Mr R J & Mrs W P Barraclough

Inwood House

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Requires improvement
Is the service effective?	Requires improvement
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

The inspection took place on 28 May 2015 and was unannounced. We also visited the home on 3 June 2015 and this inspection was announced. We had undertaken a late evening visit to the provider on 5 May 2015 following information we had received about the service. The location had last been inspected on 02 August 2013 and was not in breach of the Health and Social Care Act regulations at that time.

Inwood House provides accommodation and personal care for up to 55 older people and people living with dementia. There were 54 people living there at the time of our inspection, 22 of whom were living with dementia.

The service had a registered manager in place. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Extensive work had been undertaken to the environment of the home increasing the occupancy from 35 to 55 . The

Summary of findings

building had been altered to meet all current building standard for accessibility to suit people with a range of physical disabilities. The new facilities were of a high standard, with a modern laundry and kitchen area.

People who lived at the home and their relatives told us they felt safe at Inwood House.

Staff were able to identify risks specific to the people who lived there.

Although medicines were administered safely, we found staff were out of date with training on the management of medicines and there was no system in place to check ongoing competencies. This breached Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the proper and safe management of medicines.

We observed moving and handling practices that were not in accordance with good practice.

Although there were enough staff, they were not deployed efficiently to ensure that people's needs were responded to in a timely manner, particularly around mealtimes.

Systems were in place to ensure staff were recruited appropriately and had the right skills and behaviours for their role.

The registered provider invested in training to ensure staff had the right skills and knowledge to perform in their role. Staff had regular supervision and appraisals.

The registered manager had complied with their responsibilities under the MCA 2005 and DoLS. They had a good understanding of when a person might be deprived of their liberty.

People had not been adequately supported at meal time during our inspection and a drink was not offered to all the people who used the service until after the main course. This was a breach of Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs.

The property had been extended and the new facilities were of a high standard to meet the needs of people with a physical disability. Signage and facilities for people living with dementia were more limited.

People and their relatives told us staff were caring and one person described the staff as "out of this world". Another preson told us " I am very happy here."

We found care records were not held confidentially behind the reception desk and there was no privacy curtain in one of the double rooms which meant the person's dignity or privacy could not always berespected. This was a breach of Regualtion 10 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Staff knew people well and their likes and preferences. Care files were person centred and people who used the service had been involved in their compilation.

Daily logs were not contemperanous. This demonstrated a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although people enjoyed activities on offer, we found there to be limited evidence that people were supported with meaningful occupation throughout the day.

The registered manager and registered provider were on site and proactive in the running of the home. Staff told us how supportive management were and told us they enjoyed their roles as carers.

Feedback from questionnaires was positive and any negative comments were acted on to continually improve the service.

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?

Requires improvement

The service was not always safe

Although medicines were administered safely, we found staff were out of date with training on the management of medicines and there was no system in place to check on-going competencies.

People who used the service and their relatives told us they felt safe

Staff were not always observed to be utilising the most up to date moving and handling practices, although the registered provider had placed a member of staff on an advanced training course by our second day of inspection.

Staff were not always deployed in the right place to support the people who lived there, particularly around meal times.

Is the service effective?

Requires improvement

The service was not always effective

The registered manager had complied with their responsibilities under the MCA 2005 and DoLS. They had a good understanding of when a person might be deprived of their liberty.

People had not been adequately supported at the meal time during our inspection and a drink was not offered to all the people who used the service until after the main course.

The property had been extended and the new facilities were of a high standard to meet the needs of people with a physical disability. Signage and facilities for people living with dementia were more limited.

Is the service caring?

Requires improvement

The service was caring

People and their relatives told us staff were caring

People were encouraged to remain independent in their daily lives.

People's privacy was not always preserved due to the lack of a dignity curtain in the shared bedrooms, although personal care was always undertaken in people's bedrooms and bathrooms.

Is the service responsive?

Requires improvement

The service was not always responsive.

Care plans were detailed and person centred, but daily logs had not always been completed which meant it was difficult to evidence what care had been undertaken and what choices had been offered to people.

Summary of findings

Activities were based around group activities which people enjoyed. We did not see evidence in daily logs or our observations that people were engaged in meangingful occupation during the day.

Is the service well-led?

Requires improvement 

The service was not always well led

Staff spoke highly of the registered manager and the registered provider and the support they provided.

The service had a vision and wanted to provide a high quality care and had very proactively made changes between our visits to make improvements.

Environmental and quality audits had been undertaken. However, we found areas for improvement during our inspection around the deployment of staffing, recording, and dignity and privacy which more targeted auditing would have highlighted.

Inwood House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 May 2015 and was unannounced. We also visited the home on 03 June 2015 and this was announced. We had previously undertaken a late evening visit to the location on 5 May 2015 following information we had received about the service.

The inspection team consisted of three adult social care inspectors and a specialist adviser with expertise in dementia and behaviours that challenge others. The inspection team also included an expert-by-experience with an expertise in caring for an older person. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we had received from the provider such as notifications. The registered provided had not been asked to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We spoke with the local authority commissioning and monitoring team and reviewed all the safeguarding information regarding the service.

We spoke with 21 residents, six of their relatives, one volunteer and a visiting community nurse during the inspection process. We spoke with the registered provider, the registered manager, two senior care assistants, four care assistants and the cook.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed lunch in all four of the dining areas and observed care interventions throughout the inspection process. We reviewed seven care files and daily records and the maintenance and audit records for the home.

Requires improvement

Is the service safe?

Our findings

As part of our inspection we asked people who lived at Inwood House, their relatives and visitors whether they were safe. People who lived there told us they felt safe. One visitor we spoke with told us "I've never heard one negative comment from staff to residents, even when they don't know I can hear". All the staff we spoke with told us people who lived there were safe. One member of staff said "We have the key pads, I have never witnessed any harm to the residents and the residents can move around the building freely".

During our visit we looked at the systems that were in place for the receipt, storage and administration of medicines. We saw peoples medicines were stored in a locked room and could only be accessed by people who were authorised to do so. The temperature of the medicine refrigerator was monitored daily. The registered provider checked the operation and temperature of the fridge in line with registered providers calibration procedure. We did not see a record to show when the refrigerator was last defrosted. When we looked inside the refrigerator we saw there was a significant build-up of ice. On the second day of our comprehensive inspection the medicines fridge had been defrosted.

We saw a monitored dosage system (MDS) was used for the majority of medicines with others supplied in boxes or bottles. We checked two people's boxed medicines and found the stock tallied with the number of recorded administrations. The medication administration record (MAR) for one of the medicines we checked had been handwritten by a member of staff. There was no evidence to suggest the entry had been checked by a second member of staff to ensure the directions on the MAR were accurate. Having a second member of staff check and countersign hand written entries on MAR charts reduces the risk of an error in administration occurring.

We looked at two sets of eye drops which were prescribed. The pharmacy label on both boxes recorded the medicine should be destroyed 28 days after opening. The date of opening had not been annotated on either bottle, which meant there was a risk people may have been in receipt of medication which was no longer effective. A member of staff told us all the bottles of eye drops were automatically replaced every four weeks.

Two of the staff we spoke with told us they had received training regarding medicines management. We checked the training record for one of the two staff we spoke with and saw their most recent training was dated April 2009. The registered manager told us they assessed the competency of each staff member who were authorised to administer medicine. There was no record of the criteria used to assess staff competency and the registered manager had not updated their training in medicines management since 2009. This meant there was a risk people's medicines were being administered by staff who were no longer competent. By the second day of our comprehensive inspection, all staff who administered medication had been booked onto an external medication training course.

A regular audit of the system for the receipt, storage and administration of medicines was not in place although the registered manager undertook regular checks of all the stock administration records. We found the registered provider had breached Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with a visiting community nurse who told us the nursing services visited daily. They had no concerns about the safety of people who lived there and spoke positively about the staff. The registered manager and all the staff we spoke with had undertaken safeguarding training and could tell us what type of abuse might occur in a residential setting. They knew how to report any concerns and they felt confident their concerns would be acted upon. We asked staff what they understood about whistleblowing. One member of staff told us 'it's almost the same as safeguarding', they also said if they saw something which concerned them they would speak with 'manager, owner or the CQC'.

Staff were able to identify risks specific to the people who lived at the home. We saw a number of risk assessments in the care plans. For example, we saw a risk assessment for a person who was at risk of skin tears and one for a risk of falling. Although the assessment of risk was good, the risk reduction methods were very generalised. For example, as a response to the risk of falling, the outcomes would be, 'staff to assist confused or disorientated residents off stairs

Is the service safe?

wherever possible to lessen risks of accidents'. The measures were not person specific which would have guided staff to ensuring risks were reduced to the lowest level possible.

During our inspection we observed moving and handling procedures which were not in accordance with good practice. For example, we observed the method used to assist the people who lived there to stand from their wheelchair or chair using an underarm lift. We looked at the moving and handling risk assessments and care plans and although the risk assessment had been completed in detail, the plan contained information about the equipment to be used but not the method. For example, one care plan stated a handling belt was to be used but then did not go on to describe how this was to be used, the type of transfer or how to maximise independence of the person during the transfer. This meant that there was a risk that people could be handled inappropriately due to the lack of detail in the moving and handling plan.

We asked care staff whether they had enough staff to support the people who lived at Inwood House. They all told us there were enough staff. One member of staff told us "Yes, there is enough staff. We need to get more organised following the extension though."

The registered manager told us they did not use agency staff. If a member of staff rang in sick they would contact existing staff and offer them additional shifts. They had a list of bank staff and with existing staff, they could call on between 40 and 50 staff to cover the shifts. They told us sickness was always an issue but staff pulled together at these times to support the people who lived there.

Prior to our inspection CQC had been contacted anonymously concerning low staffing levels. As part of our inspection we looked at staffing levels and the staff rota which showed six staff were on duty from 8am each morning with two more on duty from 9am making a total of eight staff at this busy time. Six staff were on the rota on from 4pm to 10pm and four night staff were on duty from 10pm to 8am. As a result of the concern regarding staffing levels, the registered provider told us they had asked staff whether there were enough staff on days and nights and the staff told them there were enough staff.

We asked the people who lived there if there were enough staff. One person said "There aren't enough staff. They could do with more. The staff that are here couldn't be any nicer, but you can sit at the table for half an hour before lunch comes and you have to wait for someone to come through the lounge if you need to go to the loo. Sometimes it takes ages for someone to come and you're sat there crossing your legs".

On the first day of our comprehensive inspection on 29 May 2015, we found there were adequate numbers of staff on duty, but at times they were not in the right place to support the people who lived there and staff were always busy. Our observation was that although there were enough staff on duty, they were not deployed in the most efficient way and there were long periods where no staff were visible in the communal areas. We observed one person waiting for 15 minutes to be assisted. In another situation, we observed a relative pressing the care call system for assistance with a transfer and it took five minutes for staff to attend to the call. However, they needed a second person to assist with the transfer and a second person was not immediately available. Three staff were observed to be in the kitchen. The poor deployment of staff was brought to the attention of the registered manager and on the second day of inspection, 3 June 2015, changes had been made to improve the use of staff time to support the people who lived at the home. For example, lunchtime staff were designated to each dining room.

Following our initial visit the registered provider was in the process of employing two new kitchen assistants to free up staff time. They had also employed a laundry assistant for 15 hours a week and recently included two extra care staff on the rota at 7 am each morning. They were also planning to employ two further staff at weekends during the day to ensure there would always be cover if staff were absent from work.

We reviewed the recruitment records for three staff. They had all had checks undertaken with the Disclosure and Barring Service (DBS) before they started work at the home. The DBS has replaced the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups. The registered manager told us all new staff were on a three month contract before being given a permanent position to ensure they had the right skills and behaviours to support the people who lived at Inwood House.

As part of our inspection we reviewed the accident and incident records. The home had a system in place for

Requires improvement

Is the service safe?

recording and analysing any incidents. Staff told us they reported all incidents to the registered manager and recorded as per the home's protocol. On our first day of inspection we found that the home did not utilise body maps to mark any injuries received, but they had put paperwork in place to record this by our second day of inspection. They also utilised crash mats besides beds and a bed wedge system to prevent people who used the service from rolling out of bed.

We observed several wheelchairs at Inwood House had missing footplates. We raised this issue with the registered provider who told us they had already made a note of this and would be disposing of many of the wheelchairs accordingly. It is essential that wheelchairs are used with footrests to prevent harm to people who are using them for transport.

Requires improvement

Is the service effective?

Our findings

The registered manager told us the registered provider invested heavily in staff training to ensure staff had the skills to perform in their role. They told us they had outsourced training of the new Care Certificate for staff induction and this training was due to start in July 2015. We saw the content of the registered providers existing induction process and basic training for new starters and found this contained sections on process, policy and procedures and observed practice. Staff we spoke with told us they had received an induction when they started in their employment at Inwood House and we reviewed this in the training matrix. They told us they shadowed a shift for a week and also had a mentor. One relative we spoke with as part of our inspection told us they found the care staff to be well trained and capable.

We also noted that although training around new equipment such as a new hoist had been provided staff had not undertaken a moving and handling refresher course. However, the registered provider had been proactive between our first and second inspection dates and had booked a care assistant onto a train the trainer course to be able to deliver moving and handling training in-house. The identified member of staff was on the moving and handling course on our second inspection date. This would enable the home to review the paperwork, and staff practice to ensure the safety of the people who lived there.

Staff we spoke with told us they had supervision with the registered manager every three months and an annual appraisal. The registered manager also completed a supplementary supervision note for staff. We saw the latest one, which detailed the expectation of staff in terms of training, prompt cleaning of spills, meeting people's nutritional requirements, staff handover, privacy and dignity and choice. This showed the registered manager aimed to ensure all staff understood the values the home worked towards.

One member of staff we spoke with told us they had completed dementia awareness training recently but had not had training regarding managing behaviours that challenged the service. Training had also been planned for the day after our first inspection day on health and safety and 15 staff were to attend. The registered provider also had Deprivation of Liberty Safeguard training and end of life care training booked in August 2015 which demonstrated they were investing in developing staff at the home to gain the knowledge and skills to perform in their role.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act (MCA) 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. On the day of our inspection two people were subject to DoLS authorisation and eight further requests had been made to the local authority by the registered manager. It was clear the registered manager had a good understanding of what constituted a deprivation and how people who used the service needed to be safeguarded.

All the care files we looked at contained a section on capacity and how to support the person who could not make a decision for themselves . However, the assessment of a person's capacity did not follow the principles in the Mental Capacity Act 20015 which meant there was no recorded evidence that the home was protecting people's human rights.

People we spoke with told us the quality of the food was very good. We observed food was well presented and in good sized portions. Staff told us people who used the service were weighed monthly and if weight loss was observed people were seen by their GP who referred them to the dietician.

As part of our inspection we spoke with the chef who told us about the meals served at the home. They said people were offered a hot option for breakfast with no cut off time. People were offered drinks, with biscuits and fruit at mid-morning and early afternoon drink and supper at 7 pm. We observed the chef showing people a pictured menu book which enabled them to choose what they wanted to eat. The chef told us five people need blended diets and they set them on the plate nicely for people to look more appetising. They told us they fortified meals with cream and full fat milk.

We observed the lunchtime experience in the four dining areas in the home was uncoordinated and disorganised on the first day of our inspection. People were served shepherd's pie, and choice was not offered at the table.

Requires improvement

Is the service effective?

Lunch was brought to people nicely presented, individually in a covered plate from the kitchen. Gravy was offered individually to people. As two of the dining areas were on the other side of the building from the kitchen, this process was lengthy and some people waited up to an hour to be served. Staff were observed to be rushing about trying to serve people as quickly as they could. People were seated at the table with nothing to do, with no drinks available and with no staff around to attend to their needs if required. One person said "I've been ready for something to eat as soon as I came in".

Another person told us "I'm fed up waiting. I want to go to my son's". Other people at the table tried to persuade the person to stay and wait, but they continued to try to leave. They kept saying "I'm so hungry. I'm just so hungry." There were four people at this table and the other people were given their food but this person sat and watched them eat for 17 minutes before being given their meal, which they did not eat and then left the table.

We observed one person who had told us before they were seated, they were 'starving'. They proceeded to eat their own meal, and then eat the person's meal on the same table, and then attempted to take a third person's meal, which was dropped on the floor with the plate. Although there was a large bang when the plate hit the floor, no staff were in the vicinity to hear this, nor did they notice a plate was missing as they offered this person another meal when they were collecting the plates, as they thought they had not been offered one. The home's dog proceeded to eat the spilled food from the floor and the persons lap. We asked the carer who was clearing the plates, how they monitored what people ate. They told us they monitored this from the empty plates. We pointed out that one person had finished off the meals of three of the people at the table, so this would not have been an accurate measurement of the food consumed. We noted that one person whose care plan recorded they required a plate guard was not offered this, and food was spilled onto their lap and they were eating this from their lap. We also saw a person eating shepherds pie with their fingers, when finger food would have been a more appropriate option.

There were no jugs on the table in one of the dining areas, and people were offered a drink 45 minutes after they had been seated for their meal in two of the dining areas. They were offered a cup of tea, coffee or juice. One person asked "Can I have a biscuit?" with their tea. The carer responded "No, we don't have them at this time" Then said "I can bring one around for you". Yet, in the dining room near the kitchen, people had been offered a drink with their meal which demonstrated inconsistent practices between the dining areas

We asked another member of staff how they knew if everyone who lived there had a meal including those people eating in their rooms, we were told there was a list in the kitchen to tick when people have been given a meal. However, this list did not indicate whether the person had been offered a drink with their meal or that the meal had been eaten as we had observed on our first inspection day. Changes had been made by the second day of our inspection and staff had been deployed in the dining areas to assist the people who lived there.

The above examples demonstrate that the provider did not ensure that people were adequately protected from the risks of poor hydration and nutrition and illustrated that the provider was in breach Regulation 14 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw evidence in the care files we reviewed that people were appropriately referred to health care professionals, such as community nurses, GP's, opticians and the dentist.

The property had recently been extended with all areas fully accessible to people using wheelchairs. Attention had been paid to suitable seating and furnishings giving Inwood House a homely feeling. Signage and orientation to assist those people with memory problems could be improved particularly to people's rooms and communal facilities. The registered provider had recently installed a café area to the main foyer, which was decorated and furnished as a working café. We observed relatives and people who used the service utilising this facility. Residents who were able to utilise this facility independently could access this by using a fob.

Requires improvement

Is the service caring?

Our findings

One person who lived at Inwood House told us "They've been marvellous with me. What surprised me was I thought I'd have to fit in with their rules, but they ask me what I want and consult me about things. I feel reassured. I trust them." One person told us " The staff are out of this world." Another person told us "I am very happy here. I prefer to stay in my room."

We spoke with one visitor who said "The care is brilliant. Brilliant.". Another visitor told us "We feel very fortunate. We like the staff. The staff are extremely cheerful. It makes a big difference [relatives name] has put on weight and looks better than [they] have for years. We are confident they are safe and well cared for".

The registered manager described the staff at Inwood House as "a good, caring team". They told us "The staff laugh, joke and have banter with the residents." The registered provider told us they were planning a party for a person who lived there's 90th birthday. They would provide all the food and 20 people were attending.

The registered manager told us how people thrived when they came to Inwood House. They told us people often came from hospital and gained independence with encouragement. They told us one person recently went to live back in their own home from Inwood House. The registered manager told us "Staff speak to the residents on a daily basis about how they are feeling. Residents are very much involved". During our inspection we overheard a member of staff talking to a person who lived there. They were discussing what clothes to wear and the conversation was friendly and relaxed."

We looked at the bathing records of one person we case tracked. There was only one entry indicating the person had a bath between 16 April 2015 and 28 May 2015. There was no evidence in daily records that people were being offered the choice of a bath on a daily basis and whether this option had been declined. One relative we spoke with told us they had to ask the staff to give their relative a bath, which demonstrated that the opportunity to have a bath had to be requested rather than offered.

Staff we spoke with told us how they protected people's privacy and dignity. One member of staff told us personal care was always carried out in people's rooms. They said they respected people's confidentiality and did not talk about one resident in front of another. They always undertook personal care in private and closed the doors and curtains. We found a dignity curtain in one of the shared rooms to protect the privacy of the people who shared the room. However, in another twin room, we saw no privacy curtain and although we were assured it was there on further checking later in the day, it was still not in situ. This meant that the provision of care without a privacy curtain would not ensure a person's dignity or privacy was respected.

The staff we spoke with told us they had a handover for all staff at each changeover of staff. We observed the handover on the first day and staff were provided with information to enable them to support the people who lived at the home. We were concerned there was no designated private area for these discussions which occurred in the reception area or within the corridor areas. We were told by the registered manager as part of the on-going refurbishment there would be a staff area for these confidential discussions and they ensured no visitors were present during these discussions.

These examples concerning privacy and dignity demonstrated a breach of Regulation 10 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans were kept in the reception area and although were hidden under the desk were not locked away. The registered manager told us a separate area was planned as part of the on-going refurbishments but they would look at ensuring these were locked away to ensure information was kept confidentially.

We observed details for those requiring an advocate was displayed on a wall. We were told that no one at the present time was utilising the services of an advocate. An advocate is a person who is able to speak on people's behalf, when they may not be able to do so for themselves.

Requires improvement

Is the service responsive?

Our findings

We found the contemporaneous daily records did not indicate what care had been provided during the day and therefore we could not evidence choice had been offered to people. We also found the repositioning chart of a person who was cared for in bed did not contain a name, date or frequency of turns required although it had recorded two hourly turns had been completed. Some of the charts were missing from the bedroom. For example, 18, 21, 24, 26 and 27 May were all in the bedroom but the 19, 20, 22, 23 and 25 were missing. We asked the senior carer for copies of the missing charts, and were told these would be in the office, but we saw no further charts. For this same person, we found the fluid balance chart of 18 May was not totalled and at times the amount was not recorded.

This meant that there was no evidence to demonstrate people received the care at the time they needed the care or whether they had been offered choice about the care they received. This demonstrated a breach of Regulation 17 (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as we found accurate, contemporaneous records had not been kept.

The registered manager and the registered provider undertook a pre-admission assessments before anyone came to live at the home. They told us they also considered the needs of other people who lived there before considering any applications. Once a person came to live at Inwood House, a detailed care plan was compiled.

We asked how the registered manager determined people's needs were being met once they came to live at Inwood House. They told us they saw everyone who lived there on a daily basis. We found the care plans to be detailed and person centred and contained information to enable staff to care for people.

We asked the registered manager how staff ensured choice was offered to people who lived there. They told us "Choice is always discussed at supervision. It's the little things that make the difference. We saw information in peoples care files detailed people's choices and preferences. For example, in one record, it stated the persons preferred time for rising on a morning could vary from day to day, but usually they liked to get up between 8-9am. It also stated the person had no particular favoured time for going to bed, so staff would ask and assist when ready. The registered manager told us "We are always saying to the staff, they can have what they want when they want it. They can have tea in their rooms whenever they want it." Though we had also observed that at mealtimes peoples preferences were not always followed.

Staff we spoke with told us there was an activity programme. The activities on offer were as follows: 18 May Chair aerobics, 19 May bun decorating, 20 May music, 21 May singing. The registered manager told us they had taken seven people who lived there to the cinema recently to see 'Far from the Madding Crowd". Another person liked to go to the pub which the Registered Manager facilitated.

However, we observed very little meaningful occupation taking place during the first day of our inspection, particularly for those people living with dementia. On the second day of our inspection, entertainers came in for a sing along which people were observed to enjoy. We looked at the records of people who had undertaken activities which showed one person had undertaken chair aerobics 17 April, house activities 21 April and chair aerobics 24 April. Another person had been in the garden on 13 April and enjoyed listening to music on 23 April. This showed staff had not kept a contemporaneous record of the activities which people undertook.

We found most of the bedrooms were personalised and people were encouraged to bring in items from home. They were decorated to a high standard. However, we found one person's room was very sparse with no personal effects, no television and nothing for the person to occupy themselves with. The registered manager told us the family of the person had been happy with the room as it was but they would look at making this bedroom more suitable for this person.

We observed this person in their bedroom for 45 minutes after lunch walking back and forward between the furniture. We looked at the care plan for this person and found they had exhibited behaviours such as trying to climb out of the window. This person was disorientated to time and place. There was a "dementia and agitation" care plan in place which noted their signature behaviours with an action to observe at a distance. Diversion tactics of a cup of tea were to be used. We discussed our concerns with the registered manager, that leaving this person alone without any means of undertaking any activity was not in line with current practice guidance for supporting a

Requires improvement

Is the service responsive?

person with dementia and could be a cause of the behaviours they exhibited . By the second day of inspection, the registered manager had referred the person to the GP for a reassessment by a dementia specialist. This showed the registered manager had acted on the concerns that had been raised.

The registered manager told us all complaints were acted on. The registered manager and the registered provider dealt with all complaints and met with the complainants to respond to any concerns. We reviewed the complaints received and noted these had been dealt with appropriately and concerns acted upon. The home also kept a record of all compliments regarding the service. They took pride in the fact that relatives of people who had passed away still keep in touch with the service.

Requires improvement

Is the service well-led?

Our findings

We found that although many aspects of the service and the environment were of a good standard, there had been a lack of oversight from management to certain aspects of the day to day running of the home. Had more detailed audits and observations been undertaken, the issues we found relating to staff deployment, competencies and recording would have been highlighted. When issues were raised with the management team, we found they were proactive in resolving the issues quickly.

There was a registered manager in place at the time of our inspection who had been registered since 2001. They had worked at the home for 26 years. We asked staff about the management and leadership at the home. One staff member said the manager was "Supportive and approachable and never loses [their] cool" "100% brilliant manager" "That's one of the reasons that team morale is so good". Another staff member spoke highly of the registered provider stating "they have been brilliant".

One member of staff we spoke with told us there was a 'stable staff group' and Inwood House was a good home to work for. Another member of staff told us "Everything is fine here. I really like it here at Inwood. It's looking so nice now. It's a good home".

Another member of staff told us they had staff meetings 'every few months.' We saw the minutes of the night staff meeting of 5 May 2015 and the day staff meeting of 3 and 4 May 2015. These demonstrated to us that the management team were proactive in resolving issues that had been raised. They told us they had invested financially and emotionally into the home and they wanted to run the home as a five star hotel, with luxury facilities .

We asked the registered manager and registered provider how they kept up to date with best practice. The registered provider told us "We visit the care shows. We went every year to look at the best call systems, hoists, and flooring. Staff told us they wanted a steam cleaner to clean commodes so we purchased one. We reinvest in the building. We took advice from infection control before we undertook the renovations to ensure we had the best systems. They gave us advice about out laundry". "We know we provide good care when professionals, district nurses, family members, GP's and infection control give good feedback." They told us they also attended the local authority contracts meeting with other providers to ensure they kept up to date with contractual requirements.

They registered provider shared their vision for the service. They told us they "Wanted to be the best. We say what we do and do what we say". They said 90 % of staff shared their vision. They described the culture of the home as very open. They shared social occasions with staff but also had high expectations from staff in return. They told us "We treat the staff how we want to be treated and expect the care they provide to be how they or how their mum wanted to be treated. We pay a living wage to our staff. We look after the staff."

The registered manager had told us they had brought in extra staff at 7 am in the morning after they analysed what time people preferred to get up from choice. They told us they were on site most days to support the registered manager. They told us they had an external monitor of the quality of their service to meet the ISO9001-2008 standards. They had to complete 19 quality procedures and were externally audited once a year. We asked specifically about falls analysis and themes around incidents. We found these were being analysed every month, including an analysis of the time of the fall. However, information was found to be missing as to what the person was trying to do when they fell which would inform their falls prevention strategies. The registered provider acted on this immediately and added it to their incident form.

We found all the environmental and maintenance audits to be up to date. The home employed a maintenance man two days a week and there was a maintenance schedule for each room. Mattress audits were undertaken by the cleaning staff or the registered manager in line with infection control advice.

We saw the client satisfaction survey which was completed annually and had been completed in April 2015. 58 questionnaires had been sent out and 34 received back. We saw comments including "The home is bright, spacious and has good facilities and caring staff. Once the refurbishment of all rooms are completed. It will be a superb facility." And "Everything works well with good staff and very good senior staff in first class surroundings". "We are pleased with Inwood and the staff. The café is terrific and [my relative] enjoys her visits there and "improvements in the return of laundry to the correct people".

Requires improvement

Is the service well-led?

We saw an action plan following a quality audit. The registered provider told us "We have always scored low on feedback about laundry. If a person loses an item or it is ruined, we will give the person a refund if necessary" The home scored 66% on its laundry measure at April 2015. As a result of this, the home had initiated a programme of naming clothes with "Attach tags" a professional solution for clothing labelling provided free of charge to the people who lived there and they had employed a dedicated laundry person for at least 3 hours each day.

We were shown a 'You Said, We Did' board which had been purchased and awaiting installation to show people what the provider had done as a result of feedback received.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Accurate, contemporaneous records had not been kept.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems for the proper and safe management of medicines were not in place.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Nutritional and hydration needs were not always met.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **There was a lack of meaningful activities during the day for all the people who used the service.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.