Larchwood Care Homes (North) 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

We under took a comprehensive inspection on 19, 20 April and 10 May 2016. The 19 April and 10 May 2016 was unannounced which meant they did not know we were coming.

Wordsworth House is registered to provide care for up to 40 people. The home is registered with the Commission to provide accommodation for persons who require nursing in a care home without nursing for older people, people with a mental health diagnosis, younger adults or people living with a dementia related condition. At the time of our inspection there were 38 people in receipt of care from the provider.

The registration requirements for the provider stated the home should have a registered manager in place. There is no registered manager for this service. The home manager told us they had started the application process for registered managers with the Commission. 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.

Systems to monitor and review concerns were inadequate. During our inspection we identified a number of concerns relating to allegations of abuse that had not been reported in a safe and appropriate way. We asked the home manager to refer the concerns that had been identified during our inspection to the Local Authority safeguarding team.

The system to record, investigate and monitor allegations of abuse was inadequate. The home manager showed us a safeguarding file. However this contained only a cover sheet and no record of the any current or previous investigations.

There was a risk assessment file which indicated a general risk assessment had taken place recently. Areas included; kitchen equipment, housekeeping and maintenance. However we identified some concerns relating to individual risk assessments for people living in the home.

Observation of medicines administration identified concerns relating to the length of time it took to administer all the medicines. Some medicines that were required before breakfast were not given as directed. We noted gaps in Medicines Administration Records (MAR) and the coding system lacked clarity on why medicines were not given.

Monitoring of room and fridge temperatures did not take place in line with guidance to ensure safe storage of medication. We saw on two occasions that the medicines trolley was left in the lounge on one of the floors and it had not been secured to the wall.

We looked at the training matrix and saw evidence of training taking place. However there was also some gaps in training.

Some staff we spoke with raised concerns about the staffing numbers in the home. Examples of comments received were, "We are falling behind. We keep having to do medicines on both floors if there is sickness." Another said, "Staff morale is low". However one person said it was a, "Good staff team". Senior management and the home manager told us they were in process of recruiting senior staff for the home.

We asked about how people were assessed when a Deprivation of Liberty Safeguards (DoLS) was required. We saw DoLS applications that did not reflect people's individual and current needs. Evidence of training for DoLS and Mental Capacity Act (MCA) identified that not all staff had completed the required training.

Systems to protect people from the risks of infection were ineffective. We saw evidence of an outbreak of diahorrea and vomiting that had not been referred to the relevant authority. We observed staff entering the kitchen without using appropriate personal protective equipment. We saw a sling in a bathroom that was stained and dirty.

We identified some concerns relating to maintenance checks in the home. For example the monthly room checks had not been completed since February 2016 and had identified areas that had 'failed' the check. Eight rooms had been identified as having no buzzers in the bedroom and two records had identified broken radiator covers. There was no reference to any actions that had been taken as a result of the concerns. We checked these rooms and identified three rooms did not have access to a call bell system.

We looked at care records including two short term care plans. We could only see reference to obtained consent in one of the file we looked at. This meant records did not reflect agreed care delivery.

People did not receive adequate fluids and care records did not reflect current individual diets. Weight recording lacked consistency and gaps in recording were seen. We saw evidence of weight loss for a number of people in receipt of care who had not been weighed for three months prior to the inspection.

During our inspection we spoke with people who used the service about the care they received in the home. We received positive feedback. Examples of some of the comments received were, "The staff are lovely, I have no concerns. You will not find a better place to live if you need a bit of help." However we noted occasions where we were concerned about the care provided to people living in the home and the response of staff to them.

During a tour of building we saw there were picture cards on people's bedroom doors which contained confidential information about them. We were told the content on the cards had also been raised prior to our visit by a professional visiting the home. However no action had been taken.

We observed activities taking place in the home and people we spoke with confirmed activities were offered. There was evidence of activities recorded in peoples care file. However one of these we looked at recorded an activity when they were in hospital.

We saw some evidence of involvement and review in the care files we looked at. However on checking information in peoples care files we identified concerns relating to the response of staff relating to changes in their condition and appropriate referrals to a professional for one person who used the service.

All the people we spoke with confirmed staff discussed their care with them. The home manager told us, "I would speak with the family and gain opinions of other family members and carers. I follow the processes and document outcomes. Documentation is the key for every area. We are waiting for new paperwork to arrive."

We asked about the reviews of care files taking place in the home. We saw two audits for care plan reviews in the office. We spoke with home manager about this who told us she had completed more reviews; however, she was unable to locate them during our inspection. We saw on the third day a care plan matrix had been updated to reflect the reviews that had taken place.

During our inspection we reviewed a number of care files for people currently in receipt of care along with two files for people who no longer lived in the home. We identified some evidence of care plans in place and included reviews of care and identified needs; however, there were gaps and inconsistencies in them. Systems to ensure records reflected people's individual care were inadequate.

Staff told us they felt supported by the provider during the takeover of the home. However, staff we spoke with provided conflicting information about the management in the home.

Systems to monitor incident and accidents were inadequate. Records indicated that four records had not been signed as reviewed by the home manager. We found evidence of some incident reports relating to people who used the service; however, these had been left on the desk with other records. There was no evidence that any analysis of the concerns had taken place.

We were shown an action plan for the home. There was some evidence of audits for nutrition observations; however, there were some inconsistencies and gaps in other records. For example we saw pressure relief turn charts, accident and incident audits; however, none of these had been completed.

We asked the home manager about how they received feedback from people living in the home and their relatives. There was an evidence file which had sample records for feedback from visitors, staff and people who used the service; however, these had not been completed.

We looked at the records relating to staff meetings. We saw records relating to regional home managers meetings which included dates, attendees and topics covered for example; weekly reports, health and safety and impact audits.

During our inspection we discussed the responsibility of the provider to notify the Commission of notifiable incidents such as deaths, serious injuries and allegations of abuse. We identified a number of concerns that required a notification; however, we saw these had not been sent to the Commission.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safeguarding from abuse, safe care and treatment, staffing, premises and equipment, nutrition, person centred care, dignity and respect, receiving and acting on complaints, good governance and fit and proper persons. We also found a breach of the Health and Social Care Act 2008 (Registration) Regulations 2014 in relation to notifying the commission of notifiable incidents.

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.

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.

Systems to monitor and review concerns were inadequate because during our inspection we identified a number of concerns relating to allegations of abuse that had not been reported in an appropriate way.

There was a risk assessment file which indicated a general risk assessment had taken place recently. Areas included were; kitchen equipment, housekeeping and maintenance. However, concerns were identified in relation to individual risk assessments for people in receipt of care.

Medicines were not administered safely due to the lateness of the medicines round. Monitoring of room and fridge temperatures did not take place in line with guidance to ensure safe storage of medicines.

People were not protected from the risks of infection. We saw evidence of an outbreak that had not been reported to the relevant authorities.

We saw evidence of certificates in place such as electrical and lift checks.

Is the service effective?

Inadequate

The service was not effective.

We looked at the training matrix and saw some gaps in training.

People had not been appropriately assessed to ensure they were not being deprived of their liberty unlawfully.

Records relating to fluid intake and weights were incomplete.

Is the service caring?

Requires Improvement

The service was not caring.

We spoke with people who used the service about the care they

received in the home. We received positive feedback. However, we saw one person did not receive care in a timely manner.

During a tour of building we saw there were picture cards on people's bedroom doors. These contained information including the name and photograph of who the bedroom belonged to. However, there was also confidential information recorded on them.

Is the service responsive?

Inadequate

The service was not responsive.

We observed activities taking place in the home and people we spoke with confirmed activities were offered.

Care files had evidence of reviews by health professionals; however, we saw concerns relating to reviews for one person.

All people we spoke with confirmed staff discussed their care with them.

We saw some improvements in the reviews of care files; however, we identified gaps and inconsistencies in recording.

Is the service well-led?

Inadequate

The service was not well-led.

Staff told us they felt supported by the provider during the takeover of the home; however, some staff raised concerns about the management in the home.

Systems to monitor incident and accidents were inadequate. There was evidence that records had not been stored in an appropriate way and we could not see any evidence that analysis of concerns had taken place.

We asked the home manager about how they received feedback from people living in the home and their relatives. We were told they were waiting for new questionnaires to be delivered. We saw some completed questionnaires. However there was no date on them and they had the previous provider's details on them.

We identified a number of concerns that required notification; however, we saw these had not been sent to the commission in line with current guidance.

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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 19, 20 April and 10 May 2016. The visits on 19 April and 10 May 2016 were unannounced. This meant the provider did not know we were coming. The inspection was undertaken by one adult social care inspector on the first two days and two adult social care inspectors and a pharmacy inspector on the third day.

Prior to our inspection we looked at information we held about the service including notifications, safeguarding information and any feedback held on our system and we spoke with professionals from the Local Authority.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with eight professionals, six people living in the home, six relatives' nine staff members, the home manager as well as the regional manager. We undertook a tour of the building which included the public areas of the home, the kitchen, bathrooms, shower room and with permission, some peoples bedrooms. We also carried out observations in public areas of the home at various times during the inspection days including the lunch time period for two of the days.

We looked at a number of records which included audits and quality monitoring, training records, complaints, incidents, four staff records, feedback from people using services, and the care files for ten people. In addition to this we also looked at parts of a further three care records for people currently in receipt of care.

Inadequate

Is the service safe?

Our findings

During our inspection we spoke with six people who used the service and six visiting family relatives about whether they felt safe in the home. People told us they felt safe. A visiting relative said, "They are happy here I have no concerns". Staff we spoke with were able to discuss the appropriate actions to take if abuse was suspected. They said, "Keeping service users safe from harm. I would report it straight away" and, "I would report it no matter what kind of abuse". Staff we spoke with were aware of the Whistleblowing policy (reporting bad practice) and felt confident to act on any concerns.

Staff we spoke with told us they had completed safeguarding training. However, when we checked the staff records only one of the four had evidence of completed safeguarding training. The regional manager provided us with a copy of the training matrix which showed only eight out of 43 staff had completed safeguarding of vulnerable adults training. This meant people were at risk because staff did not have up to knowledge to ensure people were protected from the risks of abuse.

Systems to monitor and review concerns were inadequate. During our inspection we identified a number of concerns relating to allegations of abuse that had not been reported in an appropriate way. For example one person's records identified unexplained bruising, however there was no evidence to confirm this had been documented as an incident, internally investigated or reported to the relevant authority. Another person's record identified an incident with another person living in the home. Again there was no evidence of an internal investigation or reporting to the local authority safeguarding team. We asked the home manager to report these concerns to the local authority safeguarding team as a matter of priority so that an assessment could be made about whether a safeguarding investigation should take place.

We asked the home manager about how they monitored and recorded allegations of abuse. We were shown a safeguarding file and saw there was no evidence of any investigations recorded in it. The home manager told us she was in the process of transferring records in to a new file. We checked this file and saw evidence of a cover sheet; however, there was no detail on any previous or on-going investigations. This meant systems to record, investigate and report allegations of abuse were inadequate.

This was a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014.

We looked at a total of nine Medicines Administration Records (MARs) and spoke with the senior carer responsible for medicines on the third day of the inspection. There were appropriate arrangements in place for the management of controlled drugs; they were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely.

During the first day of our inspection we looked at how room temperatures where medicines were stored were recorded. We noted that there were gaps in the recording of room temperatures on seven occasions in March and nine out of 19 occasions in April. We discussed our concerns regarding this with the home manager and the lack of recording of these temperatures. This demonstrated that systems to ensure medicines were being stored safely were inadequate.

We checked medicines which required cold storage. We saw gaps in the records on two separate occasions in March and 10 occasions in April 2016. This meant necessary checks on appropriate storage were inadequate. Records relating to the defrosting of the medication fridge identified the fridge had not been defrosted since January 2016. Guidance recommends fridges should be defrosted regularly and dated records kept. Records were not always completed in accordance with national guidance because only the current temperature had been recorded. The staff we spoke with did not know how to operate the thermometer to obtain the maximum and minimum temperature. During our visit the thermometer showed the temperature had been outside of the safe range for storing medicines. This meant we could not be sure the medicines were safe or effective to use.

Medicines were not always given as they had been prescribed by the GP. One person was prescribed a medicine used for behaviours which challenged which could be given up to twice daily, if required. Another person was prescribed two inhalers. We checked the dose counters of the inhalers and found there were more doses remaining than the administration records indicated there should be. This meant the person had not been given their inhalers correctly although staff had signed to say they had been given. A third person was prescribed a medicine for dementia and one for cholesterol, both to be given at night time. We found several doses of these medicines were still in the packaging because they had not been given. When we checked Medicines Administration Records (MARs) some of these doses had been signed as given by staff which meant records did not accurately reflect the treatment people had received. Three of the nine records we checked contained gaps where medicines had been given but not signed for. Systems to ensure safe administration and recording of medication were inadequate.

We were concerned about the length of time the morning medicines round took on the day of our inspection. One senior carer was responsible for giving medicines to 35 people. This meant some people did not receive their morning medicines until after 11:00am. This included medicines which should be given before breakfast (on an empty stomach), medicines for the heart and blood pressure, pain killers, and medicines for Parkinson's disease. Receiving these medicines late may have meant that people experienced unpleasant unwanted symptoms or pain.

We noted that medicines charts included the use of a coding system. However we saw these were not consistent in their use and were difficult to follow. For example one record had no timings recorded for the administration of paracetamol to ensure these were given at appropriate intervals. Another record had no details relating to any actions that were taken when one person's medicine had been refused for several days. We saw one person's MAR did not include all the medicines that were listed on a recent GP list. Records identified a number of medicines had been missed on the MAR that had been provided by the home manager during our inspection. Another MAR chart for one person identified a gap in administration of a number of days for two separate medicines. We asked the home manager about this. They told us that during the changeover to new MAR charts at the end of the month this medicine had been missed; the error had not been noted until ten days later. Another MAR identified specific administration instructions for a controlled medicine patch which was not in-line with manufacturer's recommendations. We discussed this with the home manager who told us this had been directed by the GP. We checked this person's medicines care plan which identified there was no guidance for the administration of this patch. Systems to protect people who used the service from unsafe medicines administration were inadequate.

During a walk around the building we saw that some people had medicines creams had been stored in their bedroom. These had not been stored securely because they were not in a lockable cupboard; therefore, easily accessible to anyone entering the bedroom. We also saw two prescribed creams that had been dated as opened in December 2015 left in an unlocked shower room on one of the units. We would expect that all prescribed creams are secured safely to prevent misadministration. Guidance for storage and use of creams

also indicates that the disposal of creams should take place 28 days after opening. Systems to protect people who used the service from inadequate medication management were ineffective.

We looked at the controlled drugs register and saw gaps in the checking of stock numbers of medicines. For example records identified two staff were required to check the stock amounts of medicines twice per day. However we saw for one controlled drug that only one check had taken place over a three day period and there were three days where no check had been completed. We found a further two occasions where only one staff member had signed for the checks. We spoke with the staff member responsible for this on the second day of our inspection who confirmed the expectation was for two staff to check controlled medicines and ensure it was counted twice daily by two members of staff. The staff member acknowledged this had not taken place. Systems to ensure the safe storage of medications were inadequate.

We observed the medicines trolley had been left in the upstairs lounge area on two of the three days of inspection. The trolley was locked however it had not been secured to the wall as we would have expected. On the first day of our inspection we saw that the clinic room was disorganised and contained a large amount of medicine that required returning to the pharmacy. This meant the medicines trolley would not fit in the room to enable safe storage. We discussed this with the home manager and the regional manager who organised the collection of this medicine and implemented safe disposal bins for unused medicines.

The area manager told us the home had recently introduced a fortnightly medicine audit; however, only one completed audit was available on the day of our inspection. Although the audit was detailed, only a small sample of MARs were reviewed and it had failed to identify the shortfalls we found. For example, inappropriate recording of fridge temperatures and a lack of guidance for 'when required' medicines.

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

There was a risk assessment file which indicated a general risk assessment had taken place recently. Areas included were kitchen equipment, housekeeping and maintenance. The home manager told us risks were discussed in the 'daily huddle' (head of department) meetings.

During our inspection we looked at how the service was managing risk in the home. There was some evidence of risk assessments in place in the care files for people who used the service; however, we noted these did not always reflect the person's current need. For example we observed one person was being moved in a wheelchair in the home on the first day of our inspection. We saw a staff member pushing them with no foot plates to support their feet and they were holding their legs up off the floor. We spoke with the home manager about this who told us it was the person's choice to be moved in this manner but could not confirm if this was reflected in their care file. We checked this person's care file and saw no risk assessment relating to mobilising around the home to ensure staff had access to up to guidance to protect the person who used the service from these increased risks. Another two people's records identified risk assessments in relation to nutrition had not been reviewed since January 2016 despite evidence of weight loss. Systems to assess and manager risk to protect people who used the service were inadequate.

During a walk around of the service we saw a box of gloves in a corridor where people living with a dementia were cared for. We asked the home manager if a risk assessment had been completed to ensure the risks of having gloves available in a public area were identified to guide staff so that people who used the service were protected from the associated risks. The home manager told us there was no risk assessment in place to protect people in the event of misuse of the gloves. Also on the third day of our inspection we saw a hoist had been left across the bedroom door of a person who was unable to mobilise. We asked the staff member about this who told us this was usual practice overnight to stop another person who used the service

entering their room. We also saw on one of the units all peoples bedrooms had separate locks and keys that staff told us were stored in the office. We asked the home manager about this who told us there was a master key; however, this could not be located due to maintenance staffing changes. This increased the risks to people using services because in the event of an emergency staff would need to locate the relevant key to access these rooms to assist people to safety if the bedroom door was locked from the inside.

This was a breach of Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014.

We spoke with people about the numbers of staff on duty to meet their needs. People told us, "Carers are fantastic", "The staff are wonderful I come here every day". However, one person said, "At the weekends there is no staff, and they all sit around the table".

Some staff we spoke with raised concerns about the staffing numbers in the home. They told us there was usually a senior staff member on duty for each floor but at present there was only one to cover both floors. We were told that one staff member did a number of consecutive shifts to cover the morning medication round. One staff member said, "We are falling behind. We keep having to do medicines on both floors if there is sickness. There are a few staff off sick and a lot of people followed [name of previous manager]." Another said, "On a normal shift there are seniors and carers on both floors but over the last six weeks there has been only one senior" and, "Staff morale is low." However one staff member told us it was a, "Good staff team". And another staff member we spoke with felt there was enough staff on duty to meet people's needs. Senior management and the home manager told us they were in process of recruiting senior staff for the home.

During the third day of our inspection we arrived at the service at 6am and noted there were two staff members on each floor. On one of the floors we saw three people were already up and dressed and sat in the communal area of the home. We observed periods of time when these people were left unattended due to staff undertaking tasks for other people in their bedrooms. We asked if the home completed a staffing needs analysis, to ensure adequate staffing numbers were on duty to meet individual needs. Senior management confirmed there was no staffing needs analysis in place at the home. Following our concerns regarding staffing in the home overnight the provider increased the numbers and undertook to complete a comprehensive staffing needs analysis. People were at risk because staffing numbers were inadequate and failed to ensure they were monitored to maintain safety.

We looked at the duty rotas for the home and saw gaps in cover for some shifts. Examples seen included four shifts which identified that there were only three staff members on duty and a number of occasions where there was only one senior staff member to cover both floors. We also saw one shift had senior cover for only three hours and we could not see evidence that appropriate arrangements had been made to provide senior support for the rest of the shift. People were at risk of ineffective care because adequate numbers of staff were lacking.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulations) 2014.

We looked at the records for four currently employed staff members. There was evidence of safe recruitment processes taking place. This included completed application forms, relevant references to confirm appropriateness for post, identity checks and disclosure and baring service checks. The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

During our inspection we looked at the systems in place to prevent the spread of infection. There was a

nationally recognised procedure for staff to follow in the event of an outbreak and the home had policies in place to guide staff on infection control. There was a form for observing staff using hand rub; however, this was blank along with information regarding the vaccination of staff. On the third day of our inspection we identified signage on one of the units which advised people that it was closed due to a diahorrea and vomiting outbreak. However, we could see no advice on the other unit or upon entering the home. Staff we spoke with told us the signage had been on display for three days. We spoke with the home manager to check whether this had been reported to the relevant authorities. We were told that three people who used the service and one staff member had symptoms; they told us the signage was precautionary and the outbreak had not been reported to the relevant authorities. However, when we checked the communication diary we saw staff had identified six people with symptoms of either diahorrea or vomiting out of the 13 people on the affected unit. Three of the care files for these identified symptoms of diahorrea. We checked nationally recognised guidance which stated, 'An outbreak can be defined as two or more cases of the same illness occurring around the same time or within days of each other'. Systems to protect people from the risk of infection were inadequate.

During our observations in the home we saw the door to the kitchen had been propped open with a mop for a considerable period of time. We noted staff were entering and leaving the kitchen on a number of occasions without using protective clothing. This was despite clear signage on the door advising staff to make use of the kitchen hatch and not to enter. Systems to protect people using the service from the increased risk of infection were inadequate.

We observed the staff responsible for cleaning were wearing the appropriate protective equipment and were seen taking cleaning products into individual rooms when cleaning. This would ensure they were able to monitor their equipment safely. However, our observation of the home identified further concerns relating to infection control. For example in one of the bathrooms there was a sling that had staining on it and one person's bedroom had a strong smell of urine. We also saw a used syringe in one of the offices which had been left on a tray. We asked staff about this who could not confirm who had left it but that it had, 'Been in the office overnight'. We asked the home manager about this who told us it had been used to give a liquid medication. We also checked the clinic room and saw that the sink was dirty and stained and there was a used syringe in it. We looked at the night cleaning file and saw this had not been completed. Daily records of cleaning included wheelchairs, commodes dining chairs and hoovering of the lounge. Systems to protect people using the service from the increased risk of infection were inadequate.

We saw that there was a completed infection control audit from February 2016 and included comments relating to identified actions to be taken.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulations) 2014.

We undertook a tour of the building including, the kitchen, both lounges, dining rooms, corridors, one bathroom, a shower room and a toilet as well as a number of people's bedrooms on both floors. We noted required checks and certificate had been obtained such as lift checks, hoist and electrical checks.

We noted both public areas as well as bedrooms were clean and tidy. We identified some concerns relating to the environment. For example, in one of the lounge we saw an electric extension plug had been left out in front of a television unit, a sensory room was left unlocked with a crash mat and a bean bag left in it. We also saw that a hoist had been left across a bedroom door overnight. On the first day of our inspection we noted in one of the lounges all but four of the cushions were on their side after breakfast. This meant not all of the chairs were available for people who used service.

On the first day of our inspection we looked at records relating to fire safety checks and saw that these had been completed including an evacuation register. We also checked the daily maintenance sheets and saw records relating to maintenance and actions required; however, we could not see actions taken to resolve them. We checked all the areas and identified all but one had been resolved apart from a concern relating to a plug that had been identified as broken in December 2015.We checked this room and the plug socket was loose and required fixing. We brought this to the attention of the home manager who confirmed they would ensure this was fixed. However, during the third day of our inspection we rechecked this room and saw the plug socket was still loose on the wall. Systems to protect people from an unsafe environment were inadequate.

During our second day of inspection we looked at records relating to maintenance rooms checks and identified some concerns relating to the checks taking place. For example the monthly room checks had not been completed since February 2016 and had identified areas that had 'failed' the check. Five rooms had been identified as having no call systems in the bedroom and two records had identified broken radiator covers. There was no reference to any actions that had been taken as a result of the concerns. We checked the bedrooms identified as having no call system and saw that this was the case in three rooms. The home manager told us they would ensure this was resolved as soon as possible. During our third day of our inspection we undertook a tour of the building and checked all people's bedrooms. We saw a number of bedrooms where people did not have access to a call system on one unit. Five bedrooms had no call bell. The home manager told us two of these people were unable to use call bells. We checked their records and records indicated they were unable to use them. We looked at a further three rooms where pressure mats were required. One member of staff told us these were not working. However when we checked, one worked successfully. Another was not plugged in properly and a third did not work. On the other unit we saw two buzzers were located behind people's beds and a third was on the floor. This meant people did not have access to call bell systems if required the assistance of staff when they were in their rooms.

We looked at one of the public bathrooms and saw evidence of maintenance work required in the room. We saw there were exposed pipes which had evidence of discolouration on them under sink. The radiator cover was also broken and there was cracked and marked flooring around sink and the toilet. A maintenance audit also identified a number of fans were not working in some of the en-suite bathrooms. We checked these rooms and saw that three of them were still faulty. We informed senior management about this who told us this had been reported but were waiting for the commencement of the new maintenance person to post.

There was evidence of weekly water temperature checks. However they only included the bathroom and showers. We could not see evidence of any water checks in people's en-suite bathrooms. We also saw there was evidence of Thermostatic Mixing Valves (TMV) checks. However we noted only nine had been completed for March and 16 for February. There was a note in the comments sections which stated TMV's were not being checked monthly. There was no reference as to the actions taken to ensure all required checks had taken place. All but three of the recordings were noted not to have reached the required temperature and there was no evidence to confirm guidance for actions had been followed.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulations) 2014.

Inadequate

Is the service effective?

Our findings

During our inspection we spoke with people who used the service about the skills of the staff delivering their care. We received positive feedback. Examples of comments seen were "I am happy I have no concerns"; "The carers [staff members] are fantastic". Relatives visiting the home told us they were confident in the care people received. All professionals we spoke with told us they had no concerns about the staff in the home.

We asked staff about the training they had completed to care for people who used the service effectively. One staff member said they were, "More or less up to date with training" another said, "I did my medication training in a previous role. I have done dementia and safeguarding training online." And another told us they had completed the required training online.

We asked the home manager about the training for staff in the home. We were shown a training matrix which identified gaps in training for the staff team. The senior management told us they were aware of the gaps in training and gave assurances that they would ensure all staff received the relevant training for their role. We saw some improvements in the number of staff who had completed mandatory training on the third day of our inspection. The senior management informed us of their plans to ensure all staff were up to date with mandatory training and discussed the actions they would take if staff failed to undertake the required training.

We looked at the training matrix and saw some gaps in training. Records indicated 35 out of the 43 staff had completed dementia awareness, equality diversity and inclusion, 34 of 43 staff had undertaken fire safety at work and all staff had completed nutrition awareness. However we saw that only 17 of the 43 staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and only 13 had completed dignity and respect with customer care. We saw evidence of planned dates for training on display in the office. However during our third day of inspection we noted the dates for training for MCA had been cancelled by the trainer and new dates in June had been planned.

We looked at four staff files. Two files had evidence of some training in place for example, safeguarding for vulnerable adults, dementia, mental health awareness as well as a nationally recognised qualification. However a further record identified no training had been undertaken since the end of 2013 and the last medication assessment had taken place in November 2014. Another staff file identified they had not completed an induction programme to the home despite starting employment recently. People were not protected by an up to date and knowledgeable staff team.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulations) 2014.

During our inspection we spoke with people who used the service about the quality of the food in the home. We received positive feedback. Examples of comments received were, "The meals are lovely, we get choices" and, "The food is great." A visiting professional to the home said, "The food is always well-presented and they offer a variety".

We undertook observations of the meal times in both dining areas in the home. We saw some evidence of positive interactions taking place between staff and people using the service whilst being supported with their meals. For example we observed one staff member showing all the meals on offer on the trolley so that people were able to make a visual decision on what they wanted to eat. Another staff member was seen to be engaging in meaningful conversations and encouraging people to eat. Tables were nicely set and included condiments, cutlery and table cloths. This ensured the dining experience was a positive environment for people using services.

However we identified some peoples experience in the dining room was less positive. We observed one person being supported by a staff member who engaged in little meaningful conversation with them. Food was being offered to one person without any explanation of what was being offered. We saw a second person using a knife in an attempt to eat their dinner. We noted it was a number of minutes before staff intervened and offered appropriate cutlery. Systems to ensure people received meals in an appropriate manner were ineffective.

We checked how the service was monitoring weights for people who used the service. The home manager told us there was a weight file on each unit where staff recorded weekly and monthly weights. When we asked to review the file the home manager was unable to locate it initially. Once located we checked the file and saw records for weekly weights were not up to date and were incomplete as there was no analysis of weight loss, food requirements and any mitigating factors such as; disease. The homes manager told us there were further weight recordings and provided copies of these. However, we found these difficult to follow as these were on hand written on pieces of paper and there was no reference to any weight changes or actions taken as a result of the changes. We saw these were transferred on to a computer matrix. However, again there was no reference to weight changes recorded on it, despite evidence on the record of increases as well as losses.

We were shown another record that had been completed which identified eleven people whose weights had not been recorded recently. Records identified five people who required their weight recording on a weekly basis. However we only saw three people had been placed onto a weekly weight monitoring system and two of these had not been obtained weekly. Systems to ensure peoples weights were monitored effectively were inadequate.

We looked at a care file and saw documentation relating to weight records stated, 'Unable to record weight". We saw that no further details were recorded; this was despite guidance for staff to follow for an alternative assessment for weight loss. A second care file we looked at identified the last weight had been recorded in January 2016 and it noted a loss in weight. There were no records of actions taken as a result of the weight loss or any further weights obtained. A third care file identified no weight had been obtained since January 2016. This was despite the person's weight being low. A fourth care file identified a weight loss of over 3kg in January and again there was no recent weight recorded for them in their care file. We saw a weight audit had been completed in February and March 2016. There was reference to obtained weights; however, the form had not been completed in full and there was no evidence of malnutrition assessments in place. Systems to protect people for the risk of weight loss were inadequate.

We looked at the food and fluid charts for two people who used the service and identified gaps in the records on a number of occasions. We saw a lack of fluid intake for one person across a period of eight separate days. This persons care plan also identified they required thickened fluids, however this had not been recorded in their fluid charts to ensure staff had access to their specific fluid requirements. On one of the records we saw an entry that indicated staff had given fluids with the use of a syringe; however, it was not clear if thickened fluids had been given. We checked this person's care plan and saw that a review had

taken place recently and the requirement relating to food for this person had changed from a pureed diet to a soft diet. We could not see who had directed this change or if a review by a professional had taken place.

We checked the food and fluids charts for another person and again identified gaps in their records over a number of days prior to a hospital admission. Records lacked detail and consistency and identified people were receiving inadequate fluid intake and monitoring.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulations) 2014.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated Deprivation of Liberty Safeguards (DoLS), with the management team. The Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for them and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken.

We asked staff about their understanding of DoLS and the MCA. One staff member was unable to evidence detailed knowledge. However another staff member demonstrated a detailed knowledge of MCA. They told us, "You have to act in people's best interest's, you have to presume people have capacity". A senior member of staff was unaware of changes in guidance relating to DoLS that could have impacted on restrictions and relevant applications for people who used the service.

In the four staff files we looked at we could not see any evidence of training in DoLS and the training matrix highlighted only 17 staff members had completed this training, seven had expired and 19 staff had not commenced this training.

We looked at the care files for people living in the home and saw regular reference to best interests in care plans; however, we could not see any evidence of who had been involved in the decision making for them or any reference to involvement by professionals or family members. We asked the home manager about whether anyone living in the home was subject to a Deprivation of Liberty Safeguard. During the first two days of our inspection we were shown a DoLS file; however, evidence in the file identified all but one of the records related to urgent applications which had been completed. The home manager told us all of the applications were out of date and needed to be updated, records indicated the last date for these was six months prior to our inspection. On the third day of our inspection we were told all DoLS applications had been completed and sent to the assessing authority. We saw evidence of completed applications in place, however we identified that two application forms did not reflects people's individual current needs. Systems to ensure people who used the service were protected from unlawful restrictions were inadequate.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulations) 2014.

We looked at how the service ensured they had consent to offer and deliver care to people who used the service. We observed staff knocking on people's doors and waiting to enter until invited into the rooms. We saw that people were offered explanations prior to any delivery of care to ensure people agreed and understood what was being offered. People using services we spoke with confirmed staff talked to them about care delivery and they agreed with their care.

We looked at care records including two short term care plans. We could only see reference to obtained consent in one of the files we looked at. This meant record's did not reflect agreed care delivery.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulations) 2014.

We asked about the supervision taking place in the home to ensure staff were able to discuss their progress and support in their role. On the second day of our inspection we saw a supervision matrix on display in the office to monitor staff supervision dates; however, we noted these had not been completed since November 2015. On the third day of our inspection we were shown a new supervision planner which had dates recorded for completed supervision; however, we noted all of the supervisions were completed on the same day. We were told group supervision had taken place. We looked at the supervision records and saw details of staff names recorded; however, we saw not all of the records had been completed. This was because there was no evidence of a summary of issues or what actions were to be taken individually as a result of the supervision.

Completed records indicated a number of topics were discussed. However topics appeared to be more information giving than supervision. There was no evidence of individual supervisions taking place. This meant staff were unable to develop and discuss individual skills or concerns. Following or inspection to provider sent us an action plan which identified individual supervision would be undertaken. Systems to monitor and support staff were inadequate.

Requires Improvement

Is the service caring?

Our findings

During our inspection we spoke with people who used the service about the care they received in the home. We received positive feedback. Examples of some of the comments received were, "The staff are lovely, I have no concerns. You will not find a better place to live if you need a bit of help" and "The home is fantastic. I wouldn't change it for the world, I am happy here."

Relatives visiting the home told us, "I am a regular visitor. The staff are lovely I am happy and have no concerns", "My [Relative] has been here for two years, I am happy, the staff are wonderful", "You know who the good workers are, it is pretty good care, I am happy with the care being delivered" and "You have to trust the staff. Like anywhere else they seem to have an A and B team. Some work better than others. I have trusted them to look after [Relative] and I was able to go on holiday".

Professionals visiting the home were complimentary about the care delivered. We were told, "It is a nice home, the staff are very helpful", "The care is good, I would put a relative here. [Staff] have never delivered bad care" and "I am happy with the home, the staff will call if I am needed."

We spoke with the home manager about the care delivered in the home. She said she was confident that the care delivered was "First class". She said, "I feel I offer extra to make this home special in people's latter years".

We observed staff were kind and caring to people who used the service and generally responded positively to people's needs. Staff were observed singing and interacting in the public areas of the home and responded in a timely manner to buzzers. However, we noted occasions where we were concerned about the care provided to people living in the home. For example, we saw that two people's finger nails were long and underneath their nails were dirty. One person was observed later to be eating their meal with their fingers. We also saw one person who required support with personal care and attention to their clothes. However a number of staff in the lounge did not act to maintain this person's personal care and dignity. We raised this with the home manager to request immediate action was taken. We also observed one person who used the service raising concerns about a change in their condition. However this was not acknowledged by the staff member involved. Systems to maintain effective care delivery were ineffective.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulations) 2014.

During a tour of building we saw there were picture cards on people's bedroom doors. These contained information including the name and photograph of who the bedroom belonged to. This would help people identify their own bedrooms. However, we saw that confidential information was recorded on the cards; including peoples allergies as well as information relating to resuscitation status for some people where a 'do not resuscitate' agreement was in place. We were told the content on the cards had also been raised prior to our visit by a professional visiting the home; however, no action had been taken. This meant that people's privacy was not maintained. We spoke with home manager about the information contained on the picture cards. They could not confirm that consent had been obtained for this information to be

displayed from all of the people currently in receipt of care. The home manager asked staff to remove the picture cards form peoples bedroom doors during our inspection. Systems to protect people's privacy and dignity were ineffective.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulations) 2014.

Inadequate

Is the service responsive?

Our findings

The complaints procedure was on display in the entrance to the home as well as on display in the public areas of the home and the lift. There were also details of the complaints procedure in the homes statement of purpose and in a welcome pack for people who used the service. This ensured people had access to the details of how to raise any concerns.

We asked the home manager how they responded to complaints in the home. We were told complaints would be well received and information was taken on board. The home manager advised that she would direct people to the complaints procedure. The home manager discussed the investigation process to ensure complaints were dealt with in an effective manner. However, when we looked at records relating to complaints we identified gaps in records. We were shown a file which had details of a complaint; however, we did not see any evidence that an audit had taken place of the response.

We looked at how complaints were dealt with in the home. We saw records relating to complaints lacked consistency in their recording and filing. A system to establish an effective investigation and evaluation of complaints was inadequate. There was little evidence of the complaints or how they were dealt with despite evidence of complaints located in a number of different files in the home. For example one record was seen which had no evidence of the details surrounding the complaint other than the comments on actions taken to resolve. Another record identified concerns which had been raised with the home manager; however, again these were incomplete. We could not see details relating to any outcomes of actions taken as a result of the complaint. We also saw records of notes from the home manager to staff which indicted complaints relating to an activity undertaken by staff. However, again there was no reference to the specific complaints, records of any investigation, outcome from the actions taken or any learning from the event.

There were ineffective procedures and a lack of effective systems and processes to establish evidence of investigations and an audit trail of complaints.

We saw evidence of thank-you cards on display in the entrance to the home. Examples of comments seen included, 'A big thank you for taking care of my [Name] for the past few weeks', 'I was so sorry [Name] left Wordsworth' and 'A big thank you for the care and attention you gave to [Name]".However, these were not dated so it was not possible to ascertain if these were recently received.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulations) 2014.

We asked professionals visiting the home whether staff appropriately referred people using service to them and if they were involved in reviews when required. All professionals we spoke with told us the home made appropriate referrals and staff responded well to direction of guidance for care delivery. People confirmed staff contacted them appropriately when required.

We saw some evidence of involvement and review in the care files we looked at. However, on checking information in people's care files, we identified concerns relating to the response of staff concerning

changes in their condition and appropriate referrals to a professional for one person who used the service.

For example one person's care file we looked at identified six occasions where a change in condition was recorded in the communication sheets and a further recording in the 'handover sheet'. We could not see any reference in the care file that confirmed advice was sought for these changes in condition. We discussed this with the home manager. Following our inspection these concerns were investigated by the home. There was some evidence of recording by district nurses in records relating to a particular change in condition and two notes of a GP review; however, there was no reference to another condition where we would have expected a review by a health professional to have taken place.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations) 2014.

We asked people using services and visitors to the home whether they were involved in making decisions about their care. All the people we spoke with confirmed staff discussed their care with them. We asked the home manager about the arrangements in place to ensure care files reflected people's current needs. She told us, "I would speak with the family and gain opinions of other family members and carers. I follow the processes and document outcomes. Documentation is the key for every area. We are waiting for new paperwork to arrive."

The home manager told us staff completed a communication passport which contained personal details including likes, dislikes and allergies. We were told this would be used in the event of a hospital admission.

We asked about the reviews of care files taking place in the home. We saw two audits for care plan reviews in the office. We spoke with the home manager about this who told us she had completed more reviews; however, she was unable to locate them during our inspection. There was a care plan review matrix on display in the manager's office; however, we noted this was out of date on the first two days of our inspection. We discussed this with the home manager and on the third day we saw this had been updated and contained some evidence of reviews of care plans which had taken place for 14 of the 38 people currently in receipt of care. There was a further care plan review named, 'Night care plan review' on display in a second office that identified a review had taken place in April; however, we could not be confident when this had occurred as there was no year recorded.

During our inspection we reviewed a number of care files for people currently in receipt of care along with two files for people who no longer lived in the home. We identified some evidence of care plans in place and included reviews of care and identified needs; however, there were gaps and inconsistencies in them.

For example one record we looked at was for a person who we were told was in receipt of short term care. However, we noted they had been in the home for a number of months. We saw no evidence of an assessment taking place other than a pre-admission assessment which had minimal information included. One staff member we spoke with told us, "There isn't one, never has been. We have been telling them and they have not done anything about it." There was no evidence of a care plan in place for most assessed needs. Records also indicated a number of reviews had taken place by professionals for changes in conditions, however daily records did not provide comprehensive information relating to their directions. This meant staff did not have up to date and relevant information to care for their needs safely.

We also reviewed a further two short term care plans and identified they had not been completed in full. One of the records had no details to guide staff on what support was required to meet their needs, despite concerns about specific medical conditions. We had been made aware of a medical incident that had occurred with this person, however when we checked the daily communication sheets, there was no record

documented relating to the incident or any investigations and outcomes from this. Another care file recorded that staff had identified records were incomplete; however, there was no record to confirm the care files had been updated. Systems to ensure care files reflected people's current individual needs were inadequate.

We also identified concerns relating to the content of a fourth care plan. Records were held in people's bedrooms where staff were expected to record personal care undertaken and these had a number of gaps in them. One week only had a record for two of the seven days and a further two weeks had no records relating to care offered. There was a coding system available for staff to use when care was refused or not applicable however we saw no reference of these in any of the gaps in recording. We saw another record which directed staff to ensure this person was, 'Turned as per care plan two hourly'. However, we saw no record to indicate this person had been turned for 12 hours. And a further record for this person indicated, 'Fluids pushed throughout the night.' However, when we cross referenced this information with the fluid records there was no record for 12 hours. Systems to ensure records reflected people individual care were inadequate.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations) 2014.

We asked about activities taking place in the home. We were told the service employed an activities co-ordinator who worked Monday to Friday and we saw her on duty during our inspection. We asked people who used the service about the activities in the home. One comment received was, "I can get involved if I want to" and another said, "[Name of home manager] once got me a railway magazine as she knew I was interested in railways". A visiting relative told us singing took place regularly. We heard appropriate music playing during our inspection and people taking part with singing along with a number of staff. However, another visitor told us there was, "Nothing going on at weekend". A visiting professional to the home told us, "There is always something going on; there is activities taking place. They [Staff] take people out." We also saw there was a resident cat as well as two caged birds on the down stairs unit. Staff told us people who used the service enjoyed the animals in the home.

We saw evidence of activities taking place on the day of our inspection. People were observed potting plants in preparation for planting in the garden. They told us they enjoyed this activity. And we saw a number of people were enjoying the warm weather in the garden on the downstairs unit. However, we also observed a member of staff turn off the music and put on the television without asking anyone sat in the lounge if this was their preference.

During our observations of the home we saw that there were three activities boards, none of which had any activities recorded on them. We discussed this with the home manager who told us two of the boards had locks on them and they had no access to the key and the third board was in the process of review. We rechecked this board on the third day and saw limited information relating to activities in the home.

We looked at records relating to activities in the home and saw some evidence of records relating to activities taking place such as nail painting and singing. However, one record we looked at relating to activities undertaken had a date recorded when they were in hospital. We could not be confident records reflected actual activities undertaken.

Inadequate

Is the service well-led?

Our findings

The registration requirements for the provider stated the home should have a registered manager in place. There had been no registered manager for this service for 33 days. The home manager told us they had started the application process for registered managers with the Commission. 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.

We asked people who used the service, relatives and visitors to the home about the management and leadership in the home. People told us, "[Name of home manager] is totally approachable"; "I think she is a brilliant manager. She is doing a lot of good for the home. You can see she is a worker."

We saw the home had introduced a spotlight on excellence for staff in the home. The home manager told us these were being undertaken monthly and staff nominated their peers for the award. We saw evidence of nomination forms which identified positive feedback about staff. Examples of comments seen were, 'She genuinely goes that bit further when caring for the residents' and 'She delivers first class care and doesn't forget the little details'. This promoted positive attitudes to care delivery in the home.

Systems to monitor incident and accidents were inadequate. During the first two days of our inspection the home manager told us she had removed the records from a file to reorganise and they were currently on a chair in the office. Records indicated that four incidents had not been signed as reviewed by the home manager. We found evidence of a number of incident reports relating to people who used the service; however, these had been left on the desk with a number of other records. We could not see evidence that any analysis of the concerns had taken place or any actions taken to mitigate the risks. On the third day of our inspection we were shown an evidence file for incidents and accidents which included a brief summary of the concerns including some evidence of actions taken. However, we found a further incident report with a number of other records on a shelf in one of the offices and a second in a care file that had not been recorded in the daily communication sheets. There was no evidence of what actions had been taken following the accidents or an investigation into the circumstances surrounding them. Systems to ensure monitoring and evaluation of risks were inadequate.

We were shown an action plan for the home. There was some evidence of audits for nutritional observations; however, we saw some inconsistencies and gaps in other records. For example we saw there were pressure relief turn charts, accident and incident audits; however, none of these had been completed. There was a health and safety audit that had been completed in August 2015. There were details relating to actions taken and dates for them; however, these had not been completed in full. There was also a record named, 'Daily walk around' however, we saw only one had been completed and this was dated in March 2016.

During our inspection we looked in the manager's office as well as the offices located on each of the floors.

We saw the manager's office was chaotic and disorganised. Various records were seen on the floor and on the desk. The manager explained that she was going through documentation to update into new files since the home was transferred to new provider. This documentation was currently filed on a chair. We checked the files on display in the office and found a number of these contained new documentation; however, they were blank. It was impossible to establish effective systems for quality monitoring because when we asked for information such as safeguarding investigations, we were told these were located on the chair; however, when we checked we could not find them. On the third day of our inspection we checked the manager's office and saw that improvements had been made, records were filed away and there was evidence of monitoring on display for example, DoLS and supervision. However, the other two offices in the home were disorganised and had evidence of loose records in them. We saw records piled up on the floor in one of them and the other had various documents such as care plans, evaluations and MAR charts on a shelf as well as in a box on the floor with a television and door signage. We noted one of these rooms had no lock and the other was at times left unlocked. This would mean people had access to confidential information about people who used the service. Systems to ensure effective secure storage of records were inadequate.

We asked the home manager about how they received feedback from people living in the home and their relatives. There was an evidence file which had sample questionnaires for feedback from visitors, staff and people who used the service; however, these had not been completed. We were told that there were plans to obtain feedback from people but they were waiting for the forms to be delivered from the printers. We saw some completed feedback questionnaires; however, these had the details of the previous provider and had not been dated; therefore, we could not be confident when they had been completed. Systems to seek and act on feedback were ineffective.

We looked at the records relating to staff meetings. We saw records relating to a regional home managers meeting which included dates, attendees and topics covered for example; weekly reports, health and safety and impact audits. There were also minutes from a staff meetings dated January 2016, which included the names of attendees and topics covered. We looked at the content of the minutes recorded and noted concerns relating to reporting to the Commission and the impacts on the home and staff. There was also evidence of daily meetings taking place for heads of department at the home called 'Huddles'. The home manager told us this was to discuss topics such as infections, pressure sores, falls and planned appointments. We saw evidence of notes from March for topics discussed such as activities, and planned appointments.

We asked about relatives meetings. The homes manager told us she had organised a relatives meeting but that no one had attended. We were shown a letter that had been sent to people inviting them to a meeting; however, there was no evidence to confirm a meeting had been cancelled due to no one attending. Visitors to the home said they had not been able to attend the meetings due to the times of them.

We asked about staff supervision. Staff we spoke with gave mixed responses. People told us, "[Name of home manager] gave us all supervision cards with a date on". Staff were instructed to go to the home manager when due; however, staff reported that the home manager was unable to complete them as they were busy. Another told us, "I was supposed to do it a couple of months ago, I need to re book". We asked the home manager if spot checks over the weekend and nights took place. She told us she had stayed late on evening shifts to see night staff and had visited the home a couple of times at the weekend. They told us they had not completed any spot checks overnight since commencing employment with the home.

Following our inspection we asked the responsible person to provide us with an immediate action plan to identify how they would ensure concerns identified at the inspection would be resolved. We were provided

with details of immediate actions to be taken, and included time scales and who would take responsibility for ensuring concerns identified were resolved. We were told that senior management support would be provided in the home daily until actions were completed.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulations).

During our inspection we discussed the responsibility of the provider to notify the Commission relating to specific information such as deaths, serious injury or allegations of abuse. During our inspection we identified a number of concerns that required notification. However we saw these had not been sent to the Commission despite guidance in the regulations that they must be sent without delay. We asked the home manager to ensure that notifications were sent following our inspection. Following our inspection we received three notifications; however, there should have been a further seven. On our third day we again discussed the regulatory requirements for notifying the Commission without delay. Senior management completed the notifications and submitted them to the Commission.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Registration) Regulations 2014.

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 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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure service users care and treatment was appropriate and met their needs. Regulation 9. - (1)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The provider failed to ensure service users were treated with dignity and respect. Regulation 10. - (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to ensure service consent was obtained. Regulation 11. - (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to have suitably qualified and skilled staff to care for people using the service. Regulation 19. - (1)(b)