Larchwood Care Homes (North) Limited

Wordsworth House

Inspection report

Wordsworth Street
Hapton
Burnley
BB12 7JX

Tel: 01282778940

Date of inspection visit:
30 January 2018
31 January 2018

Date of publication:
05 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 30 and 31 January 2018. The first day was unannounced.

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. The Care Quality Commission (CQC) regulates both the premises and the care provided, and both were looked at during this inspection. The care home accommodates 40 people across two separate units, each of which has separate adapted facilities. One of the units specialises in providing care to people living with dementia. At the time of the visit there were 32 people who received support with personal care. There is no nursing care at this service.

At the time of our inspection there was no registered manager in post. The registered manager had recently left. A new manager had been appointed and was in the process of completing an application to become the registered manager. A registered manager is a person who has registered with the CQC 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.

At the last inspection in December 2016, we found shortfalls in the safe management of people's medicines. This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following the inspection, the provider sent us an action plan, which set out what actions they intended to take, what they would do and by when to improve the key question, 'Is the service safe?, to at least good.

During this inspection we reviewed actions the provider told us they had taken to gain compliance against the breach in regulations identified in December 2016. We found necessary improvements had not been made in relation to the safe management medicines. We also found improvements were required in relation to the control and prevention of infection and good governance at the service.

During this inspection we found breaches of regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider had not ensured the safe management of people's medicines and there was a failure to establish effective measures for the prevention and control of infections. You can see what action we told the registered provider to take at the back of the full version of the report.

This is the second consecutive time this service has been rated Requires Improvement.

There was mixed feedback from people and their relatives regarding the quality of care at the home. Visiting professionals we spoke with also gave us mixed feedback about the service. People who lived at the home told us that they felt safe. There was mixed feedback about the staffing levels in the home. There had been a high staff turnover. We found in majority of the cases, cover had been provided using agency staff. However,

there were times when adequate cover had not been provided. The manager was in the process of recruiting new staff in order to address this matter.

We found there was a negative culture and low morale within some of the staff team. This had impacted on the quality of care provided and necessary improvement needed in the home had not been achieved. Risk assessments had been developed to minimise the potential risk of harm to people who lived at the home. However improvements were required to the risk management procedures.

Staff had received safeguarding training and knew how to report concerns to safeguarding professionals. Accident and incidents had been recorded. However, unwitnessed falls that involved head injuries had not always been referred to medical professionals. There were improvements in the safe recruitment of staff and checks were carried out to ensure suitable people were employed to work at the home.

The staff who worked in this service made sure that people had choice and control over their lives and supported them in the least restrictive way possible. Staff and the manager had knowledge and understanding of the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). People's consent to various aspects of their care was considered and where required DoLS authorisations had been sought from the local authority.

Risks associated with fire had been managed and fire prevention equipment serviced in line with related regulations.

Care plans were in place detailing how people wished to be supported. People's independence was promoted. People's privacy and confidentiality was respected.

The provider had sought people's opinions on the quality of care and treatment being provided. Relatives and residents meetings and surveys had been undertaken to seek people's opinions.

During the inspection we observed that regular snacks and drinks were provided between meals to ensure people received adequate nutrition and hydration. People who lived in the home, staff and relatives informed us there were times when food stocks had not been adequately monitored. However, on the days of the inspection we found food stocks had been maintained and people had sufficient food. Risks of malnutrition and dehydration had been assessed and monitored.

We found people had access to healthcare professionals and their healthcare needs were met. Relevant health care advice had been sought so that people could receive the treatment and support they needed.

We observed people being encouraged to participate in activities of their choice. People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaint's procedure was available and people said they were encouraged to raise concerns.

Staff had been provided with ongoing training and development. Supervision and appraisal was provided.

The manager and representatives of the registered provider used a variety of methods to assess and monitor the quality of care at the home. However, governance and management systems in the home needed improvements. There were checks in various areas such as medicine, care plans, health and safety. The quality checking systems were effective in identifying faults and areas of improvement. However we found these findings had not been acted on.

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 consistently safe.

People's medicines had not always been managed safely. Practices in relation to infection control and prevention were not effective.

Risks to the health, safety and well-being of people who lived at the home were assessed and plans to minimise the risks had been put in place. However, medical advice was not always sought when people experienced unwitnessed falls.

Relatives felt their family members were safe. Feedback was positive.

Staff knew how to protect people from abuse and some had received safeguarding training. Risks of fire had been managed.

Is the service effective?

Good

The service was effective.

The rights of people who did not have capacity to consent to their care were protected in line with the MCA principles.

Staff had received training, induction and supervision to ensure they had the necessary skills and knowledge to carry out their roles safely.

People were supported with their nutritional needs. People's health needs were met and specialist professionals were involved appropriately.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and their relatives gave mixed view about the caring nature of the staff.

People's personal information was managed in a way that protected their privacy.

Staff knew people and spoke respectfully of people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had plans of care which included essential details about their needs and outcomes they wanted to achieve. However, they did not always contain accurate information and were not always reviewed.

People were provided with appropriate meaningful day time activities and stimulation to keep them occupied.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their family member's care and treatment. Complaints had been dealt with in line with policies and procedures.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Policies for assessing and monitoring the quality of the service were in place. However, they had not been effectively implemented to improve the service.

Management oversight had been provided to care staff and the overall running of the service. However, there was high staff turnover and a negative culture in the service.

Systems for assessing and monitoring the quality of the service and for seeking people's views and opinions about the running of the service had been implemented.

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 visit took place on 30 and 31 January 2018. The first day was unannounced. The inspection team consisted of two adult social care inspectors including the lead inspector for the service and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The experts involved in this inspection had expertise in the care of older people and people living with dementia. The inspection team also included a specialist professional advisor who had expertise in community and general nursing for adults and dementia nursing as well as a pharmacy inspector who specialised in medicines management.

Prior to the inspection we had received information of concern and other safeguarding concerns about this service. The concerns had been reported to the local safeguarding authority who were undertaking investigations. We also explored how safeguarding concerns were managed in the service as part of this inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service.
Before the inspection we reviewed the information we held about the service. This included safeguarding alerts and statutory notifications sent to us by the manager about incidents and events that had occurred at the service. A notification is information about important events, which the provider is required to send us by law. We contacted health and social care professionals who worked alongside the service. We also reviewed the information we held about the service and the provider.

We spoke with a range of people about the home including 11 people who lived at the home, three visitors and three staff. In addition, we also spoke with, the chef, the deputy manager, the manager and regional

manager, the maintenance officer, housekeeping staff, activities co-ordinator and seven care staff.

We looked at the care records of five people who lived at the home, training records and four recruitment records of staff members and records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our last comprehensive inspection of Wordsworth House in December 2016, we found the provider had failed to protect people against the risks associated with the unsafe use and management of medicines. This was because there were issues with delays in administration, use of thickening agents, administration of 'when required' medicines and applying topical preparations. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to send us a report on how they were going to improve the service in relation to the breach.

During this inspection, we reviewed the actions that the provider told us they had taken to gain compliance against the breach in regulation. We found some improvements had been made; however, some of these issues had not been addressed, which meant we found continuing shortfalls on this inspection.

We looked at how medicines were handled in the home. We reviewed records about medicines and arrangements for ordering, storing and administering medicines. We looked at medicine administration records (MAR) for eight people who lived in the home.

The home had a locked treatment room on each floor where medicines were stored. The rooms were generally tidy but we found a capsule on the floor in one room,. In addition, the waste bin was not stored securely, in accordance with the medicines policy and there were out of date medicines in the fridge. Staff told us they did not make a record when medicines were disposed of and the records demonstrated that only medicines returned to the dispensing pharmacist had been recorded. In previous months, the room and fridge temperatures had been recorded daily. However, there were gaps in the records held in relation to the ground floor treatment room and there were no records of temperature checks for January 2018 in one part of the home. This meant there was no assurance that medicines were stored properly.

Controlled drugs were kept in an appropriate locked cabinet. However, we found weekly audits had not been carried out regularly in accordance with the medicines policy for the home. The audits had failed to recognise that the controlled drug register had been completed incorrectly and we found one injection that was out of date. Some medicines in use in the trolleys with shorter expiry once opened did not have the date of opening recorded on the containers. This meant there was no way of knowing when they went out of date.

We looked at the MARs for people on both units of the home and found that medicines were not always given as prescribed by the doctor. For example, a medicine prescribed twice a day for anxiety had only been given once a day for 10 days in January 2018. The stock remaining for another medicine meant it could not have been given as often as it had been signed for. Some people were prescribed paracetamol 'when required' for pain relief. The staff recorded the number of tablets given but did not record the time of administration, so we could not be sure that a safe time interval had passed between doses. One person had been given two paracetamol tablets when only one had been prescribed.

Some residents were prescribed one or more medicines to be given 'when required'. Additional information

to help staff give these medicines safely was not always seen. Some residents were prescribed pain-relieving medicines to be taken when needed that had a variable dosage and it was not clear what dose staff should give or what the maximum dose was.

One person was prescribed a powder to thicken their drinks because they had difficulty swallowing. Details of their requirements were well documented and the powder stored safely. However, staff did not record when the powder had been used. This meant we could not be assured people received the powders as prescribed.

We looked at topical application records and arrangements for the storage of creams and ointments. Care staff applied these as part of personal care and a separate trolley was used to store these medicines safely. We saw the home had records including a body map that described where and how often to apply these preparations. Our review of records showed some creams had not been applied as often as prescribed.

Regular audits had taken place in the home until December 2017 when the manager left the service. An audit had been carried out the day before the inspection and the new manager had highlighted many of the issues that we found. A plan was being prepared to rectify the concerns. The manager assured us there were sufficient staff competent to administer medicines in the home at all times.

The home has received support to improve their medicines practices from the local clinical commissioning group's (CCG) medicines management support team. However the intervention and recommendations had not been effectively used to improve the safe management of medicines at the Home. There was failure to protect people from risks associated with the unsafe use of medicines.

These issues meant that there was a continuing breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

There were policies in the service to protect people from risks of infection. Staff had received training as part of their induction on infection control and prevention and information about the spread of inspections was readily available. However, the infection prevention and control practices were not robust. During the inspection we found some shortfalls that demonstrated infection control practices needed to be improved. For example, we found three toilets had run out of hand washing soap and alcohol gel for disinfecting hands. We also found the kitchen and one toilet and the sluice did not have paper towels for people to wash dry their hands. The lack of hand towels had been pointed out by a visiting food standards inspector shortly before our visit. However, this had not been rectified at the time of our inspection.

In addition, there were no disposable bowls for people to use in the event of a sickness. We found areas of the home that had not been cleaned for a number of days. For example, the carpet in the main lounge in one unit was stained with vomit which was reported by staff and one person who lived at the home to have been there for seven days. Cleaning and hygiene audits had not identified the shortfalls before our inspection. This would expose people to the risks of infections.Following our inspection we referred the home to the local authority's infection prevention and control department There was a failure to operate effective systems to prevent and control infections in the home.

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

We reviewed how the service protected people from abuse, neglect and discrimination. People who lived at the home told us they felt safe living at Wordsworth House and with the way staff supported them.

Comments from people who lived at the home included, "I do feel safe in this home though I am not sure if there are enough staff. Anyway they do their job very well when I do need them. I don't use the buzzer and don't need personal care but I make my own choices about what I do and I think the management and staff are good at what they do", "In terms of safety it's not bad but I don't feel as safe as I used to. I don't feel anybody's going to harm me." Comments from relatives about people's safety were positive.

Before this inspection we received notifications relating to concerns. We had also received concerns from whistle-blowers from the organisation about the quality of the care and people's experiences. We shared the concerns with the local safeguarding team. At the time of our inspection there were also a number of concerns under consideration by the local safeguarding team. However, some of the safeguarding concerns had been investigated by the local authority safeguarding department and substantiated. This included incidents involving altercations between people who lived in the home and unwitnessed falls. At the same time some of the concerns had not been substantiated. The service took action in line with their own safeguarding and disciplinary policies to investigate the concerns and take appropriate action. We found lessons had been learned from some of these events. However, this was not always consistent to prevent incidents from occurring again. For example, we found a number of unwitnessed physical altercations between people had happened in the service. On the day of the inspection we witnessed two potential incidents and intervened in one incident to prevent physical confrontation between people. We found staff deployment in the service had not been reviewed to ensure that those at risk were monitored. We shared our observations with the manager who informed us that they would review the situation. This would assist in ensuring staff were able to intervene and protect people who may be at risk.

Staff had received safeguarding training at the beginning of their employment and undertook refresher training. We found safeguarding procedures took into consideration the wishes and feelings of people and their relatives. Staff we spoke with knew how to report safeguarding concerns and were confident their concerns would be taken seriously.

In majority of the cases, risks to people were assessed and their safety was monitored and managed so they could stay safe and their freedom respected. We found accidents and incidents had been recorded and in some cases support had been sought from emergency services and health professionals where this was required. Accident and incidents had been analysed to identify patterns and trends. Staff had recorded the support they had provided to people after the incidents. This included records such as post-falls observations. Staff had also reported significant injuries and incidents to the local safeguarding authority in line with local and national guidance. However, we found staff did not always seek medical advice in cases where people had unwitnessed falls that included head injuries. This meant people could not be assured they would receive the correct support following a fall.

Risk assessments had been undertaken in keys areas of people's care such as, falls, nutrition, skin integrity and moving and handling as well as behaviours that could pose a risk to self and others. The manager had reviewed risk assessments and took appropriate action when people's needs or risks had increased. However, we found risk assessments had not been reviewed in October and December 2017 and also that some risk assessments were not accurately reflecting people's needs. For example, one person had several pieces of equipment to reduce the risk of falls from bed and subsequent injuries. However, they had been assessed as not at risk of falls and had no risk assessment completed to demonstrate why this equipment was required. The records and guidance would be important to remind staff why the equipment was required and in turn help to ensure that the person was provided with the necessary equipment at all times.

We looked at the risk assessments in place concerning fire safety and how people would be supported in the event of an emergency. Each person had a personal emergency evacuation plan (PEEP). This provided staff

with guidance on how to evacuate people safely in the event of an emergency. We saw the service had contingency plans in place and a building evacuation plan. There was an up to date overall fire risk assessment for the service in place. We saw there were clear notices within the premises for fire procedures and fire exits were kept clear. Records showed that staff had regularly tested firefighting equipment.

Maintenance records showed regular safety checks had been undertaken as well as the servicing of emergency equipment, fire alarm, call bells and electrical systems testing. These measures helped to make sure people were cared for in a safe and well maintained environment.
The provider had a system for assessing people's dependency and required staffing levels to ensure sufficient staff were available to provide the support people needed. However, the system had not been updated to reflect people's needs and their dependency levels or the numbers of people living in the home.

Before the inspection we had received information from whistle-blowers informing us that there were significant staff shortages at the home. There had been a high staff turnover two months before this inspection and the provider had used agency staff to provide cover. We looked at the staff rotas for December 2017 and January 2018. We noted that, in majority of the cases, the manager had ensured that there were adequate numbers of staff in line with people's dependency levels. However, this was not always consistent and records showed there were four times in one week in December 2017 when the provider had failed to maintain the staff numbers that they had recorded as being necessary to meet people's assessed needs. We spoke to the regional manager wo informed us this had been due to staff sickness and staff leaving the service without adequate notice to allow them to source agency staff.

During the inspection, we received mixed responses regarding the staffing levels at the service. Comments about staffing included; "It appears work that used to take three staff is now being done by two and, as a result, staff are leaving out of total dissatisfaction" and "This used to be a good , homely, place with a pleasant atmosphere but some good carers have left and some others will go." Four of the staff we spoke with informed us that staffing levels had not been consistently maintained and that this had impacted on the quality of care provided in the home and had also led to the departure of staff.

We spoke with the manager and the regional manager about the feedback we had received regarding staffing levels. They informed us that they were aware of the situation and that they had recently lost a significant number of staff. They informed us that in response they had been actively recruiting new staff as well as using agency staff when there were shortages. We noted that during the inspection they were interviewing for new care staff.

Before the inspection we had received concerns regarding shortfalls in the safe recruitment of staff. We looked at the records of four staff members employed at the service, including the file for the staff where concerns had been raised. We saw that all the checks and information required by law had been obtained before staff had been offered employment in the service. Staff files were well organised, which made information easy to find. All the files we looked at contained evidence that application forms had been completed by people and interviews had taken place before an offer of employment was made. At least two forms of identification, one of which was photographic, had also been retained on people's files. Staff members we spoke with confirmed they had been checked as being fit to work with vulnerable people through the Disclosure and Barring Service (DBS). This meant the provider had taken appropriate steps to ensure only suitable staff were employed to work in the service.

Good

Is the service effective?

Our findings

People who lived at Wordsworth House and their relatives told us they felt their needs were effectively met. Comments included, "Yes the staff seem to have the skills and experience they need; I don't have any problem with their knowledge and "I get to see the doctor when I need one; they are good at doing that."

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes 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.

When we undertook our inspection visit DoLS authorisation requests had been submitted to the local authority; none of these requests had been authorised. However, the registered manager was regularly checking on the progress of the applications. We saw evidence that people's consent in various areas been sought in all care files we looked at. This included consent to the use of photography and medicines management. Where necessary, capacity assessments had been completed in order to support people with their decision making processes.

We observed that people's needs and choices were considered during the delivery of care. For example, we saw people being asked what they wanted to eat and where they wanted to sit. People told us they could get up anytime they wanted and choose to spend time in their bedrooms if they wished to do so.

We reviewed the training records for the whole service and found staff had received regular training. They had also been provided with supervision and appraisals. Induction was offered to all staff before they commenced their role. This included spending time shadowing experienced staff. Following their induction staff completed training that was specific to the needs of people they supported. For example staff had received; training in areas such as safeguarding, managing and supporting people who display behaviours that challenge and dementia awareness and mental capacity. In addition staff were required to complete refresher courses online using e-learning. In majority of the cases staff had completed their e-learning when it was due.

There were processes in place to ensure people did not experience discrimination, including in relation to their gender, ethnicity, age or religion. For example, the provider offered their staff training in equality and diversity. There was a policy to protect people against discrimination and harassment. Information on how to report concerns was readily available in prominent places within the home.

People's individual needs were adequately met by the adaptation, design and decoration of premises. We

saw some people had brought their own personal items that helped personalise their bedrooms and made it homely for them. However, we noted that the perimeter fence required repairing to protect people as the home was next to a canal.

We observed staff supported people to eat their meals. We observed people living in the unit for people with dementia were offered wipes to clean their hands before they were served their meals. The atmosphere was calm and caring and people were able to eat their meals at their own pace and those who required support with their feeding were supported to eat at a relaxed pace. All people appeared to have enjoyed their meal and had eaten well. Staff offered a choice of drinks. They encouraged individuals with their meals and checked they had enough to eat. We observed staff gave people an alternative choice if they did not like the meals on offer.

Comments about the food were positive. One person who lived at the home said, "The food is good enough, I don't bother much about menus but I tend to eat my meals even when it is not one of my favourites." All the relatives we spoke with told us they felt people's nutritional needs were adequately met. We spoke to the kitchen staff who informed us people had two choices of hot meal at lunch time and in the evening. The kitchen staff showed a good knowledge of people's dietary needs, preferences and special requirements. However, before the inspection we had received concerns that there were times when the home had run low on food stocks before the next delivery was due. Three staff we spoke with confirmed this. Two people we spoke with told us they had run out porridge for five days.

We spoke with the regional director and we checked the food stocks and records. We found there were adequate stocks and food had been delivered on the day of the inspection. The regional director showed us the records of food orders which showed food was delivered twice a week. There been concerns regarding the ordering of food supplies and planning of menus by staff who had left the organisation. They added that this had caused some of the issues in stock management. They assured us that staff had access to petty cash to buy food if they were running short on supplies. They also assured us that they had established stock monitoring systems which would prevent this from happening.

The care records we reviewed had a section that noted any special dietary requirements such as the need for a soft diet. Staff recorded in care records each person's food and fluid likes and dislikes. This was good practice to help ensure people received their preferred meals in order to increase their nutritional intake. People were weighed regularly. We found staff assessed people against the risks of malnutrition and made referrals to dieticians and Speech and language therapists (SALT) where appropriate.

People were supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support. Care records we looked at contained information about other healthcare services that people who lived at the home had access to. We noted that people had received visits from for example, GPs and district nurses and practice nurse.

Records were updated to reflect the outcomes of professional health visits. We spoke to one visiting professional who informed us the staff involved specialist professionals and that they would seek advice if they were unsure about people's conditions.

Requires Improvement

Is the service caring?

Our findings

During our inspection visit, we observed people were relaxed, happy, smiling and comfortable. We observed interactions between people and staff and we also spoke with people who lived in the home. Comments people made about staff included, "I am more or less blind now and can't walk very well either so I am glad I am in here. My carer is lovely and the assistant manager is great", "I am well looked after. I get on well with the staff, and I enjoy it here. I have not been asked for any feedback but, if they did ask, it would all be positive" and "I don't feel I know the people here well yet and I don't think they know me but we do get treated with dignity and with respect."

Comments from the visitors were mixed. All the visitors we spoke with told us that they were sure that staff knew their friend/relative well and understood their preferences. They all said they found the staff to be kind and caring and supported as much independence as possible. However, one visitor informed us that, while their relative got support and was given privacy, they were not consistently treated with dignity and respect. We shared these views with the manager and they informed us they will remind all staff the importance of treating people with respect.

We observed staff engaged with people in a caring and relaxed way. For example, in the dementia unit we observed staff spoke to people at the same level and used appropriate touch and humour. They were patient and attentive to people's needs. Before the inspection, we had received concerns that people were not always receiving personal care. However, we found all people were well groomed and well presented The registered manager informed us that they were regularly auditing and checking whether people were well kempt and whether they had received personal care in line with their care plan and preferences.

Staff we spoke with had a good understanding of protecting and respecting people's human rights. All staff had received training which included guidance in equality and diversity. When we discussed this with staff, they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

We observed people being as independent as possible, in accordance with their needs, abilities and preferences. People were encouraged to do as much as they could for themselves. For example, we observed people eating independently. Staff explained how they promoted independence, by enabling people to do things for themselves.

Staff also addressed people by their preferred names. Care records that we saw had been written in a respectful manner. Staff we spoke with described how they ensured people's dignity was maintained when they assisted them with their personal care tasks. They maintained people's privacy and dignity throughout our visit. For example, we saw staff knocked on people's bedroom doors before entering.

Relatives told us the management team encouraged them to visit at any time. They said this gave them the freedom to access the home around their own busy schedules. We observed staff welcomed relatives with

care and respect. For example, they had a friendly approach and one person said, "I do very well for visitors from family and from friends at my church, I feel they do care about me."

We saw people were supported to express their views on matters that were important to them and were also involved in making decisions about their care as far as possible. Two of the people we spoke with confirmed they had been involved in reviewing their care plans and had signed them. However, the majority of care records we looked at did not always demonstrate how people had been involved in the review of their care plans. We shared this with the manager and they informed us that this would be improved.

The registered provider had information details that could be provided to people and their families if advocacy was required. This ensured people's interests would be represented and they could access appropriate services outside of the home to act on their behalf if needed.

Requires Improvement

Is the service responsive?

Our findings

People who lived at Wordsworth House gave us positive comments about the staff team and the care and support they received at the service. Comments from people included, "I receive the care that I need and when I want it", "We don't bother with the activities much but we are both well cared for and the staff respond when we need them." Comments from visiting relatives included; "My [relative] definitely receive very good care" and "I think [my relative] mostly get care which suited their needs."

We checked how the provider ensured that people received personalised care that was responsive to their needs. The care plans we reviewed were detailed and person centred. However, we noted that three of the care records did not always have the most up to date or accurate information about people's needs and conditions. For example, details of what support people needed was inaccurate and some care plans needed rewriting due to significant changes in people's needs. One person's file stated they walked independently; however we observed they could not walk.

The majority of people who lived in the home and their relatives told us they had been informed about support that was provided before using the service. Records we reviewed showed that people's needs had been assessed before they started living at Wordsworth House. This was to ensure that the home and staff were able to meet people's needs before they decided to admit them into the home.

Staff completed a range of assessments to check people's abilities. They checked individual's needs in relation to mobility, mental and physical health and medicines. Specific requirements for each individual had been identified. For example, people who required assistance with moving, soft diet, people who were at risk of falling and people who were at risk due to their vulnerability. Assessments and all associated documentation were personalised to each individual who lived in the home. In one instance, a review had identified a need to refer to other professionals; however, there was no documented evidence to show that this had been done. This meant that we could not be assured that the person had been referred to the relevant professional. We discussed with the manager the need to ensure that changes identified on reviews were documented and acted on. This would ensure a person centred approach to care reviews.

We checked to see whether people had access to activities to occupy their time. There was a dedicated activities co-ordinator who supported people in both units of the home. In the morning we observed them supporting people in the dementia unit. They were patient, considerate and communicated well with people. Various activities had been planned including quiz, bingo, knitting club puzzles and visits by the hairdresser. On the second day of the inspection we observed people from all units of the home being involved in a knitting club. The atmosphere was relaxed, calm and people appeared to enjoy the activity. Throughout the inspection we observed the activities coordinator engaging with people in a positive and inclusive manner, taking consideration of their choice and abilities.

The provider had adopted the use of technology to support people to receive timely care and support. For example they had signed up to telemedicine services. 'Telemedicine' is the use of telecommunication and information technology to provide clinical health care from a distance. It has been used to overcome

distance barriers and to improve access to medical services that would often not be consistently available in distant rural communities or out of hours. However, evidence from accident reports showed that staff had not always used the telemedicine facility when they should have done. This meant that we could not be assured that staff had sought medical advice to ensure people received the right support. There was also a working broadband and a telephone system that was easy to use and accessible to staff and people who lived in the home. The manager informed us that a tablet computer had also been introduced at the reception to allow visitors and people to send feedback to the organisation's leadership at their convenience.

We checked whether the provider was following the Accessible information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. The manager told us they were unaware of this standard but that people's communication needs were always considered as part of the assessment and care planning process. They told us they would check the requirements of the AIS to ensure the service was compliant with them. They also confirmed information produced by the service could be provided in a range of formats if necessary.

People we spoke with knew how to make a complaint or raise concerns and felt comfortable to do so if needed. We saw people were encouraged to do so by information that had been posted in the home and in the service user guide provided to them when they first arrived.

The service had a complaints' procedure that was made available to people on their admission to the service. A copy of the complaints' policy was on display in the service and had been written in a format that enabled people who used the service to understand the procedures. The procedures were clear in explaining how a complaint should be made and reassured people these would be responded to appropriately. Contact details for external organisations including social services and CQC had been provided should people wish to refer their concerns to those organisations.

Records we reviewed showed three complaints had been received since the last inspection. Evidence we saw showed that these had been dealt with appropriately in line with the organisation's policies. We saw the complaints' process in place. It guided staff to ensure that concerns and complaints were used as an opportunity to learn and drive continuous improvement. The service had received a significant number of compliments from relatives who were satisfied with the care provided. Information on an internet service that records people's views on care homes showed that the home had high levels of satisfaction.

Records we saw demonstrated that the provider and the staff had considered people's preferences and choices for their end of life care. For example, a significant number of staff had received training in supporting people towards the end of their life. There was also a policy that asked staff to record where people wished to die, including in relation to their ethnicity, gender, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. Records of care we checked had records of whether people wished to discuss their end of life care or not. This showed that there were plans to ensure that people were supported at the end of their life to have a comfortable, dignified and pain free death.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the home did not have a registered manager in post. The previous registered manager had left the service for another role. A new manager had been employed and they had submitted their application to register with the Care Quality 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. They were supported by a deputy manager, senior carers and a regional manager. In addition, they were recruiting for a unit manager to oversee the management of the unit for people living with dementia.

During our last inspection, there was one breach of regulation in relation to medicines. At this inspection we identified the breach of regulation had not been addressed and there was a continuing breach. We also found a new breach of regulation in relation to the control and prevention of infections. This demonstrated that the governance systems at Wordsworth House required further improvements. This would ensure that the necessary improvements required for the care and safety of people living at the home are made and sustained. This would also enable the registered provider to adequately monitor and respond in a timely manner to rectify identified shortfalls to the quality of the service and ensure compliance with regulations.

We looked at how the registered provider demonstrated that they continuously learned from incident and their checks, improved, innovated and ensured sustainability in the service. The registered provider had established a formal auditing system to assess quality assurance and the maintenance of people's wellbeing. We saw that audits had been undertaken in various areas such as medicines, health and safety, staff files and care files. Medicines audits were robust and identified the same shortfalls that we identified during our inspection. In addition, regular monitoring visits were completed by the provider's representative. However, care plan audits and infection control audits were not robust and had failed to identify some of the shortfalls found during this inspection. For example, the infection control and cleaning audits had failed to pick the shortfalls in hand washing materials in the home and materials for use when people felt sick such as disposable bowls.

Care plan audits had not identified the shortfalls in the quality of information recorded in the care records we reviewed. Although accident and incidents had been analysed for trends, the provider had not identified the concerns relating to staff not always seeking medical advice in the event of unwitnessed falls which included head injuries. We also identified stock management, monitoring and ordering systems in the home were not sufficiently robust; this had resulted in essential items either running low or running out. This meant that the audit systems in the service had not been effectively used to identify and rectify shortfalls, to ensure lessons were learned and improvements were made to the quality and safety of the service.

We found there was significantly high staff turnover at the service. Eight staff had left in a month and five staff had given notice to leave the service. We also noted that there was a negative culture within the staff team which was having impact on the quality of the care people received. For example we found four of the shortfalls in the systems for managing the prevention and control of infection were known to some care staff

however, they had not shared this with relevant staff or management to ensure the shortfalls were rectified. This meant that the issues had not been resolved in a timely manner.

We discussed the shortfalls with the regional manager and the manager. They informed us that leadership concerns and high staff turnover had impacted on the service and that they were taking immediate action to ensure the concerns were addressed. The regional manager informed us that they had been working closely with the previous manager to ensure improvements were made and would continue to do so with the new manager.

The provider had failed to maintain good governance. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014.

We checked how people who used the service, the public and staff were engaged and involved in the running of the service. Residents and relatives meetings were arranged and we observed a meeting took place during the inspection. Newsletters and relatives and residents surveys had been introduced and people had been invited to share their views.

In addition, there were staff meetings and staff surveys. We saw the manager and the provider shared the vision, challenges and expectations with staff during the staff meetings. However, the negative culture meant that not all the visions and expectations were taken on board by the team. This had an impact on achieving and sustaining improvements in the home.

Three staff we spoke with told us they felt the new manager worked with them and supported them to provide quality care. They felt that the manager had brought some positive changes to the home and was committed to make improvements especially in respect of staff recruitment and retention. However, five of the staff we spoke with as well as one relative and two people living in the home felt the culture in the home was not positive. Staff said they did not feel their views were taken on board in respect of the improvements needed in relation to staffing levels. They were critical of the overall leadership in the service. We spoke to the regional manager and the manager and they informed us that they were aware of the feelings among the staff team and were actively working to improve the culture in the home.

We noted that the provider had considered best practice guidance. For example the use of telemedicine' service. We also noted that the staff and the registered manager had joined local initiatives with the local authority and local clinical commissioning groups to develop expertise in areas such as of prevention of hospital admissions. They had also been part of a pilot scheme with the local clinical commissioning group on the use of 'secure red bags' for sharing hospital transfer records also known as hospital passports. This was an initiative to improve the way services shared people's records and to reduce the risk of records going missing during a transfer between care homes and hospitals. Hospital transfer records are documents which promote communication between health professionals and people who cannot always communicate for themselves.

Staff maintained adequate communication about people's needs and the service provided. We found handovers, were used to keep staff informed of people's daily needs and any changes to people's care.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and those related to people who used the service. Notifications had been submitted and the registered manager knew their regulatory responsibilities for submitting statutory notifications to the CQC. A notification is information about important events that the service is required to send us by law.

We found the organisation had maintained links with other organisations to enhance the services they delivered and to support care provision, service development and joined-up care. They worked with organisations such as local health care agencies and local commissioning group, local pharmacies, practice nurses and local GPs. The provider had a system to ensure the service shared appropriate information and assessments with other relevant agencies for the benefit of people who lived at Wordsworth House. However, health and social care professionals informed us that professional advice was not always sought in a timely manner and when given it was not always followed consistently or used to improve the quality of the care and practices in the home. For example, when medicines such as topical creams had been prescribed they had not been applied as prescribed. We shared the feedback with the manager and they informed us that this was related to staff who had left the service and that they had established systems to ensure all professional advice was followed and monitored for its effectiveness.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that care and treatment was provided in a safe way for service users because ; People's medicines were not safely managed. Systems for assessing the risk of, and preventing, detecting and controlling the spread of,infections, including those that are health care associated were not effective. Regulation 12(1)(2)(g)(h) HSCA RA Regulations 2014 Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure governance systems were robust and systems or processes were not established and operated effectively to ensure compliance. The provider had failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2)(a)(b) HSCA RA Regulations 2014 Good governance