Akari Care Limited

Wordsworth House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Wordsworth House is a 'care home' which is registered to provide personal care and accommodation to up to 78 people in one adapted building across three floors. At the time of our inspection 47 people were living at the home.

People's experience of using this service and what we found
People were not always protected from the risk of harm. Infection prevention and control procedures did not always follow government guidance.

Systems were in place to safeguard people from the risk of abuse and a review of any accident or incident was completed. Medicines were administered to people as prescribed. There were enough staff on duty to meet people's needs and staff were recruited safely.

Quality monitoring systems had failed to identify the shortfalls in the infection control practices staff were using. Staff were positive about the management at the service and felt supported.

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

Rating at last inspection
The last rating for this service was good (published 7 February 2019).

Why we inspected
We undertook a targeted inspection as part of CQC's response to care homes with outbreaks of coronavirus. We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

We inspected and found there was a concern with infection prevention and control measures, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified one breach in relation to safe care and treatment at this inspection. In particular,

infection control practices.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well led.

Details are in our well led findings below.

Wordsworth House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors. One visited the location and reviewed evidence and the other inspector made calls to relatives.

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We contacted the service the day before our to announce our inspection visit.

What we did before the inspection
We reviewed information we held about the service, including the statutory notifications we had received from the provider. Statutory notifications are changes, events or incidents the provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams to request feedback. We also requested feedback from the local infection prevention and control team.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with the relatives of five people who used the service about their experience of the care provided and observed staff interactions with people. We spoke with six members of staff including the registered manager and regional manager.

We reviewed a range of records. This included care records for five people. We looked at recruitment records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We contacted a further 15 members of staff by email to request their feedback about the service and received six responses. We spoke with a health professional to share details of our inspection observations.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Preventing and controlling infection
• Staff did not always follow the correct procedure for wearing and removing Personal Protective Equipment (PPE). On the first day of the inspection staff were observed to provide direct support to people, such as support with moving and handling without wearing the appropriate PPE in line with government guidance.
• Equipment used to support people was not always cleaned in between use. For example, on the first day of the inspection we observed staff to use hoisting equipment without sanitising it after its use.
• The home was clean and tidy and had no malodours. However, there were recording gaps in some of the home's cleaning schedules. Therefore, we could not be assured cleaning was always taking place in line with the requirements identified by the provider.
• PPE was not stored appropriately around the service. PPE was not kept in any form of container at PPE stations which meant they were at risk of contamination. The provider responded to this feedback and PPE was stored appropriately on the second day of the inspection.

The provider's failure to ensure infection control policies and procedures were followed by staff was a breach of regulation 12(1)(2)(h) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The registered manager responded to our concerns in response to the infection prevention and control practices of staff. Action had been taken to address this with the staff team and practice had improved on the second day of our inspection.

Assessing risk, safety monitoring and management
• Risk assessments were in place for people. They had been reviewed and updated when a change in need was identified. Specific risk assessments had been completed for people in relation to Covid-19.
•. Personal emergency evacuation plans (PEEP's) were in place. They detailed the support people would require in the event of an emergency.
• Premises checks had been completed to help ensure the safety of the building.

Staffing and recruitment
• Procedures were in place to ensure staff were recruited safely. Records in staff recruitment files were well organised.
• There were enough staff deployed to meet the needs of people. We received some feedback from staff of night staff not always following risk assessments when they supported people with moving and handling tasks. We brought this to the attention of the registered manager who took immediate action to address this

issue with staff.
• Staff understood the needs of the people they supported and relatives provided positive feedback. One relative said, "I am extremely happy with the support [name] gets as they [staff] have got to know her well.

Systems and processes to safeguard people from the risk of abuse
• Systems were in place to safeguard people from the risk of abuse.
• Staff understood their role in how to protect people and told us they would be confident to raise any concerns if they suspected any form of abuse. One staff said, "I have no concerns about being confident in raising a safeguarding. It is one of our duty of care to protect people."

Using medicines safely
• Systems were in place to ensure medicines were managed safely.
• Protocols were in place for people who required medicines as required and records for medicine administrations were accurate.

Learning lessons when things go wrong
• Systems were in place to review accidents or incidents. Accidents and incidents were reviewed to identify if there were any trends or if lessons could be learned and improvement actions taken to minimise future risks.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as good. At this inspection this key question has deteriorated to requires improvement. This meant the service management and leadership was sometimes inconsistent.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- A range of quality assurance audits were completed. They had not identified the issues we found in relation to the infection prevention and control practices within the home.
- The provider was responsive to our feedback and immediate action was taken to address our concerns. This included staff completing a quiz about infection prevention and control. Additional support and training would be provided for any member of staff where there were gaps in their knowledge.
- Action plans were developed to address any areas across the service where improvements were required.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The management team were aware of their regulatory responsibilities. Any statutory notifications the provider was required to submit to CQC had been done in a timely way.

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

- Systems were in place for the review of incidents. This enabled staff to reflect on their practice to identify if anything could have been done differently to improve practice.
- Non-essential visits had been suspended due to the Covid-19 pandemic. Systems were in place to support people to maintain contact with their relatives. This included garden and window visits, video and phone calls. The provider was assessing options for how to introduce indoor visits in line with government guidance.
- The home had received infection control support and guidance from external health professionals. The provider and registered manager were committed to ensuring staff always worked following best practice guidelines and government guidance.
- Positive feedback had been received by the provider in response to a tea dance organised by the regional manager. This event was a huge success and raised a considerable amount of money for charity.
- Staff and relatives were positive about the management of the home. One relative said, "[Name of registered manager] is tops, the communication has been good from what I have seen." A member of staff said, "I feel like the team at Wordsworth house support each other in every way possible, including management."

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Infections prevention and control procedures were not robust. Regulation 12, (1)(2)(h)

The enforcement action we took:

We issued a warning notice.