Penn House Limited

Penn House Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on the 06 August 2018 and was unannounced. This was the first inspection of this service since registering with the Care Quality Commission on 17 February 2017.

Penn House Residential Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Penn House is registered to provide accommodation for up to 24 people. At the time of inspection there were 23 people living at the home. Penn House is arranged over two floors, the second floor was for people who were more independent. Many of the people living at Penn House are living with dementia.

There was a registered manager in post. 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 audits in place which were used to drive improvement within the home. However, where feedback from people was sought, this information had not been used to identify actions to improve the service for people. We also found that where people had raised verbal issues or concerns, although these were dealt with, there was no evidence of the provider taking any learning for improvements to minimise the chance of things going wrong again in the future.

People told us they felt safe and were happy living at the home. People's individual risks were assessed and minimised because staff knew people's needs well. People were safe from the risk of harm because staff knew how to spot signs of abuse and how to report concerns. People received their medication as prescribed and staff were trained to give medication safely. There was enough staff to meet people's physical needs.

People were supported by staff who had the skills and knowledge to meet their needs. Staff had a good understanding of the Mental Capacity Act 2005 and were aware of the importance of consent. People's nutritional needs were met and people had access to health professionals when required. The registered manager was aware of their responsibilities to submit and update Deprivation of Liberty Safeguards (DoLS) applications.

People were supported by kind and caring staff. People told us they were encouraged to be as independent as possible. Staff ensured they protected people's privacy and dignity. There was a homely, relaxed feel to the home and relatives and friends were able to visit freely.

People were involved the assessment and review of their care. People's care records detailed their individual needs and preferences and staff had a good knowledge of these. People were supported to engage in

meaningful personalised activities but staff did not have the time sit and chat to people. However, people and relatives told us staff did not have the time to sit and talk to people.

People and relatives knew how to complain and felt confident doing so. We saw people and relatives approach the registered manager's office to discuss any concerns or to have a general conversation.

People, relatives and staff spoke positively about the management team and felt able to approach them. The provider had strong links with the local community and professionals.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from the risk of abuse because staff had a good knowledge of how to spot signs of abuse and report concerns. There was enough staff to keep people safe.

Risks to people were reduced because staff knew what they were and how to minimise them. People received their medication as prescribed.

People were protected from the risk of infection because the home was kept clean and tidy.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the skills and knowledge to meet their needs.

People's consent was sought by staff before they provided care and support.

People's nutritional needs and preferences were met. People had access to relevant professionals when required.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff.

People were supported to communicate in their preferred way and were supported to make choices. People's cultural and religious needs were met.

People were encouraged to be as independent as possible. people's privacy and dignity was maintained.

Is the service responsive?

Good

The service was responsive.

People had activities they could engage in. However, there were periods where people were not stimulated and staff did not have time to sit and chat to people.

People and their relatives were kept up to date about changes to people's needs and people's care records reflected changes.

People and relatives knew how to complain and felt confident doing so.

Is the service well-led?

Good

The service was well-led.

People's and relatives feedback was sought but had not been used to drive improvements within the home.

There were audits in place that were used to drive improvement and reduce reoccurrence.

People and relatives spoke positively about the registered manager.

Penn House Residential Home

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.'

The inspection took place on 06 August 2018 and was unannounced. The inspection was conducted by one inspector and an expert- by- experience. An expert- by- experience is a person who has personal experience of using or caring for someone who uses this type of service.

When planning our inspection, we looked at the information we held about the service. This included the Provider Information Return (PIR), notifications received from the provider about deaths, safeguarding alerts and serious injuries, which they are required to send us by law. A PIR is information we require providers to send us annually to give key information about the service, what the service does well and what improvements they plan to make. We also obtained feedback from the local authority and from the commissioners of people's care.

On the day of the inspection, the registered manager was not available and so we provided information and verbal feedback to both the deputy manager and the provider. We spoke with the registered manager the day after the inspection. During the inspection, we spoke with three people who lived at the home and three relatives. We also spoke with four members of staff. This included care staff, senior care staff and the cook. We also spoke with three healthcare professionals. As some people were unable to share their experiences of the care they receive, a Short Observational Framework for Inspection (SOFI) was completed. SOFI is a way of observing care to help us understand the experiences of people who cannot talk to us.

We looked at the care plans for seven people to see how their care and support was planned and delivered. We also looked at Medication Administration Records (MAR), staff training and recruitment files and the

service's quality assurance records and audits.

Good

Is the service safe?

Our findings

People told us they felt safe and were happy living at Penn house. One person said, "It's a nice place here." Relatives told us they were happy with the care provided and felt their relative was safe. One relative said, "Yes it's okay for his safety and security." Another relative told us, "I can't thank them enough for the care they give [person's name].''

People and relatives told us they felt there were enough staff to keep people safe and they did not have to wait for long periods of time. One person told us, "If we say we need something, it's here, you haven't got a complaint." A relative told us, "In my view there's always adequate staff even in the evenings and at weekends.'' Another relative said, "There's enough staff there's never been a shortage.''

Staff demonstrated they understood how to spot signs of abuse and where to report concerns both within the organisation and externally to other organisations. One staff member told us, "I would speak to the manager, then the owner and then I would contact the local authority and CQC."

Where risks to people had been identified, measures had been put in place to ensure these risks were managed and reduced. We found that risk assessments were in place for areas such as; sore skin and falls. For example, one person who had sore skin, had a risk assessment detailing what was required in order to reduce this risk. This included the district nurse team visiting frequently, encouraging fluids and supporting the person to move around frequently to relieve pressure to their skin. This person also had charts in place to document staff supporting them to reposition and a body map indicating where the person's skin was sore. Staff we spoke with knew people well and knew how to manage the risks to people. For example, one staff member said, "We give pressure relief, they have their dressings changed by the district nurses and we push their fluids." There was also guidance available to staff within people's care plans to advise staff on how to support someone with a specific health need such as diabetes, sore skin and bi-polar disorder.

There was a system in place to monitor accidents and incidents. For example, the registered manager completed a monthly analysis of falls by looking at how many people had a fall within that month, what caused the fall and what time the fall happened. This information was used to identify patterns and action required.

People and their relatives told us medication was given as prescribed. One relative said, "I've seen them giving medication and that seems fine." Staff had received training on how to give medication safely and their competency to do so had been checked. The registered manager had systems in place to monitor the stock of medicines and identify any recording errors to check that people were receiving their medicine as prescribed. We saw an external audit was completed yearly. Their most recent one identified that recommendations from their previous audit had been completed and they had received positive comments from the auditor.

The provider had recruitment systems in place to ensure staff were suitable to work with people prior to them starting their employment. All staff members had been required to provide references from previous

employers and complete a check with the Disclosure and Barring Service (DBS). The DBS checks helps providers reduce the risk of employing staff who are potentially unsafe to work with vulnerable people.

We saw there was a domestic team in place to ensure the home was clean and tidy and we observed planned and responsive cleaning during our inspection. We saw that personal protective equipment (PPE) was used appropriately to prevent infection when supporting people and staff told us they had access to this when required. Relatives and healthcare professionals, we spoke with said, they always found the home to be clean and tidy and did not have any concerns. One relative said, "It's always very clean here."

Good

Is the service effective?

Our findings

Staff had completed an induction programme when they first started and had received ongoing training to ensure they had up to date knowledge and skills to meet people's needs. Staff told us they found this useful and felt confident in their role. People and relatives told us staff were skilled and were able to meet people's needs. One person told us, "The girls [staff] here know what they are doing." A healthcare professional we spoke with said, "Yes they seem well trained."

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 people lack the capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Staff had a good knowledge and understanding of this legislation and we saw them seeking consent before supporting people. One relative we spoke with explained how staff spoke the person whilst supporting them with moving around. They said, "The only way they can move them now is using a hoist. I've watched them. They talk to [person] while they do it.'' We saw that when people refused support, staff respected this and went back and tried again some time later. Where people could not verbally communicate their agreement, staff were aware of their facial expressions and body language.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked to see if the service was working within the principles of the MCA and whether there were any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications to the appropriate authority when they felt it was necessary to restrict a person's freedom to keep them safe. There was a system in place to monitor applications and authorisations of DoLS to ensure they were kept updated. Staff we spoke with confirmed they had received training on DoLS and understood what this meant for people.

People told us they enjoyed the food and were given choices. One person told us, "If you don't like the choices they'll find you something.'' We saw that people had access to food and drinks throughout the day. We visited on a hot day and in response, people were given the choice to have an ice lolly and we saw they were encouraged throughout the day to drink sufficient amounts. People's care plans detailed their nutritional needs and preferences and we saw these were met on the day of inspection. Relatives confirmed that people's nutritional needs were met. One relative told us, "[Person's] food is mashed up now. I've seen them do it so I know they are getting enough to eat and drink." Another one told us, "[Person's] not keen to eat but they [staff] give plenty of encouragement. I know they always have porridge for breakfast. There's always a steady supply of drinks."

People were supported to manage their health needs and had access to professionals when required. One person told us, "Since I've been here which isn't that long I've seen an optician a chiropractor, and chiropodist. I've seen a Dentist and had new teeth." A relative also explained, "I'm here now as they called me to say the Doctor was going to look at an adjustment to medication which should help [person's] mood.

They always act quickly if a doctor is needed.''
We saw health professionals visiting throughout the day and people's care records showed they had visits frequently from the chiropodist and district nurses where required. People's weight was monitored and the registered manager had a system in place to identify any concerns.

The premises were suitable to meet people's needs. There was an outside sitting area for people and we saw people using this. However, this area was small and there was a large grass area which was not used due to it being an incline and uneven ground. We discussed this with the provider who explained they would be starting an extension and developments in the next two weeks and this included the garden being levelled and improved.

Good

Is the service caring?

Our findings

People and relatives spoke positively about staff and told us they were kind and caring in their approach. One person said, "The staff are very good. I'm getting just what I need. When my [relative's name] is away I miss them. They know that. They keep me boosted up and keep me going.'' A relative told us, "I see them giving hugs and saying things like 'come on [person's name].' I've never met such kind people.'' Another relative said, "I've seen staff being caring to other residents not just mine. They put their arms around them.'' Healthcare professionals spoke positively about staff and one said, "I always find staff really helpful, they seem to know people really well and the residents always seemed settled."

Staff had worked for the service for a long time and had developed a relationship with people and knew them well. People's care records included information about their history, likes, dislikes and preferences so staff knew how to meet people's individual needs. Staff promoted equality and diversity within the home and communicated with people in their preferred way.

People's privacy and dignity was respected when supporting people. Staff addressed people by their preferred name and gave examples of how they protected people's dignity when supporting them with personal care. One staff member told us, "We make sure the door is closed, curtains shut and make sure no one comes in or out." We saw that people were well kept and had been supported to wear what they wanted. For example, women had jewellery and make-up on.

People were given choices and had control over their daily routine. One staff member told us, "We ask if they want a shower, if they are happy for me to help then I will but it's up to them what time they want to get up." We saw people being asked what they wanted to do before being supported. For example, some people said they wanted to stay in the lounge area to eat and they were supported to do so.

We saw and people told us, they were encouraged to remain independent. One person told us, "I'm very independent and they recognise that. They'll give me the help I need.'' We saw where people were able to eat independently, they were supported to do so by staff cutting up their food or placing cutlery in a person's hand.

People were supported to maintain relationships, we saw relatives and friends visit throughout the day and the atmosphere was relaxed and homely.

Good

Is the service responsive?

Our findings

One relative spoke positively and said, "They still treat [person] the same even though they can't really do anything now. They're still there for the entertainers and the birthday parties.'' Another relative commented, "[Person] did enjoy a recent trip to the Pub." We saw that there were some activities for people and some of these were individual and personalised to that person. For example, one person enjoyed listening and dancing to music and we saw that staff supported them to put the music on and they went to get some CDs to choose from. We then saw them getting up, dancing and enjoying themselves. We also saw people doing puzzles and there was a regular entertainer and outings into the community.

However, we observed and people told us, there were periods throughout the day where there was a lack of stimulation for people and in particular people, relatives and staff commented on the lack of conversation they had. One person told us, "Yes I'm fine here. I'd just like to be able to talk properly with more people.'' A relative we spoke with said, "I'd like to see a bit more interaction.'' Staff we spoke with told us they felt they had enough staff to support people with washing, dressing and their meals but felt they needed another staff member to allow time to engage in conversation with people. One staff member told us, "We could do with one more staff so we can give people more time." We discussed this with the provider and following our inspection, they are looking for a staff member to be allocated to activities and providing stimulation for people.

Penn house supported some people whose first language was not English, were possible the provider had staff that could speak their language such as Punjabi. Where there were no staff that could speak a person's first language or only very little, pictures were used to help people make decisions for themselves. Staff were knowledgeable about people's cultural and religious needs and people were supported to meet them. For example, some people enjoyed church visits and others were supported to go to the temple. The registered provider told us they were not aware of anyone using the service that identified as being Lesbian, Gay, Bisexual or Transgender (LGBT). However, we saw there was an equality and diversity policy in place which included LGBT and the registered manager told us they would be protected from any form of discrimination.

People's needs were assessed and reviewed on a regular basis. People, relatives and healthcare professionals were kept updated about any changes where required. We saw the deputy manager speaking with relatives and healthcare professionals when they arrived to update them on any new information or changes to people's needs. We found that where people's needs had changed, their care records had been updated to reflect these changes and staff were also aware of them. Relatives told us that when people had first moved into the home and struggled to settle, staff had responded to them and they had made the settling process positive.

Staff told us they were kept up to date about people's needs by a daily handover and that care records were kept up to date and reviewed frequently. One staff member said, "They [care plans] are very useful." Another member of staff told us, "If there are changes, we tell staff in the handover."

Healthcare professionals we spoke with said they felt they had a good working relationship with the staff and registered manager and that they responded timely to any advice. One healthcare professional told us, "If I ever pass anything on, [registered manager] always follows it through." Another one said, "They listen to us and relay information back to us, communication is good." We saw that people had personalised care plans in place to support them at the end of their life to receive the support they wanted.

People and relatives knew how to raise concerns and felt confident doing so. They told us that when they had raised issues, these had been dealt with. We saw people and relatives approach the deputy manager on the day of inspection if they had any queries or concerns and these were dealt with appropriately. We found this process could be strengthened further by clearly showing how they put learning into practice. We discussed this with the registered manager who informed they would put this in place moving forward. We saw complaints information in the reception area of the home. However, this was not in an easy read or other format for people. We discussed this with the registered manager and they told us they would look at implementing this.

Good

Is the service well-led?

Our findings

The registered manager sought feedback from people and their relatives via a quality questionnaire, these had been completed with mostly positive comments. However, this information had not been used to drive improvements within the home. There had not been an analysis of this information to look at how satisfied people were with their care or an action plan completed to address any issues. We discussed this with the registered manager and they advised that this would be implemented.

The provider told us they had plans for building work and refurbishments to start in approximately two weeks' time. When we were speaking to a relative, they commented that they felt the garden required improving and were not aware of the plans to do this. We asked the registered manager if people and their relatives had been informed about the building work, they told us they were waiting for a set date from the provider before sending out letters to people to inform them. This meant that people and their relatives were unaware of the building work due to start and that they were not involved in the decisions about the changes to the home.

We looked at the governance systems within the home to check that areas for improvement were highlighted and actions taken as a result. The registered manager completed monthly and weekly audits for areas including; falls, medication, care plans and health and safety. We saw that where areas for improvement had been highlighted, an action plan had been completed. We also saw that where external audits had been completed and actions identified, the registered manager had ensured these actions had been completed and signed off. For example, we saw that there had been an external health and safety inspection and medication audit. All recommendations and actions from these had been completed in a timely way.

There was a management team in place which consisted of; the registered provider, registered manager and deputy manager. People and their relatives knew who the management team was and spoke positively about them. One relative said, "The Manager is lovely ever so kind. They and all the staff make me feel welcome.'' We saw that people and relatives approached the registered manager's office on an informal basis to speak about any concerns.

Staff told us that the management team were approachable and supportive and they enjoyed their job. One staff member said, "All the managers are helpful and friendly, you can talk to them about anything." Another one told us, "They [registered manager] is very supportive, best manager we've had." We saw and staff confirmed that they had regular staff meetings and supervision and found them useful. One staff member said, "We get the chance to raise anything."

The provider had strong links with the local community and professionals. we saw they worked closely with the CCG, district nurses and GPs. We saw they had regular meetings and visits with the CCG to evaluate the work they had done around areas such as pressure care. They also had links with the local church who visited regularly to meet people's religious needs.

All organisations registered with the Care Quality Commission (CQC) are required to display their rating awarded to the service. The registered manager had ensured this was on display within the home. The provider had correctly notified us of any significant incidents and events that had taken place. This showed that the provider was aware of their legal responsibilities.

Duty of Candour is a requirement of the Health and Social Care Act 2008 (regulated activities) Regulations 2014 that requires registered persons to act in an open and transparent way with people in relation to the care and treatment they received. We found the provider had been open in their approach with us during the inspection and was receptive of any feedback given.