Salisbury Christian Care Homes (Inwood House) Limited

Inwood House

Inspection report

10 Bellamy Lane
Salisbury
Wiltshire
SP1 2SP

Tel: 01722331980

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Inwood House is a care home providing personal care for up to 20 people, some of whom live with dementia. Accommodation is provided over three floors accessed by stairs and a lift. People have their own rooms and access to communal areas such as dining rooms, lounges and a conservatory. The home had an enclosed garden accessed from the ground floor. At the time of the inspection there were 13 people living at the home.

People's experience of using this service and what we found
Risk management plans were not robust and effective in mitigating risks. There was conflicting information recorded and gaps in one person's monitoring records. Some risks had not been identified and there was not always guidance available for safe ways of working.

Staff were not consistently wearing the correct personal protective equipment (PPE) and not testing for COVID-19 as required. Current safe systems of working in a care home during COVID-19 had not been identified by the provider or registered manager.

Quality monitoring was not robust or effective in assessing and mitigating risks and driving improvement. Incidents of safeguarding and one serious injury had not been notified to CQC. The provider's governance systems had failed to identify this had not been carried out.

Whilst people had their medicines as prescribed staff had not carried out all checks required for people needing medicines covertly. We also observed topical creams had no date of opening recorded consistently. The provider's quality monitoring systems had not identified these shortfalls. We have made a recommendation about medicines.

People and relatives told us they experienced good care provided by a team of staff who had a caring and kind approach. People and relatives told us they felt involved in their care and kept up to date with any changes.

People were being supported by enough staff who had been recruited safely. Staff had been trained in safeguarding and knew where to report any concerns. Staff were able to attend regular staff meetings and share their views. Staff felt well supported by the registered manager and the provider.

Incidents and accidents had been recorded and investigations carried out where needed. Action had been taken to prevent reoccurrence. Staff worked in partnership with the local authority, local mental health teams and GP's to meet people's health needs.

Visiting was being facilitated and safely managed. All visitors had to complete a Lateral Flow Test prior to entering the home. Staff checked visitors' temperatures and provided PPE to be worn. People were being

tested regularly for COVID-19 following government guidance.

The home was clean, and staff had schedules to complete to ensure all areas were routinely sanitised. Where possible windows were open to increase ventilation.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 15 November 2019) and there were two breaches of regulations 12 and 17. We carried out a targeted inspection on the 13 January 2021 and found enough improvement had been made for the breach of regulation 12. We did not check at that inspection if enough improvement had been made for the breach of regulation 17. At this inspection enough improvement had not been made or sustained and the provider was still in breach of regulation 17. We also found the provider was in breach of regulation 12 again and we identified another breach of regulation.

The service remains rated requires improvement for the second consecutive rated inspection.

Why we inspected
The inspection was prompted in part due to concerns received about safety of the premises and unexplained injuries. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.
We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Inwood House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, good governance and failing to notify CQC of incidents at this inspection. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Inwood House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Inwood House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care and support provided. We spoke with two members of staff and the registered manager. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at two files in relations to staff recruitment, quality monitoring records and incident and accident forms. A variety of records relating to the management of the service including policies and procedures were reviewed.

After the inspection
We contacted five relatives for their views of the care experienced. We also spoke with a further five members of staff on the telephone. We contacted one professional for their views about the service. We continued to seek clarification from the provider to validate evidence found. We looked at risk assessments and quality monitoring.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last focused inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

- We were not assured that the provider was using PPE effectively and safely. On the day of our site visit we observed staff were not wearing the correct PPE.
- We were not assured that the provider's infection prevention and control policy was up to date. The providers policy did not contain any information or guidance on working safely in a COVID-19 outbreak. The registered manager was not aware of the current guidance on safe use of PPE in care homes. We sent them the link to the current guidance following our site visit.
- We were not assured that the provider was accessing testing for people using the service and staff. Staff were not testing for COVID-19 following the most up to date government guidance.
- We were not assured that the provider was making sure infection outbreaks can be effectively prevented or managed as government guidance was not being followed.

We found no evidence that people had been harmed however, the provider had failed to consistently assess and prevent the risk of infection. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have also signposted the provider to resources to develop their approach.

Assessing risk, safety monitoring and management

- Risk management was not consistently safe. We observed some risks had not been identified so that suitable management plans could be put in place. For example, one person was at risk of leaving the premises on their own which was not safe. Staff were not aware of this risk. There was no risk management plan in place to mitigate the risks.
- Where risk management plans were in place records were not completed accurately and routinely to enable the provider to monitor risk management. For example, one person at risk of malnutrition had food

and fluid monitoring in place. Staff were not recording amounts eaten and drunk accurately and consistently. This meant the provider could not safely monitor intake for this person.
● One person had 1-1 support from an agency member of staff to help manage specific risks. There was no 1-1 guidance in place for this member of staff to know what to do to support this person. Staff told us they followed the person around but were not clear about what action they would take should the person become distressed with people or staff. In addition, the member of staff was not recording any details of the support provided. This meant there was no record of the 1-1 hours so the provider could monitor the effectiveness of the risk management.

We found no evidence that people had been harmed however, the provider had failed to consistently identify and assess risks so that action could be taken to keep people safe. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Prior to our inspection we received information of concern about the garden at the service and radiators not being covered safely. We checked these areas and found some action was required to mitigate risks.
● The provider took action following our site visit to mitigate risks in the garden and for one radiator.

Systems and processes to safeguard people from the risk of abuse
● People and relative told us they thought people were safe at the service. Comments included, "I am assured [relative] is safe and well cared for" and "I feel safe here, I have my call bell in reach."
● Staff had been given training on safeguarding and understood their responsibilities to report any concerns. Staff were confident management would take appropriate action in response.

Staffing and recruitment
● People were being cared for by enough staff. We observed staff responded to people in a timely way. Staff numbers were kept under review using a dependency tool which monitored people's needs.
● The service had experienced staffing shortages where staff phoned in sick at short notice. Covering the shifts had proved difficult at times. The registered manager told us there was other staff available to cover shifts such as management and activity staff.
● Staff had been recruited safely. The required pre-employment checks had been carried out.

Using medicines safely
● People had their medicines as prescribed. People had their own medicines administration record (MAR) which had accurate and current information recorded.
● For people who had medicines administration covertly we observed whilst permissions to do so were in place staff had not made the required check with a pharmacist. This check is to ensure medicines are still effective when given in food or drink. The registered manager took immediate action to ensure this check was completed.
● People who had 'as required' medicines had guidance in place for staff to know when to administer this type of medicine.
● We observed some topical creams which had not been dated when opened. This meant the provider could not be sure they were still safe to use. Staff told us they would address this shortfall immediately.

We recommend the provider review systems to ensure creams are routinely and consistently dated when opened by staff.

Learning lessons when things go wrong

● Incidents and accidents had been reviewed so action required to prevent reoccurrence could be taken. The registered manager told us they reflected on incidents in weekly staff meetings and daily handovers to ensure lessons were learned.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last focused inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At the last focused inspection in October 2019 we found the provider had failed to notify CQC of all notifiable incidents as required by law. At this inspection we found improvement had not been made.

- We found incidents of safeguarding and one serious injury that had not been notified to CQC. The service had reported the incidents to the local authority and taken steps to seek professional advice, however they had not informed CQC which they are required to do by law.

Failing to notify CQC of serious injury and all cases of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the last focused inspection in October 2019 we found the provider had failed to assess, monitor and improve the quality and safety of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

- Systems were not in place to ensure the service was always operating safely. Quality monitoring was taking place but had not identified shortfalls in practice and process.
- Quality monitoring for medicines did not include a check of topical creams. We observed some creams had not been dated when opened, this had not been routinely checked.
- Care audits carried out in June 2021 identified gaps in food and fluid charts, the care audit in October 2021 identified the same shortfall. During our inspection we found there were still gaps in food and fluid charts. Quality monitoring was not effective in driving improvements in quality and safety.
- Since our last inspection there was a new registered manager in post. The registered manager was not up to date with good practice and current guidance. They were unaware of current guidance on how to work safely in care homes during COVID-19.
- The registered manager had not followed the correct process with regards to three assessments of people's capacity. They had failed to read one person's care records which had information about risk. This meant they were not aware of the risk which placed the person at risk of harm.

We found no evidence that people had been harmed however, systems were either not in place or robust

enough to demonstrate the provider was assessing, monitoring and improving the quality and safety of the service and mitigating risks. This placed people at risk of harm. This was a repeated breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Despite the shortfalls we found during the inspection people and relatives were happy with the care provided. Comments included, "I have been having lots of conversation and communication with the home. Every time I call, there is always someone there to talk to me about [relative] They [staff] seem to know exactly what is going on", "The staff are so kind and so good with [relative], they are very patient" and "They [staff] made me feel very welcome when I arrived, the staff are good, nice and kind."

● People were being supported by a team of staff who enjoyed working at the home. Staff turnover was low, and people received a continuity in their care. Comments from staff included, "I do enjoy it as it is different all the time, different residents. I love working with older people" and "I find it really rewarding. I like making a difference."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and relatives were asked for their views and involved in care provided. One relative told us, "They [staff] have kept me updated with everything. Even [relative's] GP phoned me up and talked me through what she was doing. She wanted to let me know what approach she was taking."

● Staff were able to attend meetings regularly and minutes of the discussion were kept. Staff told us they felt able to approach management with any concern or idea for improvement. One member of staff told us, "I can get support from the manager, they are good managers. We can share anything; we can share new suggestions for the residents as we are [the ones] taking care of the residents."

Working in partnership with others

● Staff worked in partnership with local healthcare professionals to make sure people's healthcare needs were met. We observed in people's records evidence of consultation and visits from various professionals such as mental health teams, GP's and community nurses.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify CQC of incidents and serious injuries as they are required to do by law. Regulation 18 (1) (2) (b) (e)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations 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 The provider had failed to identify and assess risks so that action could be taken to keep people safe. This placed people at risk of harm. Regulation 12 (1) (2) (a) (b) (d) (h)

The enforcement action we took:

We served the provider a Warning Notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to have in place robust and effective systems to assess, monitor and improve the quality and safety, to assess, monitor and mitigate the risks relating to the health, safety and welfare of people. Failure to have robust systems in place meant they were not able to evaluate and improve their practice. This placed people at risk of harm. Regulation 17 (1) (2) (a) (b) (f)

The enforcement action we took:

We imposed a condition on the providers registration.