Mr & Mrs P J Richards

# Penmeneth House

## Inspection report

16 Penpol Avenue
Hayle
Cornwall
TR27 4NQ

Tel: 01736752359

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Is the service safe? | **Requires Improvement** |

# Summary of findings

## Overall summary

Penmeneth House is a care home which provides accommodation for up to 14 older people who require personal care. At the time of the inspection 14 people were using the service. Some of the people who lived at Penmeneth House needed care and support due to dementia and some people had sensory and /or physical disabilities.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

We previously carried out a comprehensive inspection of 31 May 2016. At that inspection we identified one breach of the legal requirements. This related to the assessment of risks to the health and safety of people who used the service, and the registered provider taking suitable steps to mitigate these risks. We subsequently issued one requirement and told the provider to take action to address the breach of the regulations. The provider sent the Care Quality Commission an action plan following the publication of the report.

We carried out this focused inspection to check to see if the service had made the required improvements identified at that comprehensive inspection.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Penmeneth House on our website at www.cqc.org.uk

During this inspection we spoke with the registered manager, and other senior staff to check actions taken since the last inspection. We were told people's risk assessments had been reviewed, for example, if people were at risk of falling. We were also told the temperature of hot water was controlled and the registered provider was in the process of fitting thermostatic valves to basins in people's bedrooms and in bathrooms. This was to minimise any risk of scalding. Lastly we were told suitable checks were being completed to ensure medicines errors did not occur due to how medicine administration instructions were recorded. We subsequently checked relevant documentation and this was to a suitable standard. We therefore judged satisfactory action had been taken regarding the action we asked the provider to take.

We could not improve the rating for the question 'Is it Safe' from 'requires improvement' because to do so requires the service to demonstrate consistent good practice over time. We will review the rating during our next planned comprehensive inspection.

## 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 safe. Improvements had been made to ensure risks were suitably managed to ensure people who used the service were safe.

# Penmeneth House

**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 23 January 2017. This was an unannounced inspection which meant the staff and provider did not know we would be visiting. The inspection team consisted of one inspector.

The inspection was to review what action had been taken to meet the breach in regulation identified during the comprehensive inspection completed in May 2016.
Before the inspection we reviewed the action plan provided by the service following the last inspection, previous inspection reports and other information we held about the service. We also looked at notifications we had received from the service. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we spoke with registered provider, and other senior managers of the service. We inspected two records relating to the care of individuals, the medicines system and records relating to the running of the service.

Requires Improvement

# Is the service safe?

## Our findings

At the inspection of 31 May 2016 we found that staff transcribed medicines for some people on to the Medicine Administration Record(MAR), but handwritten entries were not always signed and had not always been witnessed by a second member of staff. This meant that there was a risk of potential errors and could subsequently mean that people would not receive their medicines safely. We also found that some prescribed creams had not been dated when opened. This could mean that staff were not aware of the expiration of the item when the cream would no longer be safe to use.

At this inspection the registered manager told us two staff always checked any handwritten entries were correct, and signed the entry accordingly. We checked medicines records and this action had occurred in the majority of cases. However we did find two cases where two people had not signed handwritten entries to state they were correct. The registered manager said she would discuss this matter with relevant staff. The containers of creams were dated when opened so staff could monitor these and dispose of them when necessary.

At the inspection of 31 May 2016 we found assessment of risks to the health and safety of people who used the service were not always recorded, and reviewed as necessary. For example we were concerned that two people, who were at risk of falls, did not have a current and accurate falls risk assessment on their care files. This meant there was not sufficient guidance and direction for staff about how to address these risks.

At this inspection, the registered manager informed us all people had suitable documentation to highlight, minimise and review any risks staff were aware of. We checked two people's records and judged records kept were appropriate.

At the inspection of 31 May 2016 we found water coming from taps in people's bedrooms, and shared bathrooms was very hot. There were warning signs informing people the water was very hot. However we were concerned that people, with dementia, who were living at the service, may not understand the warning signs putting them at risk of scalding.

At this inspection the registered manager told us that the temperature of the hot water had been reduced. This had been done by controlling the temperature at the water tank. The registered manager also informed us that the provider was in the process of fitting thermostatically controlled valves to hot water taps in bathrooms, toilets and people's bedrooms. The registered manager said there had not been any cases where people had been scalded in the many years the provider had owned the service. She also said people were usually supervised when they were washing, and always supervised when they were bathing. The registered manager said there was an up to date risk assessment in place which also helped to identify measures which would minimise the risk.

At the inspection of 31 May 2016 we found sponges, flannels and a razor in one of the bathrooms. These items were not named and we were told were used communally which presented an infection risk. At this inspection the registered manager told us there were no communal sponges, flannels or razors used, and

there were no such items in any of the communal bathrooms or toilets we inspected.

We therefore judged suitable action had been taken since the last inspection.