Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Penrose

6 Filleul Road, Sandford, Wareham, BH20 7AP

Tel: 01929552100

Date of Inspection: 16 July 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Supporting workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Penrose Residential Limited
Registered Manager	Mrs. Jane Wills
Overview of the service	Penrose is a residential service for 3 people with a learning disability. It provides 24 hour personal care in small homely environment
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 16 July 2013, observed how people were being cared for and talked with staff. We reviewed information given to us by the provider and talked with other authorities.

What people told us and what we found

The people who use the service were well supported by staff and had clear care plans in place for staff to follow.

People received appropriate care and had mental capacity assessments and were appropriate best interests decisions were being made on their behalf.

We found evidence that medication was stored safely and appropriately and administration of medication was recorded accurately.

Records within the home were regularly updated and older records archived appropriately.

Staff are well supported by the service and had relevant training and development.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. During our inspection we observed a staff memeber ask the person "Are you happy to take your medication now" The person replied "yes" The staff member then administered the medication.

A staff member told us they always ask the person before providing care. They also explained that a best interest decision would be made and recorded in a person's care file if they were unable to make a decision. We looked at two care records and saw evidence of these consent procedures. For example one person who uses the service had become unsteady on their feet when mobilising and was now using a walking frame. We saw evidence in their care record that the decision to start using a walking frame had been discussed with the person, an occupational therapist and their family and consent had been obtained.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.A member of staff told us about someone who has capacity to make day to day decisions but not more complex decisions. They told us that they were able to gain consent from the person on day to day daily living decisions but that more complex decisions were discussed with the person's family and relevant professionals as required. We saw from the person's care records and saw evidence that recent dental treatment had been carried out through a best interest decision to enable treatment. We also saw that it was recorded in the person's care plans that the person had capacity to make decisions on their daily life.

The staff member told they always check the care plan before giving care to an individual. Staff told us they would involve health professionals, such as the person's GP and community learning disability nurses as appropriate to provide appropriate care.We looked at two care plan records. Capacity assessments had been completed and staff were aware

of the information. There was evidence of family and health professional involvement in best interest decisions being made.

The staff member told they always check the care plan before giving care to an individual. Staff told us they would involve health professionals, such as the person's GP and community learning disability nurses as appropriate to provide appropriate care.

We when looked at two care plan records. We saw Capacity assessments had been completed and staff were aware of the information. There was evidence of family and health professional involvement in best interest decisions being made.

Care and welfare of people who use services ✓ Met this standard

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

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's individual care and treatment needs were assessed and care was provided to meet their needs. We looked at care plans for the two people who lived in the home. We saw evidence that each person's care needs had been assessed and there was a care plan to meet their individual needs.

The care records also showed information on people's risks and contained guidance for staff on how to manage the risk. For example, where a person had been identified as having poor mobility and therefore at risk of falls, the care plan had been reviewed to support the person and reduce the risk of falls. The care records also contained information on how to reduce the risk of falls in the person's environment, for example ensuring the floor was free from potential trip hazards and the carpets were in good condition. From the fall's monitoring this person had in place the fall's had reduced. It has also help maintain their independence. People's risks of developing pressure area damage and associated risk management were also documented. When we spoke to staff they were able to describe what they should look for and this reflected in the care plan. We saw that people were weighed regularly which helps monitor weight gain or lose and enables meals to be given that meets their individual needs.

Staff understood people's needs. We asked a staff member about the care needs of each person. The staff member was able to tell us about each individual's care needs and how they met their needs. For example, they spoke about the mobility risks of one person and how they managed those risks. They told us how they assisted the person to use their frame to assist mobility. We saw this was documented information within the person's care records.

The care records demonstrated that people's risks were reviewed every six months by the home manager. Care records were also reviewed six monthly and more frequently if required, for example a change in a person's condition.

The home obtained professional healthcare advice when required. We saw from people's care records that contact with a healthcare specialist, for example a GP or a district nurse, had been documented. Each care record contained a continual record that showed visits

from healthcare specialists. On the day of our inspection one person was visited by their GP due to complaining of being unwell with a chest infection. The provider stated they work closely with the GP in managing this reoccurring illness. We saw evidence that there was a specific care record to help reduce the risk and manage this condition.

During the inspection we observed staff inter acting with people in a person centred way and respecting their wishes.
We spoke with a commissioning local authority and spoke to the Senior Social Worker who stated they reviewed the service and are happy with the way the persons needs are met

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

The home had a current medication policy that included information and guidance on the administration, retention, disposal and recording of medication.

We observed medication being administered to one person during their breakfast. This was done in a person centred way and on looking at the administration record at the right time.

We observed during the inspection that medicines were stored securely in a locked cabinet in the office.There were no people living at the home at the time of our inspection who were prescribed a controlled drug. We saw that the refrigerator used to store medicines had the temperature recorded daily. There were no omissions in the recording records and all temperatures were within agreed limits.

Medicines were administered appropriately. We looked at the Medicine Administration Records (MAR) for the two people who live in the service. We saw that medication administered was correctly recorded. It also showed any reasons for the person not having had their medicine, for example if they refused or were asleep. There were no omissions in the entries. Appropriate records were maintained where people were prescribed a variable dose of medicine. The MAR charts showed the maximum daily dosage people were prescribed and what increments the medicines could be given. For example, a person who was prescribed a variable dose of paracetamol could have one or two tablets up to four times daily, with a maximum dosage of eight each day. Records showed that staff had signed the MAR chart to indicate that that the medicine had been given and the amount that had been administered. There was evidence of good practice in administration of medication

Medicines were administered safely. We saw from staff records that staff who administered medicines to people had received appropriate training. We spoke with the provider about staff competency assessments in medicines who told us this is undertaken and recorded in their staff records. When we reviewed staff files we saw evidence that medication competency assessments had been carried with staff.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Staff received appropriate training. We looked at the staff training record that showed the training completed by staff. We saw that training had been completed in subjects such as moving and handling, fire safety, safeguarding and first aid. The training record identified when staff required training updates and the registered manager produced the projected training schedule for staff that showed when further training would be undertaken.

We spoke with one staff member who told us they had completed relevant training and felt competent to do their role. The staff member said they enjoyed their employment, and that they felt supported by the home management through training and guidance.

Staff had the opportunity to undertake additional training and qualifications. We spoke with the registered manager about additional training and looked at training records. These showed that some staff had undertaken and completed a National Vocational Qualification (NVQ) in care.

Staff received appropriate supervision and appraisal. The home management completed staff supervisions a minimum of six times a year, together with an annual appraisal. We saw the home had a supervision and appraisal record to monitor this. We looked at two staff files and saw the supporting documentation for the supervision and appraisal. The supervision documents showed that matters such as team working, safeguarding and health and safety were discussed. The appraisal document showed that staff performance, achievements and future aspirations were discussed. We spoke with one staff member who confirmed they received supervision and appraisal.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People who use the service have records maintained and reviewed appropriately to enable treatment and care to be given as required. All records including people's individual records and medication records were stored safely and securely.

Reasons for our judgement

People's care records included accurate and up to date information. We looked at the care records for the two people who lived at the service. There was accurate information kept for each person that enabled staff to provide appropriate care and treatment. Each person's file was sectioned to enable staff to find appropriate paperwork quickly. We saw evidence of a clear schedule to review and update records. Including archiving older care records safely and separately to current records.

People's care records were stored appropriately and safely in a lockable cabinet. When we spoke with the staff member they stated. "There were no issues with accessing care records."

Medication records and administration of medicines were up to date and had no omissions. Older medication records were stored separately and appropriately.

Staff Records are kept securely by the manager and contained relevant information, for example, information training, supervision, staff appraisal and staff rota.

About CQC inspections

We are the regulator of health and social care in England.

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

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk