Care Quality Commission

Salisbury Christian Care Homes (Inwood House) Limited

Inwood House

Inspection report

10 Bellamy Lane
Salisbury
Wiltshire
SP1 2SP

Tel: 01722331980

Date of inspection visit:
04 October 2019

Date of publication:
14 November 2019

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 to 18 people aged 65 and over at the time of the inspection. The service can support up to 20 people in one adapted building.

People's experience of using this service and what we found
Systems to manage medicines were not safe. People did not always receive support to take the medicines they were prescribed and medicines were not stored or recorded correctly.

The registered manager had not always notified us of important incidents in the home, as they are required to.

The systems for checking how the service was operating did not always identify shortfalls. Checks had been completed but did not identify medicines issues or that notifications had not been submitted.

Risks to people's well-being and safety were assessed and recorded. Staff were aware of these risks and the support people needed.

The registered manager provided good support for staff.

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

Rating at last inspection
The last rating for this service was good (published 1 May 2019)

Why we inspected
The inspection was prompted in part by notification of a specific incident, following which a person using the service sustained an injury as a result of a fall. A decision was made for us to inspect and examine those risks. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only. We found that risks relating to falls had been well managed.

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.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We have identified breaches of the regulations in relation to safe care and treatment and good governance at this inspection

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.

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 well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

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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.

Inspection team
This inspection was completed by two inspectors.

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

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. 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 members of staff, including the registered manager and care workers. We reviewed a range of records, including four people's care records and multiple medication records. We looked at a range of records relating to the management of the service.

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 good. At this inspection this key question has now deteriorated to requires improvement. 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 the last inspection in March 2019 we made a recommendation to improve the management of medicines. This was related to the temperature that medicines were stored at and guidance for medicines to be taken 'when needed'. At this inspection we found that this recommendation had not been followed and medicines management had deteriorated. The provider was not following the National Institute for Health and Care Excellence (NICE) guidelines for managing medicines in care homes.

● The medicine administration records for the two weeks prior to the inspection contained 33 gaps. This was where staff had not signed to say they had administered people's prescribed medicine. There were 15 occasions when there was no record whether people received their tablets or pain relief gel; and 18 occasions where staff had not recorded whether they had administered a person's prescribed emollient cream. It was not possible to say from the records and stock held whether people had received their prescribed medicine. NICE guidelines state staff must record medicines administration, including the date and time, on the medicines' administration record, as soon as possible.

● Six people who had medicines prescribed to be taken 'when needed' did not have protocols in place setting out how staff should make the decision to offer this medicine. This included a person who was prescribed medicine to help when they were distressed. The person had not received this medicine, despite several periods of distress that were recorded in their daily notes. The lack of clear guidance increased the risk that people would not receive their medicine when they needed it or would receive their medicine when it was not needed.

● The temperature of the medicine room had not been checked for the nine days before the inspection. If medicines are not stored at the correct temperature it can make them less effective for people. Not checking the temperature increased the risk that people would receive ineffective medicines.

● Staff had not recorded the date they opened three bottles of liquid medicine. Opening bottles of liquid medicine can change the expiry date. If the date is not recorded, staff would not know when the medicine had reached it's expiry date and needed to be destroyed.

● Staff had hand written medicine administration records for four people, transcribing information from the dispensing label. Staff had not signed these handwritten records or got another member of staff to make sure they had not made any errors. NICE guidelines state handwritten medicines administration records should only be completed in exceptional circumstances. When handwritten records are completed they should be checked for accuracy and signed by a second trained staff member. Failure to follow this guidance increased the risk that errors would be made when copying the information and people would receive the wrong dose of their medicine.

The failure to follow safe medicines management practice was a 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; Learning lessons when things go wrong
● Risk assessments were in place to support people to be as independent as possible. They balanced protecting people with supporting them to maintain their independence. Examples included support for people to manage their risk of falls, security of the building, to maintain suitable nutrition and risk of pressure ulcers.
● Staff demonstrated a good understanding of these plans and the actions they needed to take to keep people safe.
● Systems were in place for staff to report accidents and incidents. Staff were aware of these and their responsibilities to report events.
● The registered manager reviewed these reports and recorded any actions that were necessary following them. The registered manager had taken action in response to the specific incident that triggered this inspection. Changes had been made to the safety of steps in the garden and fire doors had been fitted with alarms. This ensured lessons were learnt following incidents and reduced the risk of an incident re-occurring.

Systems and processes to safeguard people from the risk of abuse
● The service had effective safeguarding systems in place. Staff had a good understanding of what to do to make sure people were protected from harm. Staff were confident the registered manager and provider would take action if they raised any concerns.
● The management team had worked with the local safeguarding team when concerns had been raised.
● Staff told us they received regular safeguarding training and records confirmed this.

Staffing and recruitment
● At the last inspection in March 2019 we assessed staff recruitment was safe, with effective systems for checking new staff. No staff had been recruited since the last inspection.
● There were enough staff available to meet people's needs. Staff responded promptly to requests for assistance.

Preventing and controlling infection
● All areas of the home were clean and smelt fresh. Prompt action was taken to resolve any unpleasant smells in the home.
● Staff had received training in infection control procedures. There was a supply of protective equipment in the home, such as gloves and aprons.

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 inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. 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
● The provider had not ensured recommendations made in the last inspection report had been actioned. Quality assurance systems were not consistently used to identify improvements that were needed.
● At the last inspection in March 2019 we recommended improvements to the management of medicines. A medicines audit was carried out in June 2019 but did not include any assessment of the issues identified in the last inspection. At this inspection we found the shortfalls in relation to storage of medicines and guidance for staff on 'when needed' medicines had not been addressed. In addition, other aspects of medicines management had deteriorated and were no longer safe but had not been picked up by the medicines audits. The systems to act on recommendations and ensure improvements were made were not effective and did not ensure people received a good service.
● The system to assess actions needed following incidents in the home did not identify when the provider needed to notify the Care Quality Commission. We identified two incidents between people in which a person had been hit. The registered manager had taken the right action to keep people safe, report the incident to the local safeguarding team and change people's care plans and risk assessments. However, the incidents had not been notified to us. The registered manager was not aware of their responsibility to report these incidents to us. The registered manager had reported other types of events as required.

The failure of the provider to always operate effective systems to assess, monitor and improve the quality and safety of the service was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The system of audits and checks had identified other shortfalls and action had been taken where needed. Examples included identifying staff were not always keeping accurate records of the food and fluid people had taken and staff use of language that did not maintain people's dignity.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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
● Staff praised the management and told us the service was well run. They said they felt well supported to provide person-centred care for people.
● The registered manager demonstrated a commitment to provide an individual service to people that

maintained their rights.

● The registered manager had a good understanding of their responsibilities under the duty of candour. Records demonstrated they had provided clear information to people when errors had been made and apologised.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● The service involved people, their families, friends and others effectively in a meaningful way. The registered manager responded to issues raised in quality surveys and let people know what action they had taken.

● The registered manager worked well with the local health and social care professionals. They had established good links and working relationships.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured systems to manage people's medicines were safe. Regulation 12 (2) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured the systems to assess, monitor and improve the quality and safety of the service were effective. Regulation 17 (2) (a).