R S Oakden

Penkett Lodge

Inspection report

39 Penkett Road
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Ratings

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

Overall summary

We carried out an unannounced comprehensive inspection of this service on 17 and 20 April 2015. During this visit a breach of legal requirements was found. We found the provider was failing to provide safe care and treatment. We asked the provider to take appropriate action to ensure improvements were made to the safety of the care provided. We issued them with a warning notice with a set deadline for meeting this legal requirement in order to ensure a swift response to any risks.

We also found a breach of legal requirements with regards to ensuring people legally consented to the care they received and the way in which the provider monitored and managed the quality and safety of the service. We issued the provider with requirement actions.

Requirement actions require the provider to make the necessary improvements to ensure legal requirements are met, within a timescale they agree is achievable, with The Commission.

We undertook this comprehensive inspection on the 23 October 2015. During this visit we followed up the breaches identified at the April inspection We found the provider had taken appropriate action in relation to the warning notice and made the required improvements to meet all of their legal requirements.

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 ' Penkett Lodge' on our website at www.cqc.org.uk'

Penkett Lodge provides personal care and accommodation for up to 27 people. Nursing care is not

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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.

A registered manager was in post at the time of our visit. 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 and associated Regulations about how the service is run.

At our last inspection in April 2015, we found safeguarding incidents were not always appropriately recognised or reported to the relevant authorities. People's needs and risks in relation to skin integrity, choking and challenging behaviour were not always adequately risk assessed or managed. The storage of some medicines was unsecure and the way in which medication was administered was not safe. The premises were not entirely safe and suitable for purpose and the systems the provider had in place to monitor the quality and safety of the service were found to be ineffective.

During this visit, we reviewed a sample of the provider's safeguarding and complaint records. All of the records we looked at, showed that an appropriate investigation had been undertaken, the relevant authorities notified and comprehensive records maintained. This meant there was a clear audit trail of how safeguarding incidents and complaints were managed. Records showed the manager had a clear understanding of the action to take in the event of a safeguarding allegation or complaint being made.

We looked at three people's care records to check suitable management plans were now in place for pressure sores, swallowing difficulties and challenging behaviour. We saw that this was the case. People's needs and care was clearly identified. Risks in relation to pressure sores, choking and challenging behaviour were assessed and care plans contained sufficient information to enable staff to care for people safely.

On the day of our inspection, we saw that mediation was stored securely. People's medication records had been completed appropriately with regards to the time of administration and signed by the staff member responsible for administering the medication.

Improvements to the premises identified by Environmental Health had been completed. As a result, the provider's food hygiene rating had been re-evaluated and they had been awarded a rating of five (very good). Actions identified by the NHS Infection Control team had been completed. This included the installation of modern sluice facilities. The home's electrical repairs had been undertaken and the electrical system was now certified by an external contractor as safe. The outside garden area containing nine planters for people to plant their own vegetables and flowers in, had been repaired and looked a safe and pleasant area for people to enjoy.

The manager had introduced processes and procedures in accordance with the Mental Capacity Act 2005 and Deprivations of Liberty (DoLS) 2009 which protected people's legal right to consent to the care they received. We saw that best interest considerations had been undertaken prior to any decisions being made to deprive a person of their liberty. Care plans had been improved with more in depth person centred information and personal life history information which enabled staff to gain a better understanding of the person they cared for. This is especially important for people who live with dementia type conditions.

A new maintenance person had been employed and we saw from the maintenance records that issues were identified and addressed promptly. Health and safety audits were also now in place to identify and mitigate risks to people's health, safety and welfare. This showed that the provider had systems in to ensure the premises remained in good repair and suitable for purpose.

Medication management checks were improved and provided an audit trail of how medicines were received, administered and managed at the home. This meant the manager was able to assess if the management of medication at the home was safe.

Accidents and incident analyses were undertaken and any trends in the way they occurred used to improve the quality and safety of the service and the provider now

Summary of findings

met with the manager on a weekly basis to support them in their management role. At this inspection, we found the manager had proactively addressed all of the concerns identified at the last visit.

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?

Good

The service was safe.

People risks and needs were properly assessed and care planned. This ensured people received safe and appropriate care.

Medicines were stored securely. Medication administration was more efficient and records in relation to medicines were properly completed.

Improvements to the premises and the home's electrical system had been made to ensure the home was safe and suitable for use.

Regular health and safety audits were now undertaken and repair and maintenance issues picked up and addressed in a timely manner.

Is the service effective?

Good

We found the service effective.

Appropriate action had been taken to ensure people's legal rights to consent were protected.

Care plans now contained more in-depth person centred information about people's mental health needs and the support they required.

Where people's capacity was in question, an assessment of their capacity had been undertaken in accordance with the Mental Capacity Act 2005 and provisions put in place to protect them from risk.

Is the service well-led?

Good

The service was well led.

Appropriate audits were now in place to enable the provider to come to an informed view of the quality and safety of the service.

Support for the manager was now planned in conjunction with the provider. This enabled any issues with the quality and safety of the service to be identified early and promptly addressed.

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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 was 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.

At our last inspection on 17 and 20 April 2015 we found a significant breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). This meant the provider had failed to ensure people received safe care and treatment. We took enforcement action. We issued the provider with a warning notice in respect of Regulation 12 and gave them until the 3 August 2015 to ensure improvements were made and legal requirements met.

We also found breaches of Regulation 11 and 17 of the Health and Social Care Act 2008 (Regulated Activities). This meant the provider had failed to ensure that people's legal right to consent was protected and failed to ensure the quality and safety of the service was adequately monitored to protect people from risk.

On 23 October 2015 we undertook a focused, unannounced inspection of Penkett Lodge to check that the legal requirements in respect of these regulations were met.

We inspected the service against three of the five questions we ask about services: 'Is the service safe'; 'Is the service effective' and 'Is the service well led'. We inspected against these questions because the service was not meeting the legal requirements in respect of Regulation 11, 12 and 17 in April 2015, to which these questions relate. This focused inspection was undertaken by an Adult Social Care (ASC) inspector.

Before our inspection we reviewed any information we held about the home. During our visit, we spoke with one person who lived there, the manager and one senior staff member. We looked at three people's care files, safeguarding records, complaints and premises related records and audits.

Good

Is the service safe?

Our findings

At our comprehensive inspection of Penkett Lodge on 17 and 20 April 2015, we found safeguarding incidents were not always identified, reported or responded to as a potential safeguarding event. People's needs and risks in relation to skin integrity, choking and challenging behaviour were not always adequately risk assessed or care planned. The storage of some medicines was unsecure and the way in which medication was administered was not safe.

This was a beach of the Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our focused inspection on 23 October 2015 we found that the provider had taken appropriate and timely action to meet the shortfalls identified and now met the legal requirements of Regulation 12.

We looked at records relating to any safeguarding concerns or incidents that had occurred since our last inspection. We found that the incidents were comprehensively documented. Records showed that a full and appropriate investigation had been undertaken by the manager and incidents reported to the Local Safeguarding Team and the Care Quality Commission in accordance with local safeguarding procedures. Any complaints which were of a safeguarding nature had been appropriately identified as a potential safeguarding concern by the manager and responded to accordingly.

We looked at three people's care records. We saw that risks in relation to skin integrity, swallowing difficulties and challenging behaviour had been assessed and simple guidance provided to staff on how to manage these needs safely. Care records now contained people's life histories and more information about 'the person' so that staff had a greater understanding of how to provide people with person centred care that met their needs and preferences. Where people had challenging behaviour or emotional upset, staff had information about the potential reasons for this behaviour, potential triggers and guidance on how to support the person when these behaviours occurred.

For example, we saw that one person's care file gave staff information on the person's background, their likes and dislikes, risk factors to further mental health decline and the signs to spot. Simple guidance on how to communicate with and support the person when they became distressed was also documented for staff to follow.

The manager had introduced a new health and safety audit, which audited all areas of the home including the outside garden. The condition of the kitchen had been significantly improved with the installation of a new extractor fan, cupboard doors had been repaired and the ceiling painted. The kitchen looked clean and well organised. The kitchen fire door however was still propped open by a sack of potatoes. We spoke to the chef about this who said that the manager had discussed this with the provider. We saw that Environmental Health had revisited the home since its last inspection and had issued the provider with a new rating of five (very good) for its food hygiene standards.

We saw that some bedrooms were still in the process of being refurbished as and when they became vacant. We saw that the nine raised wooden planters in the outside garden had been fixed and the surrounding area had been trimmed back and well maintained. This meant people were able to safely access this area to plant vegetables and flowers for their own enjoyment.

We checked that the repairs to the home's electrical system identified at the last inspection had now been completed. We saw that all of the faults had been addressed. The system had been re-inspected by an external electrical contractor and certified as safe for use.

We did not see a medication round in progress during this visit but we spoke to a senior member of staff who told us that the time now taken to administer medication was much improved. At our last visit, due to constant interruptions the medication round had taken approximately three hours to complete. This meant some people experienced a delay in receiving their morning medication. The staff member we spoke to told us that the medication round now took half this time.

We checked a sample of medication administration records and saw that people's records had been signed appropriately. Where people received their medication later than the specified time, staff now noted the time of administration on the person's medication administration records. Staff handover meetings and notes also made reference to any medication changes that may impact on

Good

Is the service safe?

people's care. Prescribed creams were no longer stored un-securely in people's bedrooms and the medication trolley was stored securely in a locked medication room when not in use. This meant medication was now protected from unauthorised use or removal.

Good

Is the service effective?

Our findings

At our last inspection in April 2015, we found that where people had dementia type conditions or short term memory loss, care plans lacked sufficient information about how these conditions impacted on their day to day lives. We also found that where people had conditions that may have impacted on their ability to make decisions, people's capacity to make decisions was not assessed and provisions put in place for legal consent to be obtained.

During this visit, we saw that people's care records now contained person centred information about the person and any mental health conditions they experienced. People's life histories were documented and care plans contained information about their likes, dislikes and preferences in care. Personal life histories capture the life story and memories of each person and help staff deliver person centred care. Personal life histories have been shown to be especially useful when caring for a person with dementia or short term memory loss.

We saw staff throughout the day checking people consented to the support they were being given. Care plans showed that people had been given a choice in how they wished to be cared for.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) is part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We saw that where people were thought to lack capacity for a particular aspect of their care, a mental capacity assessment in relation to the decision had been undertaken with the person and any other relevant parties. This included an assessment of the person's capacity at different times of the day before a conclusion about their capacity was made.

We saw that one person had their capacity assessed in respect of their ability to keep themselves safe outside of the home. Records showed the person lacked capacity to do this. A deprivation of liberty application had been submitted to the Local Authority to seek authorisation for the home to legally deprive the person of their liberty in order to keep them safe.

We saw that one person had been referred by the manager to the mental health team for further assessment and support. We saw that the advice provided to the home by the mental health team had been documented and followed.

We saw evidence in people's care files that their emotional well-being had been considered. Care records now contained concise information on people's emotional needs and behaviours and simple guidance to staff on how to diffuse any challenging behaviours through person centred care.

Good

Is the service well-led?

Our findings

At our last inspection in April 2015, we found the way in which the provider monitored the quality and safety of the service required improvement. There was no regular health and safety audits in place to ensure environmental risks were managed. No evidence that accidents and incidents were learnt from, to prevent similar accidents or incidents occurring in the future and no evidence that the manager received appropriate support from the provider. During this visit, we found these issues had been addressed.

The manager had implemented weekly health and safety audits that audited all areas of the home and its equipment. This complimented the maintenance person's weekly job sheet which logged any repair and maintenance works that were required. A new maintenance person had been employed at the home since our last inspection and we saw evidence that regular repair and maintenance issues were being identified and addressed. This demonstrated a proactive approach to protecting the health and safety of people who lived at the home had now been adopted.

Improvements had been made to the way in which medication was administered and stored. The ordering and booking medicines into the home by the manager or a senior were double checked by another member of staff. The competency of staff in the administration of medication was now formally checked and documented. Monthly medication audits verified stock levels against medication administration records and checks were made of the balance of medication carried forward at the end of each medication cycle to ensure stock levels were accurately quantified before new medication was received. This meant there was an audit trail of how medicines were received into the home and subsequently managed.

We saw evidence that accident and incident information was collated and analysed by the manager, to enable any trends in the way in which accidents or incidents occurred to be identified and addressed. We saw from the accident and incident audits we looked at, that appropriate action had been taken to prevent further accident or incidents from occurring. For example, the manager had undertaken a review of the factors precipitating an accident or incident and had ensured people who lived at the home, had assistive technology in place to mitigate any potential further occurrences.

The manager told us that the provider now met with them once a week to discuss the running of the home. They told us they had implemented a new form to record the main issues discussed at this meeting and any action taken. We saw evidence of this documentation. We saw that a recent meeting with the provider had taken place with issues associated with the management of the home discussed. For example, occupancy levels, safeguarding, complaints, staffing, audits and premises maintenance were discussed. This assured us that the manager was receiving support from the regulated provider in respect of the quality and safety of the service.

We found that the manager had proactively responded to all of the issues identified at our last inspection. We found the service at this visit to be well led.