have taken.

Other information

Please see previous reports for more information about previous reviews.

What we found for each essential standard of quality and safety we reviewed

The following pages detail our findings and our regulatory judgement for each essential standard and outcome that we reviewed, linked to specific regulated activities where appropriate.

We will have reached one of the following judgements for each essential standard.

Compliant means that people who use services are experiencing the outcomes relating to the essential standard.

A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.

A **moderate concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard and there is an impact on their health and wellbeing because of this.

A **major concern** means that people who use services are not experiencing the outcomes relating to this essential standard and are not protected from unsafe or inappropriate care, treatment and support.

Where we identify compliance, no further action is taken. Where we have concerns, the most appropriate action is taken to ensure that the necessary improvements are made. Where there are a number of concerns, we may look at them together to decide the level of action to take.

More information about each of the outcomes can be found in the *Guidance about compliance: Essential standards of quality and safety*

Outcome 01:
Respecting and involving people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Understand the care, treatment and support choices available to them.
* Can express their views, so far as they are able to do so, and are involved in making decisions about their care, treatment and support.
* Have their privacy, dignity and independence respected.
* Have their views and experiences taken into account in the way the service is provided and delivered.

What we found

Our judgement

There are minor concerns with Outcome 01: Respecting and involving people who use services

Our findings

What people who use the service experienced and told us
We were unable to get the views of many of the people living in the home on the visit of 30 December, as they were in bed. The majority of those who were first up were unable to verbally communicate their views. However, one person told us that it was her choice to be up early, and that she could have a 'lie-in' until 11 am, if she wanted to.

Our visit of 6 January 2012 was later in the morning, and we were able to ask people about their rising and retiring wishes. Most told us that they decided when they wanted to get up and go to bed, and no-one told us that staff got them up when they had expressed a wish to stay in bed.

Other evidence
We received an anonymous call telling us that people living in the home were being forced to get out of bed at 6 am, with no choice in the matter. We visited the home, unannounced, on 30 December 2011, to check this allegation.

When arriving at the home, at 5:50 am, we introduced ourselves to the nurse in charge and then did a tour of the building.

We saw that nearly every bedroom door was closed. Where bedroom doors were open,

we saw that the lights were on in only two rooms, and in each case the person was still asleep. Communal areas such as lounges were empty. It appeared that nobody was up, and this was confirmed by the staff on duty. The home was very quiet and the atmosphere calm.

We checked periodically over the next two hours. One person was seen to be awake in a bedroom at 6 am; a second by 6:15 am. The first person seen to be up and dressed and out of their bedroom was at 6:25 am (this person was unable to communicate their wishes about rising and retiring times). At 7 am, there was one person sitting in an upstairs lounge, and nobody in the downstairs lounges. By 7:20 am, the large majority of bedroom doors were still closed, and the atmosphere still calm and unhurried. Staff were seen to be responding to activated buzzers and said that they were carrying out continence checks. There was no sense that staff were doing anything other than their normal programme of work, and they confirmed this.

We spoke with the few people who were up and out of their rooms. One person, who said she had got up at 7 am, told us that this was her choice, and that could have had a lie in until 11 am, if she had wanted to.

We did notice, however, that by 7:30 am, there were seven people in the first floor dining room awaiting breakfast, and that six of these people were unable to communicate their wishes verbally. Therefore, we were unable to establish directly if they were up at the time of their choosing.

We spoke with at least nine night staff and day staff members, including qualified staff, care workers, domestic and catering staff, in the course of this inspection.

One member of staff told us that there was an expectation by the home manager that people living in the home should be up by 8 am each morning. This person told us that staff knew when people preferred to get up, but that staff didn't necessarily go by those wishes. This person told us, "If people are confused, we just get them up", and said that one person sometimes complains and says she does not want to get up.

Every other staff member we spoke to told us that there was no such expectation on staff, and that people got up when they chose to, not when staff decided they must get up. We were told that people can and do sleep in, and that it wasn't unusual for a person to still be in bed at 10 am. Staff said that only those who 'buzzed' (used the nurse call system) for staff to get them up would be up by 6 am. One staff member said, "It's definitely down to individual choice", and also said that the preferred routines of confused residents were known and adhered to. Another staff member said that staff don't feel pressured to get everyone up, and were not told off by the manager if people were still in bed at 8 am. A member of the day shift told us most people were usually still in bed at the start of the day shift, at 8 am. This person said that there was no pressure from the incoming day staff for the night staff to have got everyone up for the start of their shift.

We spoke to the manager, who strongly denied putting any pressure on staff to get people up against their wishes or at any set times. She told us that she instructed staff to make sure that people's continence needs were seen to, and that they were washed and made comfortable, if they needed changing, but to then leave them in bed if they didn't want to get up. Also, that if anyone buzzed to be up, staff were to respect their

wishes. She was clear that she did not expect everyone to be up by 8 am, quite the reverse.

We looked at people's care records, to see if individual choices had been asked and recorded, but found nothing in the assessments, personal profiles or care plans to demonstrate this was the case. The manager confirmed that sleep care plans were normally drawn up if there was a particular problem with an individual's sleep. She accepted that the lack of recorded information about people's rising and retiring choices made it difficult to demonstrate that individual preferences were being asked for and respected. She agreed to conduct an audit of when people wished to get up and go to bed, and to include this information in each person's care plan.

Apart from the issue of this information, we saw that people's needs and wishes had been properly assessed before they were admitted to the home. We saw that detailed 'personal profiles' had been drawn up, to assist staff to give individualised care. We saw a range of consent forms (for example, giving permission to take a person's photograph for their care file). Mental capacity assessments and 'Deprivation of liberty' screening checklists were in place. Where appropriate, 'best interests' decisions were documented, for people judged to lack capacity to make their own decisions.

Our judgement
We found that, on balance, people were being given choices as to when they get up in the morning, but that such choices needed to be clearly recorded.

Overall, we found that Kenton Hall was meeting this essential standard, but we have suggested improvements to maintain this.

Outcome 04:
Care and welfare of people who use services

What the outcome says

This is what people who use services should expect.

People who use services:
* Experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.

What we found

Our judgement

The provider is compliant with Outcome 04: Care and welfare of people who use services

Our findings

What people who use the service experienced and told us
We spoke with approximately twenty of the people living in the home on our visit on 6 January 2012. All but one spoke highly of the care they were receiving and of the staff. They told us that the staff were kind, gentle and attentive, and were never rough with them. They said that they were treated with respect, and that their privacy and dignity were protected by the staff. We asked people if they could suggest any necessary improvements to the home: none were able to identify any areas for improvement.

Comments included, "I'm definitely happy here. The care is second to none, it's absolutely brilliant"; "Staff are very obliging, they'll do anything for you"; and, "I couldn't be happier. You couldn't get better care".

We spoke with three visiting relatives, all of whom were equally positive about the home. One told us that her relative was very happy in the home, and was really comfortable. This person told us that there were enough staff and that staff responded promptly to any needs. Another told us that everyone seemed well cared for, and that the staff were gentle and treated people with respect. This person spoke highly of the manager and told us that she listens to any concerns and deals with them promptly. A third visitor told us that her relative felt much better since coming to Kenton Hall from another home, and said that the staff were "brilliant".

Other evidence
We observed that staff were attentive, pleasant and courteous at all times, and treated people respectfully. We saw appropriate use of moving and handling equipment, with

staff assisting people with patience and sensitivity. We observed that, when a person in one of the lounges became distressed, staff responded quickly and appropriately.

We looked at a sample of the care records of the people living in the home. We saw that each need identified in the assessment process had been addressed using detailed and highly personalised care plans. These gave clear guidance to staff, and emphasised the need to maintain people's self esteem and maximise their individual autonomy.

We observed that the people living in the home were well groomed, with some of the ladies wearing make up and accessories at breakfast.

Our judgement
We found that people living in the home were experiencing a good standard of care that met their individual needs and enhanced their quality of life.

Overall, we found that Kenton Hall was meeting this essential outcome.

Action
we have asked the provider to take

Improvement actions

The table below shows where improvements should be made so that the service provider **maintains** compliance with the essential standards of quality and safety.

Regulated activity	Regulation	Outcome
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: We found that, on balance, people were being given choices as to when they get up in the morning, but that such choices needed to be clearly recorded.	
Diagnostic and screening procedures	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: We found that, on balance, people were being given choices as to when they get up in the morning, but that such choices needed to be clearly recorded.	
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010	Outcome 01: Respecting and involving people who use services
	Why we have concerns: We found that, on balance, people were being given choices as to when they get up in the morning, but that such choices needed to be clearly recorded.	

The provider must send CQC a report about how they are going to maintain compliance with these essential standards.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us within 7 days of the date that the final review of compliance report is sent to them.

CQC should be informed in writing when these improvement actions are complete.

What is a review of compliance?

By law, providers of certain adult social care and health care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The Care Quality Commission (CQC) has written guidance about what people who use services should experience when providers are meeting essential standards, called *Guidance about compliance: Essential standards of quality and safety*.

CQC licenses services if they meet essential standards and will constantly monitor whether they continue to do so. We formally review services when we receive information that is of concern and as a result decide we need to check whether a service is still meeting one or more of the essential standards. We also formally review them at least every two years to check whether a service is meeting all of the essential standards in each of their locations. Our reviews include checking all available information and intelligence we hold about a provider. We may seek further information by contacting people who use services, public representative groups and organisations such as other regulators. We may also ask for further information from the provider and carry out a visit with direct observations of care.

When making our judgements about whether services are meeting essential standards, we decide whether we need to take further regulatory action. This might include discussions with the provider about how they could improve. We only use this approach where issues can be resolved quickly, easily and where there is no immediate risk of serious harm to people.

Where we have concerns that providers are not meeting essential standards, or where we judge that they are not going to keep meeting them, we may also set improvement actions or compliance actions, or take enforcement action:

Improvement actions: These are actions a provider should take so that they **maintain** continuous compliance with essential standards. Where a provider is complying with essential standards, but we are concerned that they will not be able to maintain this, we ask them to send us a report describing the improvements they will make to enable them to do so.

Compliance actions: These are actions a provider must take so that they **achieve** compliance with the essential standards. Where a provider is not meeting the essential standards but people are not at immediate risk of serious harm, we ask them to send us a report that says what they will do to make sure they comply. We monitor the implementation of action plans in these reports and, if necessary, take further action to make sure that essential standards are met.

Enforcement action: These are actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers are set out in the law and mean that we can take swift, targeted action where services are failing people.

Information for the reader

Document purpose	Review of compliance report
Author	Care Quality Commission
Audience	The general public
Further copies from	03000 616161 / www.cqc.org.uk
Copyright	

Care Quality Commission

Website	www.cqc.org.uk
Telephone	03000 616161
Email address	enquiries@cqc.org.uk
Postal address	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA