Akari Care Limited

Wordsworth House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection of Wordsworth House commenced on 23 August 2017 and was unannounced. A second day of inspection took place on 25 August 2017 which was announced.

Before the inspection we received notifications of incidents following which two service users sustained a serious injury. These incidents are subject to a criminal investigation and as a result this inspection did not examine the circumstances of the incident.

However, the information shared with CQC about the incidents indicated potential concerns about the management of risk of falls from beds and scalding. This inspection examined those risks.

We last inspected Wordsworth House on 29 February 2016 and found it was meeting all legal requirements we inspected against. We rated Wordsworth House outstanding in the caring domain and good in all other domains.

Wordsworth House is a 78 bed care home that provides personal and nursing care to older people, some of whom were living with a dementia. Accommodation is provided over three floors.

At the time of the inspection there were 63 people using the service.

The service did not have a registered manager. The management of Wordsworth House was being overseen by the quality and compliance manager who had been based at the home two days prior to the inspection. The previously registered manager had left their post in May 2017 but had not cancelled their registration until August 2017. Since May 2017 there had been a further two managers overseeing the home, one of whom was a regional manager.

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 legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found the registered provider had breached regulations in relation to safe care and treatment, staffing, good governance, safeguarding people from abuse and improper treatment and receiving and acting on complaints.

Not all the people living at Wordsworth House had a personal emergency evacuation plan to support their evacuation in the event of an emergency. A fire risk assessment was not evident at the time of the inspection and was scheduled to take place the week after the inspection. We received confirmation that this had been completed.

A nurse call bell sounder was not working. This had been reported on 4 August 2017 but staff said it had been out of action for two to three months with no risk assessment in place to manage the situation to ensure people received care and support in a timely manner.

Monthly profile bed checks had been completed from June 2017 onwards however the checks had failed to identify that several mattresses did not meet the providers own safety requirements. Not all the people who used bed rails had a bed rails risk assessment completed and there were gaps in the recording of mental capacity assessments, best interest decisions and care plans in relation to the use of bed rails.

The quality and compliance manager could not assure us that appropriate Deprivation of Liberty Safeguards (DoLS) had been considered for people who lacked capacity. This meant people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible; the policies and systems in the service did support this practice.

Individual risk assessments contained contradictory information, and lacked the appropriate level of detail and strategies to ensure risks were minimised. For some risks, risk assessments had not been completed or were over two years old. Care documentation also lacked detail, had not always been updated in response to changing needs and reviews were often meaningless.

There were concerns with some people's fluid intake and no action had been taken to minimise the risk of dehydration.

Everyone we spoke with raised concerns about staffing levels and observations supported this. On four occasions inspectors intervened and physically sought staff out in response to hearing nurse call bells going unanswered and hearing people shouting for help.

Medicines were administered safely, however there were some concerns about appropriate storage and recording. We have made a recommendation about medicines.

The provider had not ensured staff had access to the appropriate training, support, supervision and appraisal they needed to ensure people's needs were appropriately met.

Safeguarding concerns, accidents, incidents and complaints were logged but there was no evidence of internal investigations or analysis to identify patterns or improvements that were needed.

The provider had failed to ensure an effective system of governance and quality assurance was in place to identify concerns and action to be taken to make required improvements. Everyone we spoke with told us Wordsworth House lacked leadership, management and direction.

We found permanent care and nursing staff treated people with dignity and respect. People were complimentary of the care they received however, the provider was not ensuring appropriate systems were in place to support and develop a culture that was caring and compassionate.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.
Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Inspectors found a nurse call sounder was not working and no risk assessment was in place to manage the risk of staff not hearing people using the nurse call system. Personal emergency evacuation plans had not been completed for some people. A fire risk assessment was not available at the time of the inspection.

Some people using bed rails did not have a risk assessment in place and it was found that some mattresses did not meet the providers own safety measurements.

Everyone we spoke with raised concerns about staffing levels, which were supported by the observations of the inspection team.

Recruitment practices were appropriate.

Medicines were administered appropriately. We have made a recommendation about medicines storage.

Is the service effective?

Inadequate

The service was not effective.

There was a failure to follow the principles of the Mental Capacity Act. We could not be sure people were not being deprived of their liberty without the necessary safeguards and authorisations in place.

Staff had not attended the relevant training to support them to fulfil their roles, nor had they received regular supervision or annual appraisal.

There were concerns around poor fluid intake and a lack of action to reduce the risk of dehydration.

There was evidence that people had access to health care professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives were complimentary about the care and compassion of the permanent staff.

We observed warm and engaging relationships between staff and the people they supported.

The concerns noted in relation to the provider meant we could not be confident of the caring nature of the provider.

Is the service responsive?

Inadequate

The service was not responsive.

Care documentation did not provide staff with sufficient detail to provide safe care and treatment.

Complaints were logged but there was no evidence of investigations and outcomes.

A range of activities were offered.

Is the service well-led?

Inadequate

The service was not well-led.

There was no registered manager in post, and there had been no consistent management presence since May 2017.

The provider had failed to ensure audits were completed on a regular to identify actions required and areas for improvement.

The inspection team identified multiple concerns which had not been identified by the provider.

Everyone we spoke with told us there was a lack of leadership, management and direction.

Wordsworth 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 23 August 2017 and was unannounced. This meant the provider did not know we would be visiting. On 25 August 2017 a second day of inspection took place.

The inspection team was made up on one adult social care inspector, one bank inspector, a specialist nurse advisor, a specialist pharmacy advisor and an expert by experience. 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 the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We also contacted the local authority commissioning team, CCG and the safeguarding adult's team.

We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with eight people living at the service and four relatives. We also spoke with the quality and compliance manager, a regional manager, three senior care staff, eight care staff, four nurses, the handyman, an activities coordinator and one chef. The providers chief operating officer also supported the second day of the inspection.

We reviewed eight people's care records and 10 staff files including recruitment, supervision and training information. We reviewed medicines records, as well as records relating to the management of the service.

We looked around the building and spent time in the communal areas. 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.

Inadequate

Is the service safe?

Our findings

During the inspection we reviewed premises safety. Six people did not have personal emergency evacuation plans in place [PEEPs]. PEEPs contain information about how to evacuate people safely in the event of an emergency. The quality and compliance manager said, "Those are for people who have moved in since July. I will get them done." One person told us, "I'm just not sure what we would do in the event of a fire. I am on the first floor and I'm in a wheelchair. If the fire alarm goes and it's a real fire, we can't use the lifts. How do I get downstairs?"

There was no evidence of a fire risk assessment being in place at the time of the inspection but the provider confirmed this was due to be completed the week after the inspection. Following our site visits they have confirmed this has been completed and will share the document with the commission once received.

Inspectors noted nurse call bells were sounding for an extended period of time, for example 30 minutes on one occasion, with no staff responding to the alarm. On investigation, inspectors found the sounder was not working on part of the first floor. Care staff said, "It's been off for about two or three months." Inspectors raised this with the quality and compliance manager and the regional manager who attended the first floor and confirmed that one sounder was not alerting staff to people requesting support. The maintenance records were checked and the nurse call system had been raised with contractors on 4 August 2017 as needing repair. A risk assessment had not been completed and no plans had been put in place to manage the risk. This meant people may have been pressing their nurse call to request support and the call going unanswered for an unknown period of time. The provider completed a risk assessment on 24 August 2017 which stated, 'Staff are required to increase observations on this corridor and ensure that if staff are supporting resident's in their rooms on this corridor, then there is always another member of staff in an area where the nurse call point can be heard.' On 25 August 2017 inspectors asked staff if they were aware of the risk assessment and they said they were not. Inspectors did not observe any increase in staff presence on this corridor. This was raised with the quality and compliance manager who said, "I will reinforce it to all nurses as I said they were to raise it during handover." Inspectors had observed the morning handover and this was not shared.

The main lift had broken on 22 August 2017. Staff told us, "When the lift broke we couldn't find the on-call, there was no number for the handyman and no key for the lift. There is an alarm button in the lift but it only sounds once." Staff explained that they knew the lift had stopped and people were trapped inside as they heard shouting and called the fire brigade. The staff member said, "We have no one to go to, we don't know who to go to, we had [previous regional manager] but don't know what's happened to them."

Profile bed visual checks had been recorded as completed in June, July and August 2017 with no concerns noted. Profile beds, have integral bed rails and can be adjusted to reposition and support people according to their positional needs. There was no evidence that these checks had been completed previously. The MHRA Safe Use of Bedrails 2013 states the 'Standards for adjustable and hospital beds require that the top surface of the bed rails is at least 220 mm from the top of the
uncompressed mattress'. The handyman said, "I just did the course last week, measurements were

discussed and I'm waiting for the guide. I got a list of residents who didn't need bed rails and took them off." They added, "I will check the measurements but I'm waiting for the plastic guide." Due to concerns in relation to the management of bed safety, inspectors asked the quality and compliance manager to offer assurances. This involved the completion of a bed audit. This audit identified that eight mattresses did not meet the required measurements for bed safety. This meant, the provider had failed to identify concerns and people had been placed at risk of harm due to mattresses not meeting the required measurements for safety. It was also found that 14 people who were using bed rails did not have an individual bedrail risk assessment. A general risk assessment for the use of bed rails was in place and dated 6 November 2014 with no evidence of review.

Some specific risk assessments relating to individual needs had been completed such as for moving and handling, mobility, falls and continence. Recognised tools were used such as the Waterlow pressure ulcer risk assessment and the Malnutrition Universal Screening Tool (MUST) which helped identify the level of risk. We found some risk assessments contained contradictory information, for example, one person had two documents in relation to falls, one assessed the person as being at high risk, the other at low risk. A general risk assessment noted the person was at risk of falling from a wheelchair so the risk was to be reduced by the use of a lap belt, however it then stated, 'lap belt not left on when unattended' with no assessment as to how this mitigated the risk of falls.

We also saw a care plan for one person which stated the person did not require the use of a wheelchair lap belt, however, there was no risk assessment in place which identified why this was the case. This person was also diagnosed with diabetes, which was managed via insulin use however there was no risk assessment evident.

We reviewed records for two people who had a diagnosis of epilepsy and found there was no assessment in relation to the risks associated with bathing and epilepsy.

We found some specific risk assessments for one person had been completed in May 2015, with monthly reviews completed until December 2016 which stated, 'no concerns' or, 'no issues.' This meant we could not be sure the risk assessments were current and reflective of the person's needs and therefore could not be sure risks had been mitigated.

These concerns are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found safeguarding alert forms had been completed in response to concerns. There was no documentary evidence of internal investigation reports. Concerns included a scald, and two concerns in relation to bed safety. The quality and compliance manager said, "We would have expected to see an investigation and an outcome listed." Accidents and incidents were recorded however there was no evidence of analysis to identify trends or patterns. We noted there had been several falls from wheelchairs and without any analysis or investigation we could not be sure appropriate action had been taken to safeguard people from harm.

These concerns are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone we spoke with about staffing raised concerns that there were not enough staff. One senior care worker told us, "There's recently been lots of agency staff, nursing especially, there just isn't enough staff. It impacts as we need to double up with them consistently as they don't know people, it's hard to delegate."

They added, "We do have some regular agency who are good which helps." Another senior care worker said, "Everything is up in the air with staffing. When [staff member] is off on the ground floor there's no senior. Next weekend there's only one senior as we are covering a shift otherwise there wouldn't be any senior. There's not enough seniors but there's always a nurse on shift." They also told us, "We try to feed a couple of people at a time. On the top floor they [the provider] try to say we only need one staff but there are four or five people who need help with feeding, some people need two to one for hoists." A nurse told us, "If there's enough staff it runs okay, but there's not enough staff." A night care worker said, "Sometimes there's not enough staff, we need to do observations and changes, end of life care, people have ill health and time is needed. We do hourly checks of people and if we are on our own we can't do it." A care worker on the third floor said, "There's not always enough staff, overnight there's normally one carer and one senior but they will take the carer off if we are short and leave the senior. There are three people who need two to one support so they have to wait." They explained they could ring the other floors for additional staff support but the nurse call bell didn't sound in the other floors so staff couldn't be alerted that way. The landline phone was corded so staff could not carry this with them to call for support. As a consequence staff told us they were using their personal mobiles to contact other staff, and to contact the emergency services if urgent medical support was needed.

One staff member said, "Last Tuesday I had to work the ground floor on my own. I phoned [senior manager] and explained it couldn't happen so two staff worked the ground floor and left one staff on the top floor. There was just one agency nurse on the middle floor so the day nurse stayed back to do the ground floor medicines."

People living at Wordsworth House also raised concerns. One person said, "Staffing can vary. In an ideal situation we could do with more staff here." Another person told us, "Sometimes I have to wait ages to get off the toilet. Staff take me to the toilet, but if they are busy, they can't wait outside for me to finish and take me back to my chair. I have to wait ages." A third person said, "I often have to wait for a long time for assistance." A relative said, "Often if there are staff shortages there are cover staff on and this isn't ideal. They don't always know what they are doing or where to find things." Another relative said, "There's not enough staff, they work like Trojans but there's lots of people who need help. They need better staffing and more qualified staff."

Our observations were that there were periods of time where staff were not present, for example over lunch time all staff were in the dining room, or supporting people in their rooms which left six people on the first floor with no one available for support. During this time inspectors heard people shouting for help and had to go and look for staff to support people. During the afternoon, it was also noted that there were periods of time when staff where not present and again inspectors had to intervene and look for staff to support people.

These concerns are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed staffing levels and were told a recruitment drive was ongoing and four new care staff had been employed. A senior carer had requested a transfer to Wordsworth House and that was being completed. We asked about nursing staff and were told, "A previous manager authorised two or three nurses to have extended holiday at the same time, it needed better planning." Assurances were offered that there were no current nurse vacancies at Wordsworth House.

Appropriate recruitment procedures were in place. This ensured only suitable staff, were employed to work at the home. Before staff commenced in post two written references were sought and a satisfactory

Disclosure and Barring Service check (DBS) was completed. DBS checks are used to complete a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

Permanent staff had completed a Disclosure and Barring Service check (DBS) check prior to employment but these had not been renewed. Best practice is that DBS checks be renewed on a three yearly basis.

The Nursing Midwifery Council (NMC) registers all nurses and midwives to make sure they are properly qualified and competent to work in the UK. Nurse registration numbers were checked for both permanent nursing staff and agency nurses.

Each floor within Wordsworth House had designated medicine storage with the main treatment room located on the ground floor. Medicines were safely stored and lockable, designated drug fridges were available. There were thermometers however the temperatures of treatment rooms and fridges were either not recorded or were not recorded accurately. This meant we could not be sure medicines were being stored at the appropriate temperatures to ensure effectiveness.

An electronic medicines administration and ordering system was in operation. Paper based supplementary charts were available for people who had been prescribed warfarin or pain relief patches. There were gaps on the supplementary administration records, however the electronic records were fully completed. Staff should ensure that both paper and electronic administration records are complete for medicines which require supplementary charts.

We recommend the provider explore appropriate guidance in relation to medicine management.

Some prescription medicines are controlled under the Misuse of Drugs Act because they are liable to misuse. Controlled drug cabinets were available on each floor however all controlled drugs were stored in the ground floor treatment room. They were stored appropriately but not easily accessible with people's other medicines. A controlled drug register was appropriately completed. Medicine expiry dates were checked on a weekly basis and short dated medicines were clearly marked on the first day of opening to ensure they were not used past their expiry date.

People's photographs were available electronically with the electronic MAR chart to support identification and reduce the risk of people receiving the wrong medicines. Medicines were prepared immediately ahead of administration, set to amber on the electronic record then only confirmed once the person had actually taken the dose. One person said, "I get my medication on time. I have [specific diagnosis] and it must be given at the right time otherwise I am in great pain. Staff do this properly for me."

The process for administering covert medicines, this is medicines that are hidden within food and drink, showed a formal process had been followed including consultation with the person's doctor and pharmacist, and that covert administration had been agreed in the person's best interests.

All the people and visitors we spoke with said they felt safe but shared concerns in relation to staffing. One person said, "Yes, I feel safe." A visitor said, "[Person's] bed has an alarm pad at the edge of the bed on the floor. This is to alert staff when she tries to get up herself." The person then responded, "It doesn't always go off." Another person said, "Yes I feel safe here." They added, "The staff help me by hoisting me in and out of bed and my wheelchair. They are very careful with me."

Inadequate

Is the service effective?

Our findings

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. The application procedures for this in care homes are 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 were being met. Staff were aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards. We were shown a file which contained authorised DoLS and a list of the names of people who had applications awaiting decisions regarding their DoLS. The Commission had been notified of the outcome of 19 DoLS applications; however, the quality and compliance manager was unsure if the record was accurate as it had been completed by the previous manager. They told us, "I know there are a lot of people who still need to be assessed."

In addition there were concerns due to a lack of documented mental capacity assessments and best interest decisions in relation to the use of restrictive devices such as bed rails. There was a failure to follow the provider's own policy on the safe use of bedrails which stated the following documentation should be completed: bed rail risk assessment, mental capacity assessment and best interest decision if the person lacks capacity, and a care plan.

The MCA states a person's capacity must be assessed specifically in relation to their capacity to make a particular decision. There were limited non decision specific capacity assessments and best interest decisions. Records of best interest decisions showed inconsistent involvement from people's family and staff. This meant people's rights to make particular decisions may not have been upheld and their freedom to make decisions may not have been maximised, as unnecessary restrictions may have been placed upon them.

One person said, "I have no complaints at all apart from the lack of freedom I have. I can't go out on my own." A relative said, "Night staff are often in a rush to get residents up in the morning. Staff don't always talk to [family member] about what they are doing for her when they do it."

These concerns are a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spent time observing lunch on the first day of the inspection and there were varied observations. We were informed that the lift used to transport food to the dining area was out of order. This meant containers

of hot food were carried from the kitchen on the ground floor to the second floor where 11 people were being supported. People having pasta bake on the second floor had their meals plated in the kitchen which meant the temperature of the meal could not be maintained. We heard two people complaining that their food was "Not very warm." We spoke with the staff about this and they warmed food up for people.

The food did not look very appetising. Relatives also commented that the food was not particularly appetising. We spoke with the chef about the food and they said they were trying to gain people's view of the food and put new items on the menu which had been suggested by people such as quiche and salads.

Care staff were supporting people with their meals in an appropriate way, however one staff member said, "It's really difficult. There are so many residents who need assistance to eat; we haven't got enough time to do it." We observed one person was being supported to eat their breakfast at 1130 and lunch was being served about an hour later.

People on the second floor were served cold drinks followed immediately by a choice of hot drinks before the lunch had been served. We did not observe people on the ground floor being offered any drinks during lunch.

We spoke with staff about the monitoring of people's food and fluid intake and were told monitoring charts were completed. Some people's care records contained detail on the amount of fluid people should be aiming for each day, for example between 1500 and 2000ml for one person. Their fluid charts showed an intake of between 100ml and 900ml per day. For another person their intake was recorded as 3mls, 4mls and 6mls rising to a maximum of 650ml. We saw no evidence of any action having been taken in order to allay concerns with regards to the potential for dehydration. These concerns were raised with the local authority safeguarding team as well as the provider.

These concerns are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

On the first floor the food was presented well and hot and cold drinks were available. If people needed a specialist diet, such as pureed food, each part of the meal was pureed separately and placed on the plate in distinct portions to make it look more appetising for people.

The dining areas had no menus displayed and the people we spoke with could not tell us what they had chosen for their main meal. One staff member said, "The chef is changing the menu around so it's pork casserole today but it's not on the menu."

We spoke with staff about the support they received either formally in supervision or informally through staff meetings and hand overs. Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns or training requirements. Staff we spoke with told us that they could not remember the last time they had received supervision and they did not feel supported. They said they did not know who they could talk to for support. Most staff said the constant changes to the management of the home meant they received mixed messages about what was expected of them. Staff told us they felt undervalued and over worked especially when colleagues they were working with (agency staff) did not understand the needs of people who used the service.

Supervision records confirmed supervisions and yearly appraisals had not taken place. The quality and compliance manager told us they were aware that this was an area that required attention.

We spoke with staff about the training they had received. They said it was sometimes difficult to attend training as it meant there was no staff available to cover care duties. They said they felt they had the skills and competencies to meet the needs of people who used the service but they needed refresher training in most subjects. We saw a training matrix which included restrictive practice, challenging behaviour, end of life care and moving and handling of people including bed rails. This showed that not all staff had attended recent moving and handling training including bed rails, as identified from an action relating to a safeguarding concern. Not all staff had attended training in challenging behaviour or end of life care. During the inspection we requested the full training matrix but the training plan was provided to us. This covered training which the provider had deemed mandatory including food safety, safeguarding, medicine management, infection control, care planning, dementia care and challenging behaviour. The chief operating officer told us the plan was to redo everyone's training. We could not be sure that nursing and care staff had been appropriately trained to meet people's needs.

Nurse profiles for agency staff were in place; however not all agency nurses had completed a competency assessment in relation to catheter care or percutaneous gastronomy tube (peg feeding) so we could not be sure they could appropriately meet the needs of the people residing at Wordsworth House. PEG is a procedure to place a tube through the skin and into the stomach to administer nutrition, medicines and fluids. One person said, "I have to have a bladder wash twice per week to keep my catheter safe. Staff don't know how to do it. They don't even know how to change the catheter and I have had to go to hospital." We asked the quality and compliance manager about inductions and competencies for agency nurses and care staff and they shook their head. We confirmed these had not been completed.

These concerns are a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the quality and compliance manager about the induction of new staff into the service. We were shown copies of inductions that were completed for care staff and for nurses. She was aware of the 'Care Certificate' but was unable to confirm if any staff had completed the award. The 'Care Certificate' looks to improve the consistency and portability of the fundamental skills, knowledge, values and behaviours of staff, and to help raise the status and profile of staff working in care settings.

One relative said, "Since staff were trained by the nurse from the GP surgery, staff can deal with [specific diagnosis] well."

All the people we spoke with said they had excellent access to healthcare. A local GP practice completed a weekly visit to ensure people were well looked after. People also made reference to a visiting dentist, podiatrist and optician. One person told us, "GPs come in regularly, so do dentists and an optician. They'll pull a tooth out for me in my room if I want to."

People's care records showed details of appointments with and visits by health and social care professionals. Staff had worked with various agencies and made sure people accessed other services, for example GPs, social workers, specialist nurses and dentists. In most cases care plans reflected the advice and guidance provided by external health and social care professionals. For one person there was involvement from the behavioural team, however there was no documentation to detail information on advice or strategies offered to support the person when they were distressed or when staff were finding their behaviour challenging. For other people documentation in relation to wound care and involvement from the district nurse was difficult to find.

Requires Improvement

Is the service caring?

Our findings

Due to the concerns raised by everyone we spoke with, including people, relatives and staff we could not be assured of the caring nature of the provider in ensuring people received a high quality compassionate service. There was limited involvement of people and their relatives in developing care plans and ensuring staff had the appropriate information to ensure people's preferences were met.

All the people we spoke with appreciated the efforts staff put into their care and commented on how hard they all worked. One person said, "Staff are friendly and caring. They are well organised and I don't think they could do any better than they do." Another person said, "Everyone is very considerate. I'm well fed, looked after and safe."

We observed there was a good rapport between staff and people. Care staff spoke with people in a kind, compassionate and caring manner. One person said "Staff are very friendly and caring. At times they are too busy though. It's a shame." They added, "Staff are lovely but just don't have enough time." Another person said, "Staff do seem to have the time to care for me. They all work hard as a team."

One relative said, "All staff are very caring and compassionate but too sparsely spread. There's often only one nurse and a care worker on duty overnight. Sometimes there are relief staff too. There's no management and we need properly trained permanent nurses on duty all the time. We need consistency. Lots of residents are highly dependent and require two to one care. There should be some system where volunteers come in and help out at mealtimes."

One permanent nurse said, "The staff are very caring, they just get on with it, they are very observant and caring, it's a pleasant atmosphere. They have been here through thick and thin and are dedicated."

We spoke with people about whether they were treated with dignity and respect and whether they were encouraged and supported to maintain their independence. One person said, "Yes, I'm treated with dignity and my privacy is observed. If I need personal care, it is done well and in private." He added, "I always understand what's being done for me. Staff always tell me first."

Another person said, "I am encouraged to be independent. I can go around in my motorised wheelchair and I can go to the bathroom myself. I am allowed to go in the lift to the ground floor from the first floor if I like. I enjoy going downstairs to read the papers in the reception area." Another person said, "Staff want me to be independent, even though I cannot walk on my own. I'm allowed to go about in my motorised wheelchair."

One relative said, "We've sometimes had staff come into hospital with us and have been really good with [family member]. Sometimes staff treat difficult and embarrassing situations with [family member] with light-hearted humour. That's what you need when you have personal needs to be cared for by someone else's. It eases the awkwardness."

Inadequate

Is the service responsive?

Our findings

We reviewed care plans and associated documents as part of the inspection. We found concerns in relation to a lack of detailed strategies to ensure people were supported safely and appropriately. For example, one person had a care plan for behaviour which may present as challenging. This stated two staff should attend and 'be witnesses/enable witness.' It also stated that staff should explain, 'It is unacceptable to be spoke to like that etc.' Some detail was recorded in relation to giving the person some time, and that sometimes they responded better to male care staff however there was no detail in relation to potential triggers for behaviour. It was also recorded that the person had been prescribed some 'as and when required' medicine for agitation however this had been discontinued on 16 August 2017 but had not been updated on the care plan until 24 August 2017. In addition, we saw a behaviour chart which stated the person had 'argued' with staff and so were given their medicine. There was no detail of any strategies to follow before the administration of medicines, so we could not be sure the medicine had been administered appropriately.

We were told the challenging behaviour team were involved, however there was no evidence of this. Behaviour recording charts were being completed but the recorded information was not always meaningful or sufficiently detailed to enable behaviour analysis. The quality and compliance manager said, "I will speak to the behaviour team."

We also saw a diabetes care plan which included that staff should check blood sugar levels to ensure they were stable, administer glucose gel if sugar levels were too low and if too high administer a dose of fast acting insulin. There was however no detail as to what the person's usual blood sugar levels were or what was a high or low reading. By reading the care plan alone staff would not have been able to identify when the person's blood sugar levels were too low or too high.

Another person had care plans in relation to mobility, falls and epilepsy which were dated May 2015. They also had a care plan in relation to high risk of skin damage dated May 2013. Care plans had been reviewed on a monthly basis, however information was limited and therefore we could not be sure the person was receiving safe and appropriate care.

One person had a percutaneous gastronomy tube (PEG). The care plan detailed the medicine regime, positioning of the person and the water flushes needed however there was no detail in relation to fluid intake and output, weight monitoring, or care of the PEG tube and surrounding skin. In addition there was no guidance on when staff should seek urgent help, for example coughing or vomiting after medicine administration, severe abdominal pain or abdominal bloating. Staff told us they had not received recent training in PEG care.

Care plans in relation to epilepsy did not specify specific triggers, they did not detail what seizure activity looked like for that person so staff could easily identify seizure activity. We did not see specific epilepsy recording charts so detail could be monitored for trends and associated actions. Information was recorded within the care plan evaluations but this was not easily to navigate.

We also found concerns in relation to the recording of wound care for two people. Staff were able to talk us through people's needs in this area, and offered assurances that appropriate care was being provided however records did not clearly document what action had been taken.

One person had a care plan in relation to the management of skin integrity and pressure care which was not specific. It stated the person, 'may need' an airflow mattress and two staff to reposition them.

Care plans were reviewed on a regular basis, although comments on the reviews were often limited. It was not evident that people and their relatives had been involved in care planning on a regular basis and the care plan documentation had not been signed by the person or their family.

These concerns are a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had a comprehensive complaints procedure and a complaints log. We saw 14 complaints had been recorded; however, we were unable to determine how most of the complaints had been investigated or resolved. Most of the complaints highlighted concerns about staffing levels, excessive use of agency staff and the lack of leadership and direction. Other concerns were around laundry and food. We spoke with the quality and compliance manager who told us they intended to speak to relatives to give reassurances regarding the recruitment of a new manager for the home.

These concerns are a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One relative said, "People are so good when I want to be involved in [family members] care plan. Staff understand my concerns and when we discuss things that have gone wrong they listen and act on it." One person also said, "I'm involved in my care planning. I discuss how I want to be cared for and they take notice of this."

One relative said, "I don't really know what the procedure is (to complain), but if I'm not happy with something I tell staff and they sort it out for us." One person told us, "I would contact the manager if I had a complaint, but there isn't one at the minute."

We spoke with people about the activities that were offered. A chapel was available on the top floor of Wordsworth House, and we told there were regular services of varied denominations for people to attend if they chose to. There were church pews and a small lectern for the speaker to use. People told us they attended the services and confirmed they took place twice a week. One relative said, "[Family member] was a professional soprano singer as a younger woman and can't sing now, but she really enjoys the church services and tries to sing along."

The activities coordinator said, "We usually go upstairs to do the coffee morning and all residents are invited. However, we could not take residents up to the second floor because of the lift being out of action. We just did the best we could." We did not observe any activities taking place during the inspection however people were positive. One person said, "I do exercise classes for wheelchair uses three times a week. It's very good." Another person told us, "It was lovely when the ponies came in. They were so calm and let me stroke them." This person showed us a photograph of them with the pony and were clearly very moved by the experience. Another person said, "The food is very good. Activities are good. We saw the horses here a few weeks ago, that was lovely. Art classes are good too." Other people spoke with us about the pub quiz. One person said, "It's very well organised, its great! Staff always ask around to see if they want to join in." They

added, "I can't remember if there are any activities at weekends or evenings though." An activities coordinator said, "I'm off from tonight until next Wednesday and so is [the other activities coordinator] so there won't be much going on until then."

Inadequate

Is the service well-led?

Our findings

Wordsworth House did not have a registered manager. The management of Wordsworth House was being overseen by the quality and compliance manager who had been based at the home two days prior to the inspection. The previously registered manager had left their post in May 2017 but had not cancelled their registration until August 2017. Since May 2017 there had been a further two managers overseeing the home, one of whom was a regional manager.

During the inspection we found concerns in relation to the safety of beds and bed rails which had not been identified by the provider. We also found concerns in relation to the provider's failure to escalate and mitigate risks in relation to a faulty nurse call sounder. Once discussed with the provider they were proactive in responding to these concerns however, had the inspection not taken place we could not be sure the risks would have been mitigated. In addition we found concerns in relation to care documentation and risk assessment; concerns in relation to the failure to complete personal emergency evacuation plans for all people and a failure to provide a fire risk assessment. We could not be sure people were being appropriately safeguarded from the risk of harm as there was no evidence that safeguarding concerns and complaints had been investigated. Accidents and incidents were recorded but there was no analysis for trends or lessons learnt. There was a failure to follow the principles of the Mental Health Act and a failure to ensure staff had the appropriate training, supervision and support required to enable them to support people appropriately. Staffing levels were a concern and everyone we spoke with told us there were not enough staff to provide safe support.

At the beginning of the inspection the quality and compliance manager told the inspection them, "We know it needs improvement." There was no evidence that any form of quality management had taken place recently.

Care file audit forms had been completed in June 2017, however, these consisted of a list of documents and the comments stated whether documents were dated, not in the file, or not complete. The action plan simply stated, 'complete all action' with the responsible person being the nurse. None of the audits had been signed off as having actions completed, nor was there detail on who had completed the audit. The system was not effective as it did not provide a complete and detailed action plan, nor was a specific person identified to complete the actions therefore providing limited accountability and responsibility.
A medicine audit had been completed on 4 July 2017 however it had been identified that it was not fit for purpose since introducing the electronic system and was due to be reviewed. The daily management report was reviewed daily to ensure appropriate and safe medicine administration was in place.

The most recent quality monitoring report had been completed in April 2017 by a regional manager. This report stated, 'accidents are all analysed and reviewed on a monthly basis. Complaints are documented and logged appropriately. Dependency tool used and evidenced appropriate staffing.' Whilst a dependency tool was used, the provider was unable to evidence the analysis of accidents, the appropriate logging of complaints or appropriate staffing. There was no detail in relation to any concerns or actions that were required to improve the quality of the home.

The failure to evidence the recent completion of audits, and the concerns noted during the inspection meant the provider had failed to ensure an effective governance system was in operation to assess, monitor and improve the quality of the service provided at Wordsworth House.

These concerns are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Two weeks after the inspection a home development plan was shared with the Commission.

When asked about the management of the home, one relative said, "I don't think they have any. I know there is a regional manager but I've never seen them." One person told us, "Not at the moment, we've got no manager's!" Another person said, "There's no management and it's dreadful! No deputy and no one to take a problem to. We should have a relief manager from another home to cover. All staff are good and some are excellent but there's not enough." Another person told us, "I do think the home is open and honest, but we haven't got a manager at present. We need a manager to lead properly." A relative said, "The home is friendly, clean, warm and welcoming. Staff are very patient, there is lots of food available all the time. I'm just concerned about the ratio of staff to residents, even more so at night." Another relative said, "The place lacks a manager and a deputy."

A nurse said, "It's got a lot going for it, but we are struggling. The care staff are very supportive of each other and the nurses, they are very caring to residents and we have the potential to deliver a high standard. It doesn't reflect the home we could be, we need management back." A senior care worker said, "You can't fault the staff, no one ever goes without. We need a leader, we are desperate. Sometimes there was only one senior on shift but it is improving."

People spoke with us about improvements that were needed. One person said, "Consistent management is needed. Also trying to get my wheelchair out of the building is difficult. The paving in the garden is uneven and makes it difficult to get my wheelchair around easily. The garden furniture could do with a coat of paint." A relative said, "More consistency and staff continuity. Permanent staff know [family member] and know how to care for her. Relief staff don't understand her needs." Another relative said, "More consistency in staffing. Fewer relief staff and extra helpers at mealtimes to help feed dependent residents."

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. The provider had failed to assess risks to the health and safety of service users. They failed to do all that was reasonably practicable to mitigate such risks. There was a failure to ensure staff providing care or treatment to service users had the qualifications and competence to do so safely. There was a failure to ensure the premises and equipment was safe to use for its intended purpose. Regulation 12(1), 12(2)(a) (b) (c) (d) (e)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to ensure compliance. The provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. There was a failure to mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. The provider had failed to maintain an accurate,

complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service users.

Regulation 17(1) 17(2)(a) (b)(c)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was a failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons were deployed in order to meet peoples needs. The provider failed to ensure staff received appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to do. Regulation 18(1) 18(2)(a)

The enforcement action we took:

We issued an urgent notice of decision to impose a condition to prevent the admission of new service users.