ACG Operations LTD

Inwood House

Inspection report

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Date of inspection visit:
31 August 2021

Date of publication:
03 January 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Inwood House is a residential care home providing personal care to older people. At the time of this inspection 33 people were living at the home. The service can support up to 55 people.

People's experience of using this service and what we found
Medicines were not administered safely. People and staff all told us there was not enough staff.

We have made a recommendation about staff consistency and deployment.

Action was not always taken to mitigate against those risks. There was little evidence lessons learnt, following analysis, had been shared with staff People told us they felt safe. Infection prevention and control was in place.

The governance framework was sporadic and did not identify the issues found during our inspection visit. The actions identified following this inspection had not improved the safety or quality of the service. Provider oversight was limited to telephone calls and reports; there was no evidence the provider had undertaking any checks or audits.

Not all staff had received training in-line with the provider's policy. We observed staff were caring and gave people choice. People told us the food was good. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 13 August 2021) and there were two breaches of regulation. The service remains requires improvement. This service has been rated requires improvement for the last three consecutive inspections. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

Why we inspected
We received concerns in relation to the management of medicines and infection prevention and control. As a result, we undertook a focused inspection to review the key questions of safe, effective 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.

The overall rating for the service has remained the same. This is based on the findings at this inspection.

We have found evidence that the provider needs to make improvement. Please see the safe, effective 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 medicines management and good governance 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service effective? The service was not always effective. Details are in our effective findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-led findings below.	**Inadequate**

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
The inspection was undertaken by three inspectors.

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 did not have a manager registered with the Care Quality Commission. However, a manager was working at the home and had applied to be registered. 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 sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they

plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service about their experience of the care provided. We spoke with nine members of staff including the nominated individual, manager, deputy manager, care workers and the cook. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of records. This included four people's care records and medicines records. We looked at four staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

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 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.

Using medicines safely

At our last inspection the provider had failed to ensure robust systems were in place to manage medicines. This was a breach of Regulation 12 (Safe care and treatment) 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 12.

• Medicines were not managed safely.
• Stocks of medicines were not reviewed appropriately. For example, one person had two boxes of medicines for which they were no longer prescribed. A new system of counting medicine stocks had recently been implemented, although staff had not followed this new system. However, the medicine stock counts we reviewed tallied with those on the medicine administration record.
• Protocols to support staff to administer 'as and when' medicines were not in place. The deputy manager told us templates for these had been produced, however they had not been implemented since our last inspection visit.
• Topical creams administration had not always been recorded. Staff were unclear about how this should be recorded.
• A new recording system was being implemented at the time of the inspection. Although this made records easier to view, records for transdermal pain relief, for example, had not been carried over to the new system.
• A senior manager audit undertaken three days before our inspection had identified a number of concerns relating to medicine administration, including those we found during inspection. A new quality assurance manager, whose role included reviewing medicines administration, had started work on the day of the inspection. Since the inspection they have taken action to address the issues found.

We found no evidence people had been harmed, however systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a repeated breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure robust systems were in place to demonstrate risks to health and safety were managed safely. This was a breach of Regulation 12 (Safe care and treatment) 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 12.
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• Risks to people's safety had been assessed, however action had not always been taken to mitigate those risks.
• Records were kept for people who needed their food and fluid intake monitoring. However, systems were not in place to monitor people's fluid levels. For example, for one person staff had only offered the required amount of fluid for one out of eight days.
• Systems were not in place to monitor whether people had been repositioned in line with their care plan.

We found no evidence people had been harmed, however systems were not robust enough to demonstrate risks to health and safety were managed safely. This placed people at risk of harm. This was a repeated breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• Environmental and equipment checks were completed in line with legislation and guidance.

Staffing and recruitment
• Without exception people and staff expressed concerns about staffing numbers in the home. People's comments included: "I used to know the staff but there have been so many changes I don't know who they are. I don't know why there are so many changes they just don't seem to stay", and, "They (staff) are all very busy." One person told us they had to wait a long time for staff to get them up in the morning but they understood there was a lot of people who needed help and they didn't "mind waiting their turn".
• Staff comments included: "We have worked with low staffing levels and it is worse at the weekend. Some staff have not had much training, and some were not trained to use the hoist. This had an impact on the people who used the service", and, "We want to do the best for people, they are like our family. I feel guilty when people ask me to sit and talk to them, but I can't because I have to meet people's personal care needs."
• Our observations found when there was only one senior staff member on shift the medicines administration rounds took up all of their time. This meant senior care workers were unable to support colleagues. We also observed people did not always get timely support from staff during meal times.
• Staffing had not increased to reflect the activities role vacancy and people told us they had been affected by staff not having time to talk to them. One person said, "I feel lonely and the days are so long. Staff don't have the time to sit and talk."
• Staff were recruited safely. The home had recruited more staff recently and had increased staffing levels by one; this had started the day before our inspection visit.
• Staffing rotas were not clear about which staff had actually been on shift, for example, where staff were sick; however, these had changed the week before the inspection which had aided clarity. The deputy manager completed staffing rotas to ensure a good experience and skill mix amongst staff.

We recommend the registered provider consults with good practice guidance and implements a system to ensure staff are consistently and effectively deployed to meet peoples needs at all times.

Preventing and controlling infection
• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was meeting shielding and social distancing rules.

• We were assured the provider was admitting people safely to the service.
• We were assured the provider was using PPE effectively and safely.
• We were assured the provider was accessing testing for people using the service and staff.
• We were assured the provider was promoting safety through the layout and hygiene practices of the premises
• We were somewhat assured the provider was making sure infection outbreaks can be effectively prevented or managed. There was limited evidence of staff risk assessments, although staff were supported to self-isolate. Some staff had completed infection prevention and control (IPC) training although new staff had not received specific COVID-19 training. The manager was in the process of sourcing training from the local IPC team.
• We were assured the provider's infection prevention and control policy was up to date.
• We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Systems were in place to safeguard people from abuse.
• People felt safe. Comments included: "I prefer to stay in my bedroom, staff bring me my meals. I feel safe because I know its only staff that can get into my bedroom", and, "Yes I am safe, and the staff are kind to me they do their best to keep me safe".
• Staff were able to describe the signs of abuse and neglect and the manager was clear about their responsibilities for reporting safeguarding concerns.
• The home manager had a system in place to monitor concerns and incidents. They home manager told us they planned to use this monitoring to learn and prevent future occurrences.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience
• Not all staff were compliant with all mandatory training. The nominated individual told us they had taken steps to address this, however people were being supported by some untrained staff.
• The deputy manager told us they had recently started to complete the staffing rota to ensure a skill mix across staff; however, this did not take into account staff's training records.
• Not all staff had received regular supervisions. A senior manager had visited the home just prior to the inspection and had commenced supervisions for some staff. A supervision matrix was not up-to-date; however the home manager had commenced a new supervision plan and record.
• New staff completed an induction programme, which included shadowing more experienced staff.

Ensuring consent to care and treatment in line with law and guidance
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 they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.
• Mental capacity assessments were in place to identify people who did not have the capacity to make decisions about their care and support.
• Where people had been deprived of their liberty there was evidence of appropriate DoLS applications being made to the local authority. However, the home manager had identified tracking of these needed following-up and had made immediate plans to do this.

Supporting people to eat and drink enough to maintain a balanced diet
• People told us: "The food is always nice, we have a choice, or I can always have something else if it's not on the menu", and, "The food is always piping hot when it arrives, it's very nice". Another person gave two thumbs up to confirm the food was good.
• People's weight was monitored regularly and reviewed by the home manager. Where people's weight had

decreased the home manager ensured support was given and appropriate referrals were made to health professionals.
• The cook was knowledgeable about people's dietary needs and these were clearly recorded in people's care plans.
• People who needed supporting to eat were well identified, however recording of food and fluid intake was often sporadic.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• Assessments of people's needs were completed, and outcomes identified.
• Care and support plans were regularly reviewed. The home manager had identified more detail would be beneficial in some people's care plans and had made plans to include more personalised information.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Care records showed health and social care professionals were involved in people's care and support.
• The home identified the need for, and made appropriate referrals to health professionals.
• Information about advice given was recorded.

Adapting service, design, decoration to meet people's needs
• People's bedrooms were individualised and decorated with personal items of their choosing. Electronic fobs were used gain access to bedrooms to maintain privacy.
• The home was well-maintained and easily accessible to people using the service.
• Signage was in place to support people who lived with dementia.

Inadequate

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 inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure systems were either in place or robust enough to demonstrate good governance. This was a breach of Regulation 17 (Good governance) 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.

• The provider did not always understand their regulatory responsibilities and we were not assured they understood quality performance and management of risk. The provider has failed to be compliant with regulations at the last three inspections.
• Robust governance arrangements were not in place. Prior to our inspection the provider had arranged for senior managers to visit the service. These visits had identified some of the concerns found during our inspection visit. However, we were not assured the governance arrangements prior to this were effective as concerns identified during the last inspection had not been rectified.
• A provider action plan completed following our last inspection recorded all the actions had been completed or were scheduled for completion by 31 August 2021. However, concerns continued to be identified during this inspection.
• Medicines audits by staff had taken place regularly but had not identified concerns found during the provider audit undertaken on 28 August 2021. There was no evidence a senior manager audit regarding medicines had been undertaken prior to this date, despite concerns found at our last inspection.
• Care plan reviews had commenced, however fluid monitoring, food recording, and repositioning records were not always completed appropriately.
• The home manager or deputy manager undertook a daily walk around, although we were informed they did not always record this. During our inspection visit we found a dirty wheelchair, a commode and a dirty shower seat in one shower room. This was brought to the attention of the home manager who took immediate action.

We found no evidence people had been harmed, however this was a continued breach of Regulation 17 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• Staff told us morale was low. Staff comments included: "We have had so many managers and they all work differently so we never know what to expect when there are changes", and, "When new managers come, they don't have meetings or introduce themselves. We just get told who they are. I have not been introduced to the bosses, so I don't know who they are".
• People told us there were lots of new staff and they did not know them.
• The provider had implemented a new way of managing people's personal finances; however, how this was to be implemented had had not been communicated to people or their relatives.
• A residents and relatives survey had been conducted in June 2021 and analysis had been undertaken; however, regular contact with relatives was not embedded.
• Regular staff meetings had not taken place; however, the new home manager had commenced a programme of these.
• The home manager had an open-door policy and told us staff frequently spoke with them,
• The home manager told us they had been well-supported during their induction by peers and managers from within the organisation.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The provider understood their responsibility to be open and honest when things had gone wrong. There was a system in place to manage this.
• Our records recorded that appropriate statutory notifications were made to the Care Quality Commission.

Continuous learning and improving care; Working in partnership with others
• The home had accepted offers of support from the local IPC team and from NHS colleagues.
• The home was working with professionals to support improvement and learning.

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 Regulation 12 (1)(2)(b) The provider was not doing all that was reasonably practicable to mitigate risks. Regulation 12 (1)(2)(g) The provider was not ensuring the proper and safe administration of medicines.

The enforcement action we took:

We issued a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) The provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (b) The provider did not have effective systems in place to assess, monitor and mitigate the risks to people living at the service.

The enforcement action we took:

We issued a warning notice.