R S Oakden

Penkett Lodge

Inspection report

39 Penkett Road
Wallasey
Wirral
CH45 7QF
Tel: 0151 691 2073

Date of inspection visit: 17 and 20 April 2015
Date of publication: 24/09/2015

Ratings

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

Overall summary

Penkett Lodge provides personal care and accommodation for up to 27 people. Nursing care is not provided. The home is a detached four storey building in Wallasey, Wirral. A small car park and garden are available within the grounds. There are twenty one single bedrooms and three shared bedrooms with communal bathrooms on each floor. Some of the rooms are en-suite. A passenger lift enables access to bedrooms located on upper floors for people with mobility issues and specialised bathing facilities are available. On the ground floor, there are two communal lounges and a dining room for people to use.

The home had a registered manager. 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.'

People who lived at the home said they were happy there and were well looked after. They said they were

Summary of findings

supported to maintain their independence and treated with dignity and respect. People had access to sufficient quantities of nutritious food and drink and were given suitable menu choices at each mealtime.

During our visit, we observed that staff treated people kindly and supported them at their own pace. People looked relaxed and comfortable with staff. From our observations it was clear that staff knew people well and had the skills and knowledge to care for them. An activities co-ordinator was employed at the home five afternoons a week and provided a range of activities to occupy and interest people.

We observed the home's morning medication round. We saw that it was constantly interrupted by staff, the telephone and deliveries to the home. This meant there was an increased risk of mistakes being made and a delay to people receiving their medication on time. Records relating to some boxed medications were inaccurate. People's prescribed creams were not always stored securely. This was a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations.

People's feedback on staffing levels was mixed. Some people said that at times the number of staff on duty required improvement. We observed that staffing levels during the morning and afternoon medication round required review and that staff were often too busy tending to people's personal needs and other tasks to have time to just sit and chat to people. Staff were recruited safely and received regular training and support in the workplace.

People told us they felt safe at the home and they had no worries or concerns. The home had a safeguarding procedure and staff received safeguarding training but they did not demonstrate a full understanding of safeguarding when asked. They did however demonstrate a positive attitude to people's welfare. We reviewed the provider's safeguarding records. We found that although issues raised had been investigated and responded to by the manager, they had not always been reported to the Care Quality Commission in accordance with Regulation 18 of the Care Quality Commission (Registration) Regulations 2009. In addition, some of the complaint records we looked at, although fully investigated, where of a safeguarding nature. They had not however been treated as a potential safeguarding matter or reported to the Care Quality Commission.

We reviewed three care records. Some risks associated with people's personal care and welfare were assessed and managed however two people with skin integrity issues and a physical change in one person's ability to safely eat and drink had not been risk assessed and safely managed. People's challenging behaviours had not been assessed but staff lacked adequate guidance on how to manage them. These incidences were a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations as people's plans of care did not fully meet or manage their needs and risks.

Where people had mental health issues, their care plans lacked adequate information on how this impacted on their day to day lives and decision making. There was little guidance for staff on how to support people's emotional needs. This was a breach of Regulation 11 of the Health and Social Care Act 2014 Regulations as people's right to consent had not been considered in accordance with the Mental Capacity Act 2009.

People were provided with information about the service and life at the home. There was a complaints procedure in place and the manager had responded appropriately to complaints made.

Equipment was properly serviced and maintained but the premises were not entirely suitable for purpose. Improvements were required to meet Environmental Health legislation and good infection control standards and the provider's electrical installation had been inspected as unsafe in June 2014. There was no evidence that the provider had taken appropriate and timely action to protect people for the risks of unsafe and unsuitable premises. These incidences were a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations.

There were some quality assurance systems in place to assess the quality and safety of the service and to obtain people's views but, improvements were required to ensure that they were sufficient and effective. There was little evidence that the provider monitored the quality of the service to ensure it was safe or that they provided appropriate support to the manager. This was a breach of Regulation 17 of the Health and Social Care Act 2014 Regulations as the provider failed to have effective systems in place to assess, monitor and mitigate the risks to people's health, safety and welfare.

Summary of findings

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 always safe.

People told us they felt safe and had no worries or concerns. Safeguarding incidents were investigated but had not always been appropriately reported to the Care Quality Commission. Some complaints were of a safeguarding nature but had not been identified or responded to as such.

People's needs were identified and some of their risks assessed and managed. People's risks associated with skin integrity, nutritional and behavioural risks however had not always been adequately assessed and managed.

Staff were recruited safely. Staffing levels were adequate for the majority of the day but required review during certain times of the day.

The storage and administration of medication was not safe. The medication round was constantly interrupted and people's prescribed creams were not stored securely.

Parts of the environment required improvement to meet Environmental Health and infection control standards and the home's electrical system had been inspected as unsafe.

Is the service effective?

Requires improvement

The service was generally effective but required improvement in one area relating to the Mental Capacity Act (2005).

People said they were well looked after. It was clear from our observations that staff knew people well and had the skills and knowledge to care for them.

People were given enough to eat and drink and were given a choice of suitable nutritious foods to meet their dietary needs. Meals were served in a relaxed homely atmosphere.

People had prompt access to their GPs and access to other healthcare professionals as and when required.

The care plans for people who had mental health needs did not adequately describe how this impacted on their day to day lives and their ability to consent in accordance with the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring.

People we spoke with held staff in high regard. Staff were observed to be kind and respectful when people required support.

People's independence was promoted and people were able to make choices in how they lived their lives.

Summary of findings

Interactions between people and staff were pleasant and people appeared relaxed and comfortable with staff.

People were given appropriate information about the home.

Is the service responsive?

Good 

The service was responsive

People's needs were individually assessed, care planned reviewed regularly.

The service was proactive in ensuring people received the support they required. It responded quickly when people became unwell and ensured people received care from a range of health and social care professionals.

A range of social activities was provided by an activities co-ordinator.

People who lived at the home, relatives and the health and social care professional we spoke with had no complaints or concerns. Complaint records showed complaints were handled in a timely and appropriate manner.

Is the service well-led?

Requires improvement 

The service required improvement in respect of its leadership.

Some quality assurance systems were in place to monitor the quality of the service but they did not effectively ensure that risks to people's health, safety and welfare were picked up and addressed by the provider.

There was little evidence that the provider monitored the quality of the service or provided appropriate support to the manager.

The manager held regular staff meetings and people's satisfaction with the service was sought through regular resident meetings.

Penkett Lodge

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 17 and 20 April 2015. The first day of the inspection was unannounced. The inspection was carried out by an Adult Social Care (ASC) Inspector and an Expert by Experience. An Expert by Experience is person who has personal experience of using or caring for someone who uses this type of service. Prior to our visit we looked at any information we had received about the home.

On the day of the inspection we spoke with seven people who lived at the home, three relatives, two care staff and the registered manager. We also spoke with one visiting health professional and an Environmental Health Officer from the Local Authority.

We looked at the communal and bedroom areas that people shared in the home. We reviewed a range of records including three care records, medication records, staff records, policies and procedures, records relating to health and safety and records relating to the quality checks undertaken by the manager.

Inadequate

Is the service safe?

Our findings

All of the people we spoke with said that they felt safe at the home. People's comments included "I'm being looked after"; "I just feel safe because (name) is here, if I have any problems they'll sort them out for you"; "The staff are very good" and "They are very fair with me". Three relatives and the visiting health and social care professional also told us they felt people were safe at the home.

We saw that the provider had a policy and procedure in place for identifying and reporting potential safeguarding incidents. Staff had received safeguarding training but did not demonstrate a full understanding of safeguarding when asked. They did however demonstrate a positive attitude from protecting people from potential risk.

We saw that there were two incidents of a safeguarding nature noted in care records. We found that although they had been appropriately investigated by the manager they had not been reported appropriately to the Care Quality Commission. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 as the home is required to notify the CQC of any abuse or allegation of abuse made. We reviewed complaint records and saw that some complaints were of a safeguarding nature. Although the manager had investigated and responded to the complaints, they had failed to recognise or respond to these complaints as potential safeguarding incidents.

We looked at the care plans belonging to three people who lived at the home. We saw that people's risks in relation to malnutrition, falls, dependency and moving and handling including the use of moving and handling equipment had been risk assessed. Personal emergency plans were in place to advise staff how to evacuate people in the event of an emergency. Accidents and incidents were properly recorded and responded to.

Two of the people whose care files we looked at had skin integrity issues that made them susceptible to pressure ulcers, but their risks had not been considered. One person had been referred to specialist services for a physical symptom that affected their ability to eat and drink. No assessment of the risks associated with this had been undertaken and there was no management plans in place to mitigate this risk.

All of the people whose care we reviewed had mental health issues that meant at times people displayed challenging behaviours. Although these behaviours were assessed, their description and risk assessment was limited. This meant staff had little guidance on how to prevent such behaviours or manage the risks when they occurred. This placed people at risk of inappropriate or unsafe care.

These incidences were a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations as people's plan of care did not fully assess their needs and risks in order to prevent those risks from occurring.

Repairs were noted and acted upon but there was no regular health and safety check to ensure that the premises remained safe and suitable for purpose. One person we spoke with said the home could be "Made better by decorating, but my room is lovely" another said "There isn't sufficient lighting in the bedroom". Two relatives and two staff we spoke with commented that the home could do with some re-decoration and improvement.

We saw that parts of the home were in the process of being refurbished, for example some bedrooms had been painted and had new carpets fitted and there was a well maintained patio and lawn area with seating for people to enjoy outside. Other areas such as the communal lounge, bathroom and some of the bedrooms required improvement. For example, the garden had nine raised wooden planters for people at the home to plant their own flowers or vegetables. This area however was unkempt, difficult for people with mobility problems to access and hazardous for people to navigate around. Various parts of the building had chipped paintwork and one corridor had an offensive smell.

The temperature in the kitchen area was uncomfortably hot. We saw that kitchen ceiling was stained. The cook told us this was due to the heat in the kitchen causing condensation. One of the kitchen cupboards was broken and the kitchen fire door was propped open with a sack of potatoes. This posed a health and safety hazard. The cook told us that the automatic fire door closure on the kitchen door was broken.

On the second day of our visit, we spoke to an Environmental Health Officer who was inspecting on the same day. They told us that the food hygiene practices at the home were good but the structure of the kitchen

required improvement. We reviewed a copy of their Environmental Health Report and saw that various repair and maintenance issues were cited and that improvements to the kitchen flooring, sinks/worktops, plaster and paintwork were required including the installation of suitable ventilation.

We saw that the heating, gas, fire and moving and handling equipment all conformed with recognised safety standards and were regularly inspected and serviced by external contractors. The home's electrical installation however had been identified as unsatisfactory by an external contractor in June 2014. There was no evidence that any action had been taken so far to rectify this. This meant at the time of our visit and for approximately 9 months, the home's electrical installation was in need of repair. This meant that the provider had failed to take adequate and timely action to ensure that the electrical installation posed no risk to people's health, safety and welfare.

The manager told us the electrical contractor was due in the following week to re-inspect the home. We received a copy of the electrical report following this visit and saw that faults identified in 2014 had now been fixed.

These incidences demonstrate a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations. This was because the provider had failed to ensure that the premises used by the service were safe and suitable for use.

We saw that the NHS Infection Control team visited the home in February 2015. We looked at a copy of their report. The audit report indicated that the condition of certain areas of the home posed a risk to good infection control. An action plan for improvement had been put in place. As part of the action plan the provider had committed to a 'tidy up or complete refurbishment' of all communal bathrooms within a three month period and a review of the home's sluice facilities. We requested a copy of the provider's refurbishment plans. Costings were available for the sluice but no firm arrangements had been made. There were no costings or firm plans for the required bathroom improvements. No refurbishment work as specified in the action plan had been commenced.

This failure to ensure that the premises was adapted to meet good infection control standards demonstrated a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations. This was because the provider had not acted appropriately and in a timely manner to prevent and control the risk of cross infection.

We saw that antibacterial soap and alcohol hand gels were available throughout the home to assist with infection control. The home was adequately clean and there was ample protective personal equipment for staff to use in the delivery of personal care.

We looked at three staff files. All the files we looked at demonstrated that the necessary checks had been undertaken to ensure that staff employed were of good character and suitable to work with vulnerable adults had been undertaken. The manager told us that there were four members of staff on duty in the morning until 11 am, the number of care staff then reduced to three staff until 6pm. Two care assistant then covered the evening and night duty. An activities co-ordinator worked at the home five afternoons a week and the manager was also on duty during office hours, Monday to Friday.

People we spoke with had mixed responses about whether sufficient staff were on duty. Comments included ""Yes (sufficient) but it wouldn't come amiss if they had an extra one in the evening"; "No, there isn't usually, they're busy"; "I think so, they're pretty well hard worked and "No, they haven't got enough staff, they're rushed off their feet". Two people commented further that their time of getting up and going to bed was dictated by when staff were available.

Relatives and the health care professional we spoke with felt staffing levels were adequate. We observed that staffing levels were adequate the majority of the time in terms of meeting people's personal care needs. We noted that the time of the morning medication round was a particularly busy period and that care staff were often too busy tending to people's personal care needs during the day to spend time with people for a general chat.

People's medication was kept in a locked medicine trolley and the home had a secure medication room in which to store the medication trolley when not in use. For most of the day however the medication trolley was left in the entrance area of the home. The trolley was not secured to the wall to prevent it from being moved. This area was frequently accessed by staff, visitors and other healthcare professionals. This meant there was a risk it could have been moved without authorisation or even stolen.

Inadequate

Is the service safe?

We found that some medicines for example prescribed creams had been left in people's bedrooms. We spoke to the manager about this, and they agreed people's prescribed creams should not be stored in this way.

Medication was administered by senior care staff. We observed the morning and tea time medication rounds during our visit. People's medication was mostly dispensed via monitored dosage blister packs. Some medication such as 'prescribe when required' medication was in boxes.

People's medicine administration records (MAR) indicated people were due their medication at 8am. On the first day of our inspection, the medication round took until 11am to finish. The staff member administering medication was constantly interrupted by other staff members, the telephone and deliveries during the medication round. At one point, the staff member was signing medication records whilst talking on the phone. This meant there was a risk that mistakes would be made due to staff being distracted. Interruptions during the medication round also meant the majority of people experienced delays in receiving their medication at the right time.

One person's MAR recorded that the person had been given their medication at approximately 8a.m but we observed that they were given their medication at 10am. This meant the MAR was inaccurate. There was a risk the person could be given over the recommended dose of medication at the next medication round. We spoke to the staff member about this. They told us they did usually record the time of administration.

We checked a sample of five people's medication administration records (MAR). We found that people's monitored dosage medication was administered accurately but there were some discrepancies in respect of boxed medications. This meant a small number of medicines could not be accounted for.

These incidences demonstrate the way in which some of the medication was stored, administered and recorded was not safe. This was a breach of Regulation 12 of the Health and Social Care Act 2014 Regulations as the provider did not have suitable systems in place to ensure the proper and safe management of all medicines in the home.

Requires improvement

Is the service effective?

Our findings

All of the people we spoke with told us the care was good and that staff had the right skills to meet their needs. People's comments included "They give you a good bath, they're really good and make sure the wheelchair is there"; "I don't need a lot of help but I get what I need" ; "Yes, because its good" and "I'm so happy and content, I don't think about these things".

We asked relatives whether staff has the right skills to care for people. Their comments included "I don't know but they look like they do, they have not had any falls here, they're doing hourly checks"; "If there is a problem, they let us know" and "Most of them, some are better than others, (name) is exceptional and (name) is nice as well".

We spoke with the manager and two care staff about the people they cared for. Staff we spoke with demonstrated a good understanding of people's needs. We observed staff supporting people throughout the day and from our observations it was clear staff knew people well and had the skills and knowledge to care for them.

Staff told us they felt supported in their job role and they received regular supervision and appraisal. The manager's supervision and appraisal schedule confirmed this. Staff training records showed that staff had access to regular training opportunities.

Training was provided in health and safety; first aid; moving and handling; dementia, deprivation of liberty safeguards; safeguarding; food hygiene, the administration of medication and infection control. Staff had also attended various other courses for specific needs for example, stroke awareness and diabetes. One staff member told us the training was "Great, regular, every year". Another told us "Training is kept up to date and if there is anything new, we always do it".

Some staff members were due to complete one or two of the provider's required training courses but this was identified and monitored by the manager.

We saw staff throughout the day checking people consented to the support they were given and care plans showed that people had been given a choice in how they wished to be cared for. Where people's mental health issues meant they displayed increased periods of confusion and challenging behaviour, we saw that the behaviour had been briefly assessed and where appropriate referrals to mental health services had been made. Behavioural assessments however gave little guidance to staff on how to support people emotional needs for example, when they became confused, distressed or restless to enable people to communicate their needs in a more constructive way. There was also no evidence that where people's behaviour had changed, the reason for this change had been explored.

Where people had dementia type conditions or short term memory loss however, care plans lacked sufficient information about how these conditions impacted on the person's day to day life and their ability to consent to any care and treatment decisions made.

The manager told us that they were in the process of completing a Deprivation of Liberty Safeguard (DoLS) application for each person at the home which they intended to submit to the Local Authority. Despite this there was no evidence that people's capacity had been assessed in any of the care files we looked at or documented reasons why a DoLS would be applied for.

These examples are breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured that there were suitable arrangements in place to enable people to participate in and consent to decisions about their care.

We observed the serving of the lunchtime meal and saw that the meal was served promptly and pleasantly by staff. People had the choice of eating their meal in the dining room, the lounge or in their own bedrooms. The dining room was light, airy and the lunchtime meal was served in a relaxed atmosphere. There were three choices on offer for lunch on the day of our visit; fish, chips and beans; fried egg and chips or turkey salad with a jacket potato. The food provided was of sufficient quantity and looked and smelled appetising.

People we spoke with told us they had enough to eat and drink, that the food was good and they always had a choice. Comments included the food "Is nice, get too much, you can have a sandwich or anything really. They are very good, if you don't like anything, they'll sort it out"' "They make sure you get a good meal"; "It's good, I like the choices"'; "Very good, main meal at lunchtime, they give you too much really" and "I enjoy it".

Requires improvement

Is the service effective?

A relative we spoke with told us that the person had "Put on weight, when I take them out, the most important thing is they get back for meals". Another said "They've not got a great appetite, they're monitoring the fact that they are not eating as well as they should be". A health and social care professional we spoke with also said they didn't have any concerns about people's diet at the home.

We reviewed three care files and saw that people's nutritional needs had been assessed and their preferences noted in the planning and delivery of care. Records showed people were weighed monthly and monitored by the manager.

Where people were at risk of malnutrition, referrals to dietary services had been made and people were given prescribed supplements and milky drinks. Their dietary intake was also recorded on food and drink charts.

People's daily notes showed that staff were monitoring people's health and wellbeing on a daily basis and responding appropriately when people became unwell. Records also showed that people had prompt access to medical and specialist support services as and when required. We saw that people's health care needs were followed up promptly and acted upon where required.

People who lived at the home and their relatives told us that they had access to their GP as and when needed. The healthcare professional we spoke with said "They (the staff) are really good at contacting the doctors themselves".

Good

Is the service caring?

Our findings

We asked people if staff treated them well and respected their privacy and dignity. People said that they did. Their feedback included "I'd say so, they are caring, definitely"; "Touch wood up to now"; "Yes, on the whole, if there is anything I don't approve of, I pick them up on it and "Very much, nothings too much trouble". Relatives also confirmed this and a healthcare professional we spoke with told us "I think they really do care for residents".

Staff we spoke with said they felt the service cared for people well. One staff member told us they maintained people's privacy and dignity by not making them "embarrassed and uncomfortable" when providing them with personal care. Another said they would ask them for their consent before any personal care was provided "Tell them what you are doing" and "Treat them like you treat your own".

Most of the people we spoke with told us that they felt staff knew them well including their likes and dislikes, but two people commented that staff rarely had time to sit and chat with them.

We observed staff throughout the day supporting people who lived at the home. We saw that interactions were positive. Staff were respectful of people's needs and supported them at their own pace. From our observations it was obvious that people felt comfortable with staff. Staff maintained people's dignity at all times and people looked well dressed and well cared for.

Care plans outlined the tasks people could do independently and what people required help with. When asked, people said they thought staff helped them to remain independent where possible.

We saw evidence that end of life discussions had taken place with people and their relatives. We were told by the manager that staff at the home had recently completed and achieved accreditation in the NHS Six Steps Programme for end of life care.

We looked at the daily written records that corresponded to the care records we had seen. Daily records showed that people had received care and support in relation to their personal care and that staff monitored their general well-being.

The home had a service user guide for people to refer to. We looked at the information provided and saw that it was easy to read and included information about the home, its staff and the services. This showed us that people were given appropriate information in relation to their care and the place that they lived.

Good

Is the service responsive?

Our findings

People we spoke with confirmed that they could choose how they lived their day to day life. Comments included "More or less"; When it's sunny I get up, but there no restrictions there. I go to bed when I want, there's not rules cut and dried"; "I get up when I wake up and go to bed around ten" and "I can choose to sit here (in the lounge) or go to the bedroom.

Relatives we spoke with, felt people had choices at the home and a healthcare professional told us that "Most of the residents say they are happy" at the home.

We saw that people's needs were responded to promptly throughout the day and that the service was responsive when people's needs changed. A staff presence in communal areas however was limited.

We looked at three care files. All care files contained person centred information about the person needs, risks and preferences. It was evident that people who lived at the home and their families had been involved in discussing and planning the person's care which had been regularly reviewed.

Care plans did not include information about people's personal life histories. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. They enable the person to talk about their past and give staff, visitor and/or and other professionals an improved understanding of the person they are caring for. Personal life histories have been shown to be especially useful when caring for a person with dementia.

We saw that a poster advertising the range of social activities available at the home was displayed in the entrance area of the home and people confirmed activities were on offer at the home. On the afternoon of our second visit, the activities co-ordinator was facilitating a group quiz in the communal lounge. The activity was well attended and people actively participated.

People's feedback included "I read the paper and walk and sit in the garden when it's suitable. I go to the shops. We have an activity Monday and Tuesday afternoon, bingo and a quiz. I enjoy the quiz"; "Activities are usually quite good, we play games, throw the chicken, hook a duck, bingo, quiz and we do decorations for Easter"; "Not much, they have things on I just sit down and talk to people. Occasionally they bring singers in". When asked if they went out, some people said they went out with relatives.

We looked at the provider's complaints procedure and saw that it was easy to understand with clear timescales for the acknowledgement, investigation and response to any complaints made. Contact details for who people could contact in the event of a complaint were not provided. For example, no contact details were provided for the manager of the home, the provider, the Local Authority, Care Quality Commission or the Local Government Ombudsman. This meant people may not know who to direct to their complaint to in the first instance, or which external bodies to escalate their complaint with, should they be dissatisfied with the manager or provider's response to their complaint in the first instance.

We looked at the provider's complaints records. We saw that the manager had fully investigated and appropriately responded to the complaints in a timely manner. People and relatives we spoke with said they knew how to make a complaint.

Requires improvement

Is the service well-led?

Our findings

We observed the culture of the home to be open and inclusive. The staff team had a positive attitude. Staff we spoke with felt supported in the workplace and said the home was well run.

During our visit we found the manager responsive with a proactive approach to people's care.

At this visit, we reviewed how the manager and provider ensured the quality and safety of the service provided. We saw that the manager undertook a range of monthly audits which included a monthly medication audits, care plan audits, equipment audits and a weekly job sheet for repairs and maintenance issues. We saw that where actions were identified these were resolved without delay by the manager.

We saw that the monthly medication audit was limited in that it only checked stock levels against what had been administered. This meant that the audit did not cover the ordering, storage, observed administration, recording and disposal of medication.

There was no regular health and safety audit in place to ensure that environmental risks to people's health and safety were identified and addressed. This meant some of the premises issues identified during the inspection had not been identified.

No accident and incident audits were in place to identify trends in the type of accidents or incidents and when, where and how accidents or incidents occurred. This meant there was no learning from accidents or incidents that could be utilised to prevent similar incidents happening in the future.

We spoke to the manager about these issues during our inspection and we found the manager to be open and receptive to our feedback.

We saw that regular staff meetings took place between the manager and the staff team. These meetings discussed any issues or suggestions for improvement to the service. We saw that where actions had been identified these had been acted upon.

There was no evidence that the provider monitored the management of the service to ensure it was managed safely or to ensure that the manager received appropriate support in their job role.

These examples indicate a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010. This was because although some audit systems were in place they were insufficient to adequately assess, monitor and mitigate the risks to people's health, safety and welfare and actions identified had not always been appropriately acted upon by the provider.

We saw evidence that the last satisfaction survey last issued to people and their relatives was in 2013. We asked the manager about this. They told us that they had completed a survey in 2014, but they were unable to find the records during our visit.

Regular resident and relatives meetings were held and we saw that the manager checked people were happy with the service provided. We saw that issues relevant to people who lived at the home were discussed and their opinions sought. One person told us that resident meetings took place "Three to four times a year, we're all in them", another said "Now and again they have resident meetings. Another person told us they hadn't attend any meetings but said "They take notice if I criticise them".

A relative we spoke with confirmed meetings took place and that they were invited. They told us "They phone around before the meetings are due and ask us if there's anything we want brought up. If you've got a problem, the manager will sort it".

This assured us that there were regular opportunities for people who lived at the home and their relatives to feedback their opinions and suggestions on the service provided.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider had failed to notify the Commission without delay of any allegations of abuse whilst carrying on the regulations activity. Regulation 18(2)(e) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent People's ability to consent to decisions about their care had not been fully considered in the planning or delivery of care in accordance with the Mental Capacity Act 2005. Regulation 11(1) of the Health and Social Care Act 2014 Regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have sufficient systems in place to assess, monitor and mitigate risks relating to the health, safety and welfare of people who lived at the home. Regulation 17(2)(b)

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in safe way for service users. This was because: The risks to service users health and safety had not been fully assessed and mitigated against. Regulation 12(2)(a)and(b). The premises were not safe and suitable for use. Regulation 12(2)(d) Medicines were not properly and safely managed. Regulation 12(2)(g) Recommendations relating to premises and the prevention and control of infection had not been acted upon to mitigate the risks of cross infection. Regulation 12(2)(h).

The enforcement action we took:
We have issued the provider and the manager with a Warning Notice. This will be followed up and we will report on any action when it is complete.