Akari Care Limited

Wordsworth House

Inspection report

Clayton Road
Jesmond
Newcastle upon Tyne
Tyne and Wear
NE2 1TL

Tel: 01912121888

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 16 January 2018 and was unannounced. We also inspected on 31 January 2017 and 2 February 2018 which were announced.

We last inspected Wordsworth House on 23 and 25 August 2017 and found the provider had breached a number of regulations we inspected against. We rated the location inadequate, placing it in special measures and imposed a condition to prevent admissions. Specifically the provider had breached Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically, care and treatment was not provided in a safe way. The provider had failed to assess risks to the health and safety of people and failed to do all that was reasonably practicable to mitigate such risks.

There was a failure to ensure staff providing care or treatment had the qualifications and competence to do so safely. There was a failure to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed in order to meet people's needs and that staff received appropriate support, training, professional development, supervision and appraisal.

The premises and equipment were not safe to use for its intended purpose. And the provider had failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. At this inspection we found that improvements had been made

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

Wordsworth House can accommodate 78 people in one adapted building across three floors. At the time of the inspection 52 people were using the service, some of whom were living with a dementia.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures. The service has been rated requires improvement overall as there are still improvements to be made. Systems and processes needed to be embedded to ensure consistent good practice over time

The service did not have a registered manager. The current manager had been in post since October 2017 and had made an application to register 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.

The head of business improvement was driving improvements alongside the manager and a peripatetic support team which included a support manager, team leader and clinical lead. Everyone we spoke with had confidence in the manager to continue to make improvements and ensure stability within the service. However some relatives and staff were concerned over the when the peripatetic support team would be pulled out of Wordsworth House. We received assurances that although this would happen it would not be instant and measures would be in place to ensure appropriate monitoring continued.

Care plans had improved, however we found some further improvements were needed to ensure consistency and relevance when people's needs changed. Where risks had been identified assessments had been completed and measures were in place to minimise and manage the risk.

The management team identified training as being an area where further improvement was needed. Not all staff had attended training identified as mandatory by the provider. A training plan was in place for the whole of 2018 which was being implemented. Senior care staff and nursing staff were attending additional training to develop and enhance their clinical skills and knowledge.

Team meetings were held, however minutes were not always available. Resident and relatives' meetings were monthly and the minutes were shared following the meetings. Relatives were particularly positive about this meeting as it had provided them with regular updates on actions being taken and improvements made.

Personal emergency evacuation plans were in place and detailed the support people would need in the event of an evacuation. Staff had completed competency assessments in relation to fire safety and evacuation. Where appropriate some people had also completed an assessment to support them to evacuate safely should the need arise.

The nurse call sounder had been repaired. A handyman was based at Wordsworth House and was responsible for day to day repairs and maintenance. Specialised equipment, such as hoists and slings had been increased and renewed.

Health and safety checks had been completed and all staff had been trained in how to check bed rails to ensure they were safe. Bed rail risk assessments were in place and were regularly reviewed and evaluated.

People's nutritional and hydration needs were being met. Where risks had been identified support was sought form external professionals, their guidance was being followed and monitoring was in place.

People, relatives and staff commented that they thought there were enough staff to meet people's needs. Some staff commented that at busy times like lunch time additional staffing was needed. Safe recruitment practices were followed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Medicines were administered safely, audits had identified that some improvements were needed in relation to the management of medicines. A new system was being introduced which staff had attended training on.

Safeguarding concerns, complaints, accidents and incidents were all recorded, investigated and analysed. Lessons had been learnt and improvements made, for example to increase staff knowledge and competency, ensure documentation was more effective and provide additional equipment. Appropriate

procedures had been followed in relation to staff performance were relevant.

Governance and quality assurance systems had been introduced and were being used effectively to drive improvements.

We found care staff had warm, caring relationships with people and people were treated with dignity and respect. People told us they felt safe and well cared for.
Within our last inspection report we said that two service users had sustained serious injury at Wordsworth House and the incidents were subject to a criminal investigation. Since the inspection report was published we have concluded our review of the incidents and have closed our enquiries with no further action.

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 safe.

Improvements since the last inspection needed to be embedded to ensure consistent good practice over time.

Improvements had been made to managing the safety of the premises and equipment.

Where risks had been identified they had been assessed and management plans put in place to reduce the risk.

People, relatives and staff were positive about staffing levels and the reduced use of agency staff.

Some improvements had been identified by the provider in relation to medicines management and a new system was being introduced.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had not yet attended all the training deemed mandatory by the provider. A training plan was in place and individual development plans were being produced for each staff member.

Staff said they felt well supported and had attended supervision. Plans were in place to further improve the supervision process.

People's nutrition and hydration needs were met and people had access to healthcare professionals.

Is the service caring?

Good

The service was caring.

People and relatives were complimentary about the care and support they received. People acknowledged that improvements had been made and that they were treated with dignity and respect.

We observed warm and engaging relationships between people, staff and relatives.

People and relatives were included in making decisions about their care and support. They were also encouraged to share their view on the service and any improvements that had been made or were still needed.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements had been made to care documentation however we found some discrepancies.

A range of activities were offered and the activities co-ordinators had won the Great British Care Awards regional finals 2017 for The Care Home Activities Co-ordinator Award.

Improvements had been made to the management of complaints, outcomes were logged and lessons were learnt.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Significant improvements had been made and governance and audit systems introduced. Time was needed to embed the new systems and processes to ensure good quality care and support could be sustained over time.

Everyone we spoke with felt there had been significant improvements since the last inspection. They felt there was appropriate leadership and that Wordsworth House was well managed.

It was acknowledged by the management team that some improvements were still needed. Plans were in place to ensure progress continued.

Wordsworth House

Detailed findings

Background to this inspection

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

This inspection took place on 16 January 2018 and was unannounced. This meant the provider did not know we would be visiting. Further days of inspection took place on 31 January 2018 and 2 February 2018 which were announced.

The inspection team was made up of one adult social care inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about.

We contacted the local authority commissioning team, CCG and the safeguarding adults team. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with 15 people living at the service and eight relatives. We spoke with the manager, the peripatetic support team including a support manager, clinical lead and team leader. We spoke with the head of business improvement and the provider's chief operating officer. We also spoke with seven care staff, including seniors, three nurses, the activities co-ordinator, the head cook, and one domestic.

We looked at care records for eight people and medicine records for one floor. We reviewed six staff files including recruitment, supervision and training information. We also looked at files for the qualified nursing staff and reviewed records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

During the last inspection on 23 and 25 August 2017 we found breaches in regulations. Health and safety had not been appropriately managed, for example a nurse call bell system was not sounding and personal emergency evacuation plans (PEEPs) were not in place for everyone. We found concerns in relation to the management of bed safety and some specific risk assessments relating to individual needs were not in place.

Everyone we spoke with had raised concerns about staffing levels and we observed there were periods of time when staff were not present and inspectors had to find staff to respond to people's needs. We also made a recommendation about the management of medicines.

During this inspection we found improvements had been made and were ongoing. Due to the need for sustained improvement and the ongoing improvements in areas such as medicines management the safe domain has been rated requires improvement.

Personal emergency evacuation plans (PEEPs) had been updated and reflected people's needs in relation to safe evacuation. Fire drills had been completed, and staff complimented on their response. Staff had completed questionnaires to assess their knowledge and understanding of fire procedures. A version of this had also been completed with some people who had capacity to understand the evacuation process so they were aware of the plan that was in place.

Since we last inspected an occupational therapist had assessed each person who used specialist equipment or who had been assessed as needing mobility support. New equipment like wheelchairs, hoists, slide sheets and specialist seating had been ordered. One staff member said, "We have two hoists downstairs now, it's had a massive impact, it's a good help."

A health and safety audit had been completed to ensure all appropriate equipment and premises checks were in place and appropriate. For example, the electrical installation condition report and gas safety check were all in date.

Risk assessments were in place in relation to choking, moving and handling, the use of wheel chair lap belts, shower chair lap belts and falls. Recognised tools were used to assess the risks in relation to nutrition and hydration and skin integrity. For people who had specific risks related to their diagnosis, for example epilepsy, risk assessments were in place in relation to seizures and bathing. Triggers had been identified and there were clear pathways for staff to follow in relation to the required support. We saw one person was prescribed rescue medicine. However none of the staff had attended the required training to allow them to administer the medicine. The GP had been contacted and a protocol put in place. We asked for this to be reviewed as it still required the staff at Wordsworth House to administer the medicine. On reviewing the epilepsy monitoring chart we found the person had not had experienced seizures which required the use of rescue medicine.

We asked staff, people and visitors about safety and staffing levels. Everyone we spoke with said they felt safe, relatives also confirmed this was the case. One person said, "Oh, I'm safe here, there's always someone to help you or they pop their head into my room and have a chat when they're passing, it's nice to know there's someone there if you need something." Another person said, "This is a nice place, they're a dedicated squad of people." One staff member said, "They (agency staff) unsettle people so we only use them to cover training or sickness. It's nothing like it was; the regular staff will pick up extra shifts now. It's definitely a happier home!" One person said, "I'm adequately looked after, just what I need but sometimes they seem a little under-staffed." People told us that staff were always present, and if they needed support they pressed the nurse call and staff came quickly. Staff told us that following the last inspection the nurse call had been repaired. One staff member said, "The alarm call is much better! Everyone answers the buzzer, even the domestics will go to see what people need and then tell us." We checked the nurse call bell was working and observed that staff responded to calls in a timely manner. Some staff commented that additional support was needed at key times during the day such as meal times. We raised this and the chief operating officer said, "The nurses and seniors should be supporting at meal times. We'll address it."

The clinical lead said, "We have 12 – 14 staff a day and could probably manage with less given the current occupancy. There are two nurses on shift and a senior on each floor." A dependency tool was completed on a monthly basis to assess people's needs and this was used to calculate the staffing levels required. We saw rota's matched with the dependency tool. Agency staff were used occasionally but this had significantly reduced since the last inspection.

There had been several staff members recruited since the last inspection and we saw all necessary pre-employment checks were completed. This included two references and a Disclosure and Barring Service (DBS) check. DBS checks help employers make safer recruitment decisions as they are used to complete a criminal record and barring check on individual who intend to work with children and vulnerable adults. Systems were in place to ensure DBS checks were renewed every three years. Nurse PIN checks were completed monthly to ensure their registration was up to date and appropriate.

During the last inspection we recommended the provider explore appropriate guidance in relation to medicine management. During this inspection we were told that the electronic system for medicine administration was due to change to a paper based system. Staff had attended training and the next round of monthly medicines had been ordered. One senior carer said, "Ordering stock wasn't always easy or accurate, we are going back to paper MARs (medicine administration records) which I think is better." A nurse said, "The new system feels more dependable as machines can malfunction. We've had a day's training and there's on line training to be done too." They went on to say, "The (peripatetic) clinical lead has revolutionised the treatment room, basic admin has been put in place, she's supported us all, she's a tremendous support."

People said they received their medicines regularly and on time and that the staff gave them their medicines with a drink and watched them take it. We observed this to be the case. Staff explained why people needed their medicines and why they were staying with the person whilst they took their medicines. One person said, "I now take painkillers as I need them. I'm alright at the minute but if the pain comes back I just tell one of the girls and they'll get me what I need."

A staff member showed us the procedure they were required to follow which involved scanning the medicines, administering them and then updating the medicine administration record. Protocols were in place for 'as and when required medicines and medicine care plans were being reviewed and rewritten by the peripatetic team leader. We asked about covert medicine. A staff member said, "We had involvement from the GP, the person and their family and it was all agreed in the persons best interest. I need to contact

the pharmacy though as we've been sent a different brand so I need to check to make sure we can still crush it."

The clinical lead explained they had been in post for five weeks and were completing clinical supervisions with the nursing staff and doing their medicine competencies. Care staff said, "The clinical lead is brilliant, they've changed a lot of things and we are doing it by the book. They are drumming it into staff about PPE (personal protective equipment). They want it right. They had a fit when they saw the treatment room but it got sorted. They are straight and to the point."

Medicines audits were completed. It had been identified by the head of business improvement that they were not always used effectively to identify areas where improvements were needed. The most recent audit had identified areas to improve. For example, a full check of controlled drugs was needed and there was no evidence of GPs being contacted if medicines had been refused on three consecutive occasions. All the actions had been transferred to the home improvement plan.

The recording and investigating of safeguarding concerns had improved since the last inspection. Outcomes were documented and lessons learnt were recorded such as changes in people's needs leading to new care plans, liaison with external healthcare professionals, and the purchasing of new or additional equipment. Outcomes had been shared with relatives and where appropriate the view of people and their relatives on required action was taken into consideration. Some safeguarding concerns had led to investigations into staff conduct and disciplinary procedures had been followed.

Accidents and incidents were logged and an accident trend analysis completed monthly. The manager explained that the analysis of accidents and incidents looked back over time, as well as looking at the number of falls that month. Action had been taken in light of findings from the monthly analysis including liaison with occupational therapy and sourcing a light beam sensor for one person who was known to actively avoid stepping on the sensor mat.

We spoke with staff about lessons learnt and what improvements had been made. The clinical lead said, "We are getting over issues, the morale has lifted a lot and the improvement development team is in place."

The peripatetic support manager said, "Having the clinical lead is fantastic, they are working with the staff team. Staff are on board and want to make the changes." The peripatetic team leader said, "It's very much improved, not as quick as I would like it to but we are getting there."

A staff member said, "There are massive improvements. The support has been great which is a massive help. We are working with them (management)." They explained some of the improvements as being, "Paperwork, we have new paperwork which helps us, the daily log is brilliant. We were given it to try and to see if it works." They added, "All daily records are on the one sheet for 24 hours which works well. We have a new monthly weights page so it's personalised. Care plans are better, there are improvements but we're not there yet."

We spoke with the manager specifically about lessons learnt following safeguarding concerns or incidents. They said, "There's so much. In relation to bed rails staff have had training in how to check the rails and ensure the heights are appropriate. They have physically been shown how to do it. We've learnt that even if allegations are not upheld lessons can be learnt such as not leaving agency staff alone so we need to ensure a permanent member of staff doubles up with them. We have put risk assessments in place in relation to hot water, hot drinks, and hot meals with NICE guidance attached on every floor. Staff are aware of checking food temperature and first aid training has been booked for all staff." The National Institute for Health and

Care Excellence (NICE) provides national guidance and advice to improve health and social care.

We spoke with the manager about behaviour which challenges. The manager said, "There's no real behaviour that's challenging, it's quite low level and manageable. We can comfortably meet people's needs." We saw one person had a support plan in relation to behaviour. It detailed all the triggers that caused the person to be distressed, and everything that should be done to prevent the triggers occurring. There was no information on what behaviour the person displayed or how to distract the person if they were distressed. We raised this with the senior and the support manager. The senior was able to share all this information with us, so clearly knew the person and their needs but acknowledged it needed to be documented. The support manager said, "Yes, I see what you mean, we will have a meeting tomorrow and update it."

All areas of the home were clean, pleasant and homely. We saw domestic staff were present and were continuously cleaning areas of the home. Some areas had been recently decorated and the top floor refurbishment was scheduled to start. A bathroom and separate toilet on the middle floor was also being renovated and a new specialist bath installed.

Infection control policies were available on all floors and included information on who to contact should there be an outbreak. Hand washing guidance was displayed in all toilets and hand sanitising gel was available on all floors.

Requires Improvement

Is the service effective?

Our findings

During the last inspection on 23 and 25 August 2017 we found breaches in regulation in relation to food and fluid monitoring and a lack of action to reduce the risk of dehydration. Staff had not attended relevant training, nor had they received regular supervision and support. Agency staff did not always have the competencies needed to meet people's assessed needs.

During this inspection we found some improvements had been made. Training was acknowledged by the provider to be an area that required further improvements, which is reflected in the rating.

The manager said, "We still need to improve in things like training, the matrix is basic but we have a training plan. We need a useable system that will flag when people's training is due. Staff are being booked on training now as we have enough staff to be able to free them up to do it." This view was shared by the head of business improvement. The manager also said, "The staff feel valued now, Akari is investing in them and providing face to face training. All care staff once they are through their probation are completing NVQ level two and all the seniors have level three."

The training matrix showed that staff had attended moving and handling training and fire safety. The nurses had updated their training on nutrition and hydration, catheter care and medicines. Training was still needed in relation to areas deemed mandatory by the provider, however a training plan was in place which included care planning, communication and documentation, end of life care, challenging behaviour, falls management, safeguarding, mental capacity and Deprivation of Liberty Safeguards (DoLS).

Monthly quizzes had been completed by the staff to assess knowledge in relation to areas such as the organisation, mental capacity, safeguarding, CQC and infection control. Development plans were being introduced for each staff member so there was a summary of their training needs and information on when training needed to be refreshed.

People said they thought staff had the necessary skills to provide the support they needed. One person said, "They have the skills they need to care for me, I'm hoisted all the time and they offer reassurances and explain what's happening, they make me feel safe." One staff member said, "There's constant training. It's good and there's a competency test. Moving and handling was brilliant, it's the best I've ever done!" Another staff member said, "I'm doing my NVQ." It was explained that training was held morning and afternoon so it encouraged staff to attend, and then the same training was repeated a couple of weeks later to ensure all the staff had attended. One senior said, "I wouldn't mind doing some refresher training on care plans and risk assessments." We saw this was already scheduled.

The peripatetic clinical lead had introduced clinical supervision and clinical competency checks for all nursing staff. The first clinical supervision had been held in December 2017 and included medicine administration and covert medicines. Competencies had been assessed on medicines management and pulse, temperature and blood pressure checks. They had only recently been employed and said their induction included, "Policy and procedure, reports and action plans." They explained it was being, "Led by

the team. My role is to support the work to get done. It's a new role for Akari as I'm the clinical lead for the organisation." They added, "We have two seniors completing their CHAPs training. My role will include supporting them but they are still in the middle of training." CHAPs are assistant practitioners who have additional training and experience in clinical areas to support and work alongside qualified healthcare professionals. A senior who was enrolled on this course, said, "It's really good, I'm enjoying it, we've learnt about diabetes, medicines, wound care, bloods, we'll be doing blood pressures as well." A nurse said, "This will increase the welfare of people as seniors will be able to take blood pressures and support the nurses. It gives confidence and authority. We should be working side by side." Another nurse said they were completing a ten week clinical training course. They said, "It's updating knowledge on venepuncture, PEG feeding and medicines competency. It's good, really valuable."

A senior said, "[Manager] is supportive, so is [support manager] you can go to either of them to ask questions, share problems and you get help." A supervision and appraisal plan was in place to ensure staff attended four supervisions a year. It had been recognised that this was not going to be effective so was being re-worked. The plan was for nurses and senior care staff, once confident and competent, to take over the supervision of care staff. The peripatetic support manager had completed one supervision with each staff member so they could get to know them and identify any concerns. They told us, "Some staff have raised concerns about being supervised by other staff which is fine as they need to be comfortable to be open with their supervisor. We are looking at training and competency for the supervisors as well." They added, "We are also doing direct observations, sometimes when staff don't know they are being observed, and providing feedback, both positive and negative." Care staff said they had supervision meetings with the peripatetic support manager and that they felt well supported.

People's needs and choices were appropriately assessed and care and support was provided in line with current guidance. Staff had access to policies and procedures, and NICE guidance was used to provide staff with additional information to support them to deliver appropriate care and support.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Mental capacity assessments had been completed for specific decisions, for example in relation to the use of wheel chair lap belts. Where it had been assessed that people lacked capacity best interest decisions had been made which included the person and any significant family or friends as well as health care professionals if appropriate. We saw there was conflicting information for one person in relation to decision making and it was identified, through discussion that they had fluctuating capacity. The management team agreed that the information needed to be clarified and reassured us it would be addressed.

People and relatives said they were involved in their care and that they had access to various health care professionals such as podiatry, GP, opticians and dentists as well as specialists such as speech and

language therapy, occupational therapy and behavioural support professionals. One person said, "If I need to go to hospital someone from here always comes with me and stays with me for the appointment, if you need your nails cut you just mention it and they organise it for you. It's all very good." A care home nurse specialist visited the home on a regular basis to work with the peripatetic clinical lead and nursing staff to assess people who staff had a concern about.

One relative raised concerns about the provision of nail and hand care as their family member's hands were contracted which meant movement was restricted. A detailed care plan was in place for gentle massage and exercise for the person's hands. The care plan referenced nail care but the plan of how this should be provided was not specific. We raised this with the management team and they said they would look into how specialised nail care could be provided.

All the required information in relation to people's dietary needs was available on a white board in the kitchen, on handover sheets and in care records. We saw detailed care plans were in place which referenced the advice from dieticians or speech and language therapy. Food and fluid intake was recorded where required and reference was made in the handover meeting in relation to people's nutrition and hydration.

The head chef said, "I have a whiteboard with everyone's preferences and dietary needs, we also have diet notification sheets in place and the staff on the floor know to inform the kitchen of any changes." We asked if they provided molded food for people who required their meals to be pureed. They said, "No not yet but we are going to see if we can go on the course." We spoke with the chief operating officer about this who said, "Yes, it's being organised for them to do it."

People said they had a choice of meals and if the menu was not to their liking there were other options available. People said the food was good. One person said, "The cook is excellent and will do what you want, at lunch time we have the choice of two hot meals and at tea time we can chose either a hot or cold meal." People told us the puddings were tasty particularly the fruit pie and the crumble. They also said a choice of yoghurts and fruit were available. One person told us, "It's noted for food and fluid intake for monitoring in case people don't each much lunch." The staff member present said, "Yes we need to make sure the paperwork is done."

A relative said, "My [family member] now needs support with meals and feeds, I need reassurance that if [family member] is hungry staff have time to support them." We reviewed this person's care records and found a detailed care plan about their dietary needs and the support staff were to provide with meals. We raised with the management team that some relatives were seeking assurances about staff time and the support being offered to people. They said they would speak with the staff team and relatives.

Akari stars, which acknowledged good practice and achievements, had been given to the kitchen staff following compliments about the food, the completion of audits and the actions that were implemented to improve things. The manager said, "You can't fault [head cooks] approach."

We looked at how staff were working together to deliver care and support. The peripatetic support manager said, "I've been in post since October. I'm enjoying it; I can see we are making a difference. The people we support are amazing." They explained their role involved working on the floor to mentor and coach staff. They said, "I work alongside staff and include this in supervision. I'm looking at change but I need to experience it on the floor. The staff culture has changed. When I started I observed staff disappear when I was on the floor, I shared the findings in the team meetings and the approach of staff has changed."

The peripatetic team leader said, "My role is to audit care files. I didn't know people so I worked alongside

the staff to identify the improvements that were needed. I've now revisited audits and am suggesting where care plans are needed and where additional information can be added. For example, I've reviewed people's health needs from the initial assessment and I'm making sure the care plans reflect the person's health needs. If there's deterioration or a change in need it means a new care plan. I've also looked at skin integrity assessments to see if any referrals are needed."

They also explained how their work day commenced early so they could see the night shift and complete a walk around to see how people were and what had happened overnight. They used this as an opportunity to model good practice in terms of action they could take so staff could see a different and effective way of working. This information was then handed over to the support manager who went onto the floor to ensure action had been taken to address any concerns.

An example given was that night staff had discussed one person who was not sleeping and had suggested they needed to look at medicines. The peripatetic team leader had suggested looking at an evening routine after tea to prepare the person for bed so they knew it was night time. This was then written up as a care plan which was working well for the person.

We observed the morning handover and found this to be detailed and effective in sharing relevant information about people's health and well-being and any changes to their needs. Discussions also took place in relation to monitoring people, ensuring food and fluid intake and following up any concerns with doctors and dentists.

We looked at how the environment was meeting people's needs. An area on the first floor had recently been refurbished into a bistro area. People used this area for coffee mornings and birthdays or to meet privately with family and friends.

One person said, "I'm moving rooms." This was said with a huge smile on their face and we were able to see how happy this had made them. It was explained that the move was being made to ensure the person's needs were appropriately met. Another person had met with the handyman to design some shelving for their room which would also accommodate their mobility needs as they were a wheelchair user. The manager said, "Having a handyman on site who fixes things straight away is great."

A refurbishment plan was in place for one floor. Relatives told us they had been part of the decision making, along with the people living on that floor, in relation to the décor and flooring. The plan was that the refurbishment would increase the level of orientation and stimulation for people living with a dementia. The work was due to start the Monday after the inspection.

Good

Is the service caring?

Our findings

People and relatives told us they were happy with the staff at Wordsworth House. People confirmed that staff listened to them and they were treated with dignity and respect. People said, "The staff are very good, they're very friendly, helpful and kind and, on the whole, everything works pretty good." Another person said, "The care is as good as you get in hospital, if you need it you get it, they go out of their way to do the best they can." We were also told, "It's all okay here, you get really well looked after." People also told us, "I'm happy here, I've been here years and I like it," and "The staff are excellent, we are treated kindly and with respect. A lot are like friends. Nothings too much trouble, what I want I can ask for." They added, "The carers felt they were being marked down and weren't sure how to put things right but they seem a lot happier now, they know what they need to do and we can see improvements." Another person said, "It's my first choice, all the staff are very good and a lot are excellent." A relative said, "There's a better atmosphere, it's getting more positive. [Activities co-ordinator] is a gem and is on the side of the people. The care staff have hearts of gold."

People and their relatives told us they were involved in making decisions about their care and treatment. One relative said, "I'm impressed by the quality of care on the top floor. It's not medical or nursing care it's caring care, a caring approach, touch is very important." They went on to say, "Care plans have been updated, agreed and I've approved them. I have lasting power of attorney. I'm very happy with [family member's] care plans." Where possible people had signed to say they agreed with their plan of care and we saw review meetings had been held and attended by the person and their family if appropriate.

We observed good rapport between people and staff and staff were aware of the individual needs of the people they were caring for. People who required support with eating their meals or with personal care were treated with sensitivity and respect. We saw dining areas provided people with a calm environment; people were offered a choice of hot and cold drinks and were supported with decision making. People were asked what they would like for lunch and what portion size they would like. Staff changed the portion size for one person several times until they got it right for them. We observed people who required support to eat their meal were supported on a one to one basis and were not rushed. Staff sat with people chatting and laughing during the meal time, ensuring they were enjoying their food.

Pictorial menus were on display but it had been recognised that improvements were needed. A plan was in place to take photos of the actual meals served and add a written description added to them before they were laminated and used as the menu.

The activities co-ordinator told us they were also the dignity champion for the home. They said, "I speak to staff about the use of certain words such as 'wanderer' and explain if it should be used. I did a session for relatives on dementia awareness and suggested they write down memories of people so it can be used for reminiscence."

Staff told us about one person who did not speak English as a first language and had limited communication with staff. A staff member said she used her phone to verbally translate to the person's first

language so they had a way to communicate. The head of business improvement, said, "I'm learning a little bit of (persons first language) so we can speak, you want to see her face when I go over, full of smiles and laughter."

A regular coffee morning was held which people attended regularly. The usual staff member was unable to attend and people were able to ask why and were answered appropriately. People explained it was an opportunity for a catch up with friends but also to raise any concerns. One person told us, "It's nice to see old friends and chat to people." They added, "They look after me well, I'm comfortable here." Another person explained that there had been a residents' meeting held the night before. They said, "It wasn't relevant to me as I didn't know the agenda." They added, "We can add to the agenda but I must have missed the notice on the wall. There was an update on CQC, the minutes are shared and people are free to speak up."

People were encouraged and motivated to be as independent as possible when support was provided and this was reflected within care plans. The activities co-ordinator said, "It's my role to keep people able-bodied for as long as possible, keep them using their walker and maintaining independence."

The peripatetic team leader said, "I enjoy coming in, everyone's nice and it's about the people and making a difference. [Head of business improvement] rolls her sleeves up, we can plan solutions and they listen to you. No one is frightened of hard work to change things. We are working as a team."

Requires Improvement

Is the service responsive?

Our findings

During the last inspection on 23 and 25 August 2017 we found breaches in regulations. Care records did not provide staff with the level of detail needed to support people safely and appropriately.

During this inspection we found improvements had been made, however systems and processes for ensuring the accuracy and updates of care plans needed to be embedded. People said they were well cared for and the care they received was appropriate to meet their individual needs. People and their relatives also said they were involved in their care.

A peripatetic team leader had lead responsibility for the auditing and improvement of care records. They explained that nursing and senior care staff were now beginning to identify when care plans needed to be developed or updated. They said, "The nurses are involved in care planning. [Nurse] will review them or ask me to review them. They do the clinical aspects of the care plan." A nurse said, "[Peripatetic team leader] has guided with care plans and safety, (ensuring we are) responding to changes. They are now tailor made to each person. It's improved skills in auditing and spotting detail to ensure the information links together so safety and welfare improves."

We found one person's care records had a contradiction in relation to the size of the sling that needed to be used when the person was being transferred in the hoist. There was also some confusion in the care records around the person's decision making capacity in relation to the use of a wheelchair lap belt. Another person had a care plan which stated they were nursed in bed. This had been evaluated regularly and one evaluation stated that they 'attended the day room.' Further care plans detailed how the person was to be supported to spend time in their specialist chair, with pressure relieving equipment. We spoke with the staff who said, "You won't believe the difference in [person], they are out of bed, laughing and joking, singing, they love their therapy doll." We saw this to be the case and requested the care file be reviewed in relation to documentation about the person being nursed in bed.

Other care plans were detailed and personalised, they described how people wanted to be supported as well as how they needed to be supported. For example, care plans in relation to the management of epilepsy were detailed and contained information on triggers, how to identify if the person was about to experience a seizure, how to monitor and how to support the person afterwards.

If people needed support with positional changes to maintain their skin integrity the frequency was recorded and monitoring charts were in place to show that people had been re-positioned. Detailed plans were in place to ensure people's needs were met in relation to nutrition and hydration. Monitoring charts ensured relevant information was recorded and any concerns were shared in the daily handovers so appropriate action could be taken.

Staff had identified in handover that one person had been unsettled over a period of nights and was not sleeping. The GP had prescribed sleeping tablets which had resulted in the person being tired during the day but had no impact at night. The peripatetic support manager had discussed the person's night time routine

with the staff team and had identified that there was no routine. Together with the person, their family and care staff a night time routine care plan had been developed. When this was followed consistently it was found that the persons sleep pattern had greatly improved.

Social assessments were completed which included information on people's life history, including people who were important to them, their work history, achievements and important life events. This information was particularly valuable in forming relationships with people and in ensuring activities were relevant to people's hobbies and interests. The activities co-ordinator said, "The domestics interact with (person) who loves to dust. They were an ex housekeeper so they have their old name badge in their memory box." They also said there was a professional singer who was now a member of the choir. They said, "They have the voice of an angel."

People said they received a weekly sheet which listed all the daily activities so they were free to choose whether to take part or not. They also told us the gardens were nice to spend time in during the summer. One person said, "There's a list of activities every week. [Activities co-ordinator] is excellent. We won an award." This was in reference to being winners of the regional Great British Care Awards 2017 for The Care Home Activities Co-ordinator Award. The judges stated, '[Activities co-ordinators] make a real difference, they are connected to both the physical and emotional needs of their residents in the activities they provide, they do some inspirational activities that brought a tear to the judges eyes.'

One person said, "75 children came in at Christmas." The staff member explained this was to sing Christmas Carols. They added," [Name of school] wants to join up with us and share some things, maybe a small orchestra." We observed there were several activities each day such as chair exercises and prize bingo, as well as one to one support with hand massage and manicures. One person said, "I enjoy bingo but I can't see very well so [activities coordinator] helps to mark my card." A relative said, "[Family member] enjoys art and knitting and [activities coordinator] supports her to do these things." One person did mention that they would like it if there was more opportunity for days out as these had not been offered recently. Another person said, "I like to get out so when the weather is ok [activities co-ordinator] will take me out, maybe around the exhibition park. He's hoping to get a mini bus so a few of us can go out on trips."

The activities co-ordinator said, "I need to stimulate people's physical and mental wellbeing and prevent social isolation. It's about person centred care for the resident. People are invited to activities but not forced to attend. I like to do bubble therapy (blowing bubbles) and doll therapy as it provides stimulation." They also spoke about the benefits of providing physical stimulation and chair exercises. Other activities included PAT dogs, therapy ponies, arts and crafts. One person was an artist and was designing a 'talk to me poster' as they wanted people to acknowledge that as a wheelchair user they still had a voice.

People said they could have visitors at any time and that the bistro area was a nice place to meet. One relative said, "A few months ago I brought my Northumbrian pipes in and mum made some Northumbrian cakes, [activities coordinator] got out some little plates and serviettes and we had a lovely half hour. [Family member] said it was the first time he had seen some of the residents tapping their fingers or feet to music. We are going to do it again in a few weeks."

One of the domestic staff said, "I come in in my own time, or stay behind and play my guitar and sing for people. I ask them what music they like so I can learn it for them. They are harsh critics! I love it; I absolutely love seeing the smile on people's faces. It's calming for people with dementia, it meets their sensory needs and they enjoy old time songs." A member of the care team had learnt that one person enjoyed Bollywood films so they were going to bring in sari's for the person to look at and touch. We also saw them engage the person in some Bollywood dancing at which the person instantly smiled and their eyes lit up with

enjoyment. The chapel area was also used and people and relatives said it was a really nice and peaceful place to go.

We spoke with people and relatives about the management of complaints. One person said, "I've got no complaints and I speak as I find." Some concerns were raised with us during the inspection. On discussion with the management team we were able to confirm that some of these concerns were historical and appropriate action had been taken to resolve them. A relative said, "The office staff are very good. I've not complained but if I've had a query I ask them and they get the answer there and then or for the next time I come in."

Since the last inspection improvements had been made to how complaints and concerns were managed. Complaints were logged and investigated in a timely manner. Feedback to the complainant was recorded, as were circumstances when the provider had apologised to complainants. The date the complaint was resolved was documented. Lessons had been learnt in relation to complaints and new recording systems had been introduced. One person had been referred to physiotherapy following a concern and family meetings had been held in some circumstances to discuss concerns about care provision.

A compliments file had also been introduced and it was positive to see that relatives were sending thank you cards or emails thanking the staff for their care and support. A healthcare professional had also contacted the manager to compliment a member of care staff on the positive support they provided to a person attending accident and emergency.

At the time of the inspection no one being supported was at the end of their life. Information was included in care records in relation to people's wants and wishes when the time should come if they had felt able to discuss this. Do not attempt cardio pulmonary resuscitation orders (DNACPRs) were in place for some people and had been appropriately reviewed. The manager told us that on the day of the inspection, two people who had capacity had chosen to rescind their DNACPR as they had changed their mind about resuscitation. An end of life policy was in place and we saw compliments had been received from relatives from times when people had been supported at the end of their lives.

Requires Improvement

Is the service well-led?

Our findings

During the last inspection on 23 and 25 August 2017 we found there had been no consistent management presence since May 2017. We also found a breach of regulations. There had been a failure to ensure audits were completed regularly which meant areas for improvement had not been identified. There was a lack of leadership, management and direction.

During this inspection we found improvements had been made. Systems and processes for auditing and good governance had been introduced but they needed to be fully embedded to ensure consistent good practice over time.

Most people and relatives discussed the number of managers that had been at Wordsworth House over recent years. One relative said, "I've seen an improvement in staff effectiveness and staff morale since [manager] has been here."

At the time of this inspection a manager was in post and had made an application to the Commission to be registered. They were awaiting confirmation of their interview with the Commission.

Most people said there had been an improvement in staff morale in recent months. One person said, "It's well managed and the staff get on together." A relative said, "The staff used to run around like scalded cats but they weren't very efficient or effective but staff now work as a team, sharing tasks. There's been a difference since [manager] came and I hope she stays." Another relative said, "The office staff are excellent, very helpful and the catering staff." We were also told by a relative, "I'm impressed by the new organisation, I'm pleased with the progress and with the communication, the managers are nice and friendly, you need managers who are the interface between staff and senior managers."

We also received positive comments from the staff. One staff member said, "It's nice to have a manager, we have people to turn to now. I love these residents and that kept me going. We knew we would get help and its getting back, it's better." They added, "Relatives had confidence in us and they didn't move people." Another staff member said, "They (management) say what's needed and how to get there. We can say if we think it's not going to work but they ask us to try it then review it." They added, "We don't want [peripatetic support manager] to leave, we know things will get done if we go to her and she gives feedback. She's a breath of fresh air." We were also told, "I've never heard her lose her temper (manager), she wants explanations for things but won't rant and rave, it's professional and her approach means a lot as we are treated with respect now. It's about team work."

The activities co-ordinator said, "There are still improvements that are needed. There needs to be more understanding about people. The focus seems to be care plans and documentation; some staff seem scared to interact with people in case they get into trouble." We did not observe this during the inspection and found staff were happily spending time with people.

A peripatetic team leader had been based at Wordsworth House since September 2017 with the primary role

of auditing and re-writing care plans. We found care plans and risk assessments had improved significantly but did identify some improvements were still needed. It had been acknowledged by the management team that there were still areas for improvement.

The home manager had been recruited in October 2017 and additional peripatetic support roles had since been introduced including the support manager and the clinical lead. The head of business improvement had also been based at Wordsworth House and was leading on developing and improving the service. The head of business improvement said, "I used the last report to develop the improvement plan and we pull actions from any audits, or quality team visits through onto the improvement plan so we have one action plan."

The manager completed a walk around when they arrived on site and used this as an opportunity to say hello to people, but also to see if there were any concerns or actions that needed to be taken. We saw they spent time throughout the day on the floor chatting to people, visitors and staff.

Minutes from a managers meeting held in October 2017 were available and included discussions about CQC inspections, lessons learnt, governance and audit completion and ensuring action plans were developed and met. It was clear that the provider was encouraging managers to 'take ownership' of the quality and governance of their homes.

A range of audits had been introduced from November 2017. The head of business improvement said, "The audits are mainly done by me and [peripatetic support manager] and then we will work with the staff team on completing them. It gives us a baseline of what action is needed. The initial priority was the staff team so audits were introduced afterwards as we needed to prioritise staff, investigations and safeguardings." It was explained that the initial priority was for the management team to work on the floor alongside the staff supporting people. This provided support, guidance and mentorship for the care staff whilst also providing the opportunity for the management team to experience working on the floor, to identify concerns and be visible for people and their relatives. This had been effective in improving the culture and the morale of staff.

A robust health and safety audit had been completed by the peripatetic support manager which had identified when all equipment and premises safety checks had been completed. From gathering this information a file of all certificates had been put into place and a system was evident which ensured all servicing and safety checks were compliant. The audit also included fire safety records, equipment checks, including bed rails, water records, policy and procedures, the environment, boiler rooms, laundry and incident reporting.

Audits had also been completed in relation to the kitchen, allergens, infection control, housekeeping, hand hygiene and maintenance. Dining experience observations had been introduced and had been completed in September and December 2017. Unannounced night time checks were also completed. Any actions were transferred to an overall home development plan which was regularly updated.

Medicines audits had been completed and it had been identified by the head of business improvement that they were not being completed appropriately. In response they had completed a further audit with the nurse to coach them on how to complete an effective audit. This had led to actions being identified which were added to the improvement plan. The head of business improvement said, "I would sooner any improvements were identified then we can do something about them, staff need to know its fine to say if things aren't right."

The home development plan had been created following the last inspection and had been reviewed and added to since then. We could see all actions that had been identified, who was responsible for completion and when. The actions had been reviewed to assess if additional work was needed or if they were complete. If complete the action had been signed and dated as such.
The management team acknowledged that there were still some improvements that were needed but we saw there were implementation plans in place.

A new key performance indicator report had been developed as it had been identified that the previous version was not providing managers with the required information. The new form would be used to provide monthly statistics and trend analysis in relation to areas such as nutritional care and weight loss, safeguarding, mental capacity assessments and DoLS applications, pressure care and skin integrity and medicine errors. We were unable to assess the effectiveness of the report as it had not yet been implemented.

People and relatives told us resident and relative meetings were held regularly. They had been introduced in October 2017 and were well attended. Some relatives were aware of the meetings but had chosen not to attend. One relative said, "If I have a concern or suggestion I just call into the office." Another said, "The meetings are at night and I don't go out at night."

Minutes were seen from each meeting and included discussions held around CQC updates, recruitment, refurbishment and the re-introduction of Akari stars which recognised staff for good practice and achievements. Concerns from people and relatives were also raised and addressed. The manager said, "The minutes of the meeting are always sent out to everyone so if people can't attend they can still see what was discussed." A relative said, "The meetings are monthly and minutes come out. They include targets for achievements and we get updates on progress, communication is good."

We saw one relative had emailed the manager thanking them for the minutes of the meeting, they wrote, 'It helps to get so much detail, good to hear of the clinical lead as it could make a huge difference to [family member] who has complex needs.' One staff member (peripatetic team leader) said, "There's lots of support from managers, you can say if you agree or not." A person said, "We can have one to one time with the manager, we are getting to know her more so now than when she first started."

Staff explained how new equipment had been purchased such as stand aids, hoists and slings. They added that new key pads had been added to doors. They said, "Anything we want for people is provided." Another staff member said, "Things are in order now, there's authority, it's nice to have a boss so you can go and see them. [Nurse] is really good and gets things done. The nursing staff listen and we can raise things. It's a good team; we crack on and get on with it. The manager even works a weekend!"

Team meetings were held however minutes from the meetings were not always available. We raised this with the manager who said, "I'm aware team meetings don't have minutes so information isn't being cascaded in written format. They are held monthly and I am concerned as staff need the minutes but I've prioritised getting the resident and relative meeting minutes out and do realise how important it is that minutes are shared." Nurse and senior care staff meetings had also been introduced as had heads of department meetings. Again minutes were not always available. We were made aware that there had been a gap in administrative support at Wordsworth House.

We asked people, visitors and staff if they thought there had been improvements since the last inspection. A relative said, "I'm really impressed with [manager] and [support manager] there are significant improvements, my only disappointment is that [peripatetic clinical lead] isn't here all the time. [Family

members] quality of life has improved, staff morale has improved, there's laughter here now."

One staff member said, "Paper work is trial and error. Different teams work differently and some staff still need more time so we try to support them with the changes." They added, "The communication book is used all the time now, there's not so many improvements needed care wise it's more paper work."

One staff member said, "Staff morale has lifted. We've got some new staff. It's been challenging trying to change staff attitude but they (managers) are not the enemy, they are approachable and we can say if we disagree. They will ask us to try things and see how they go then review things." Another staff member said, "Managers are here all the time, they are approachable. The chief executive even changed mattresses, is that normal? They'll also support people." They added, "If something goes wrong they manage it, they are firm but fair, we can go to them with personal problems as well as work." They went on to say, "Residents saw how down we were and it affects them, they know. Christmas lifted our spirits, staff were uncertain and there were whispers." They added, "We want our manager rather than a full team of managers but at the same time we don't want to be abandoned." One staff member said, "We just want to be managed by our manager now but I am worried about when everyone else pulls out." A relative said, "The teams efforts are working, it was in a poor state and we were quite alarmed by the deterioration. The concern is that it remains good. The ratio of staff to residents is good and the care is much improved. I am concerned that it needs to continue." We sought assurances from the head of business development about this. They said, "I will have a team meeting and discuss it, the peripatetic managers will be pulled out but not until things are settled." The manager said, "I am still recruiting for a clinical lead so nothing will change yet." We also received assurance that it would be discussed in the relatives and resident meeting.

The head of business improvement said, "Staff on the floor are the biggest improvement, they were on tenterhooks and didn't want to come into work but they are gaining knowledge and sharing information, there's a policy file on each floor now so everyone has access to information. There are improvements to data protection, confidentiality and understanding." They went on to say, "Care plans have massive improvements. There's been audits since September which led to actions and then re-audits with reduced actions. Evaluations are audited and we now there needs to be more cross reference from the evaluations to the care plans. We've got audit schedules and DBS schedules, review schedules. Because it's a big home we need to be able to see things at a glance."

A nurse told us, "There was previously no meetings, it was so badly lead, not person centred and very rigid. Since then it's turned around, as nurses we are supported, communication is good, safety is ensured, things are working like clockwork. Significant discussions have been introduced which gives control to lead the shift and raise concerns. We have the authority to speak to staff about showing dignity and respect to people, we can record and it goes to the manager. There's a communication book which is written in daily re updated care plans, medicine changes, action needed for people. It's always read out at handover." They added, "I love the person centred care now, I can see that it's changed, it's peoples home. People are getting the care and I feel supported. There's no reason for there to be a barrier between nurses, care staff and management, we should all work together."

Another nurse said, "We need to implement and embed all the things that have been put into place now. We can discuss things in team meetings and everyone's trying hard with the person centred approach. Dignity training and team building is available." They added, "I'm happy here, I love my job!" A senior said, "It feels better, there's no tension, feels great, so much better. Management are in which makes it better. There's a massive difference with care staff, we can do our work and spend time with people. There's nothing major left to improve. Nice morale, happier and more confident. There are audits now so we know what we are doing, I feel I can do the care plans now and know we need to evidence what we are doing for people."

The manager said, "The staff are much more positive, they were initially wary of the management team but they can see we are working alongside them now, supervisions are in place and team meetings and staff approach us now with concerns. Morale has improved, everything feels better. Families share this too and are positive about the staff." They added, "There's been four months of support, leadership and direction so we are now looking at competency if staff aren't on board with the changes as they've had the support needed to change. 95% of staff are with us and know the direction of change."

The manager also said improvements had been made in relation to the handover, staff were now allocated specific people whose care and documentation they were responsible for; daily notes and the overall systems for communication. They said, "People know the expectations, their role, their responsibilities and were to find information."