Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Queensway House

Jupiter Drive, Hemel Hempstead, HP2 5NP

Tel: 01442266088

Date of Inspection: 28 November 2013

Date of Publication: January 2014

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✖ Action needed
Cleanliness and infection control	✖ Action needed
Staffing	✖ Action needed

Details about this location

Registered Provider	GCH (Queensway) Limited
Registered Manager	Mrs. Christine Larner
Overview of the service	Queensway House is an 80 bed care home without nursing for older people.
Type of service	Care home service without nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 28 November 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

What people told us and what we found

We carried out this inspection following information of concern we received. We looked at the care and welfare of the people, staff training, staffing levels and infection control. We found that the home did not meet any of the outcomes we looked at.

We received mixed responses from the people who used the service and from their relatives about the care and support they received. Some people were happy with the service and others told us that they were bored and had nothing to do. One person we spoke to said "It is chaos. I would not have signed up for this." Another said "Everything here is okay". One person asked us why they were in prison.

A visiting relative told us " I am happy with the care. The staff are fine and keep me informed but there could be more activities for people". Another relative was happy with the care of their relative and said that they had become more social since coming to live at Queensway House. Other people said that they had very little choice about how they spent their time or what time they got up and went to bed.

Staff told us and we saw that they did not have time to spend with people. We found that the care was based on the tasks that needed to be done rather than on caring for the person. We found that the home was not hygienically clean and there were not sufficient procedures to prevent the spread of infection.

A visiting professional told us "the staff are very good and the level of care is very good."

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 10 January 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

Care and treatment was not planned and delivered in a way that was intended to ensure people's health and welfare.

From our observations and from speaking to staff and to the people we saw staff focused on the task they were completing rather than on the person they were caring for. We saw that staff did not address people by their name. For example people were called 'love, darling or sweetie'. We saw that staff did not allow the person to set the pace of walking, we saw that staff held them by the hand and led them in a manner that was undignified and at a speed that was too fast for the person.

We saw that there was not enough space for the people to be cared for in the Sunflower unit, the part of the home where people who lived with dementia were cared for. We saw that people had to sit very close together and did not have any space between their chairs for tables to be placed. This meant that they had no place to put drinks or personal possessions or objects of stimulation or comfort. There was no space for staff to sit and chat to people or to offer them comfort if they were upset. We were told that the behaviour of some people could be difficult to manage and at times could be violent, which meant that the close proximity of people to each other could put them at risk of injury. The communal lounge in Sunflower did not have objects of comfort or stimulation. We were told that there were 'rummage boxes' in the lounge, the manager was only able to find one that was neglected and contained left over food and crumbs.

Some people were not well groomed, some of the men had not been shaved, people had not had their hair combed and their clothes were crumpled. This meant people were not cared for in a dignified manner.

We saw that people in their rooms did not always have access to call bells or drinks. Some drinks were in the rooms but were out of reach of the person. We saw one person laying in a urine soaked bed, naked and unable to call for assistance. We checked the person's care plan and it stated that they were fully continent. This detracted from the dignity of the person.

One person told us "I would like a shave today as I like to be clean shaven". We saw that this person also had large dark skin marks to both hands. When we checked their care plan and body maps, there was no entry to reflect these marks the last entry was in June 2013. Staff we spoke with were unable to tell us how the person had got the marks. We also saw that this person was at high risk of falls and their manual handling plan said they needed supervision, but the care plans did not give sufficient guidance to staff as to support them or how to reduce the risk of falls. We saw this person become physically aggressive to another person but the care plan did not say they could be aggressive, nor give guidance to staff to manage their needs for behaviour. This presented risks to the people and to the staff as staff did not have effective guidance to understand and meet the person's need or to deliver appropriate, safe and effective care.

None of the care plans we reviewed contained sufficient detail for staff to care for people in a person centre manner for example we saw one person was alone in a small lounge for over one and a half hours this person was heard to call out in a distressed manner and no staff member responded to them. The care plan for this person did not contain sufficient guidance for staff to be able to recognise and understand the person's distress or to offer comfort to them.

We found that stationary wheelchairs and a hoist did not have their brakes on, which presented a falls risk to people if they leaned on them whilst walking by them.

Cleanliness and infection control ✖ Action needed

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was not meeting this standard.

People were not cared for in a clean, hygienic environment.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not effective systems in place to reduce the risk and spread of infection.

Overall the home was not hygienically clean. For example we found that some bedrooms and the communal lounge in Sunflower unit were not visibly clean and were malodorous. We found that the approach to cleanliness and infection control was lacking thoroughness. An example of this was we saw underwear that had been worn under one of the chair cushions. .

The kitchen area in Sunflower unit was not visibly clean and the doors and work surface were damaged this meant that it could not be cleaned effectively. We were told that the dishwasher in the unit, had not worked for over two years, was not clean and had food and waste materials inside it. The fridge contained food that was not wrapped appropriately nor did it have a date of opening or a use by date. This posed a risk of food poisoning and a risk of cross infection due to unclean food preparation areas and inappropriate food storage.

We saw that the home used wheeled plastic bins to store and transport used clothing, sheets and towels. Soiled items were placed in red dissolvable bags. We noted that two of these bins did not have lids and they were not visibly clean inside. This presented a risk of cross infection.

Communal toilets and bathrooms had supplies of protective equipment for staff use but one bathroom and one en-suite toilet did not have any hand soap available. Not all bedrooms had waste bins in them to facilitate safe disposal of used protective equipment. This presented a risk that as universal infection control precautions could not be followed safely.

Some of the bedrooms that we visited were not visibly clean and one had faeces stains on the carpet. In four of the bedrooms, we found that the mattresses were not clean: one had a pool of urine between the mattress and bed base and was malodorous. In another room, we found that the bed had been made, but the bed sheet was stained with dried urine.

This presented risks of cross infection.

We were informed that the home did not have a formal cleaning schedule for removing lime scale from taps and shower heads and we saw lime scale had built up on the taps and shower head in a communal bathroom, and also the taps and sink area in the sunflower unit kitchen area. Lime scale build up presented risks as cleaning cannot be carried to a standard that would prevent the spread of infection.

The home did not have the requisite system in place of using different coloured mops and buckets for different areas in the home, and we were told by two staff that the same bucket and mop was used for bedrooms, toilets and bathrooms and that the water was changed in between different areas. The home did use different coloured cloths for different areas but there were no notices in staff areas to this effect. We were told that mops are left in buckets in disinfectant overnight and mop heads were changed every other day.

The cleaning schedules in the home had not been followed. For example we saw that the night staff had completed their cleaning duties, however we found that some of the communal lounges were not clean. In the Sunflower unit we found that the wheelchairs and their cushions were not clean.

There were two clinical waste bins outside the home, these were not locked nor were they in a secure area. There was also large number of used plastic gloves on the ground surrounding the bins. This posed a risk of cross infection as this was in an area accessible to the public.

The manager had carried out monthly audits but these audits did not reflect the risks of cross infection that we found on our visit. The lack of an effective cleaning schedule meant that people were at risk of cross infection.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were not enough qualified, skilled and experienced staff to meet people's needs.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

There were not enough trained staff on duty to meet the needs of the people who lived at Queensway House in a person centred manner. We were told that most of the people in the home had dementia. We saw from training records and from discussions with staff that training in the care of people with dementia had been carried out and that the manager had an appropriate qualification, however we saw that this training was reflected in the care of the people. We found that the care was task focused and not conducted in a manner that promoted the person's personhood and welfare. This meant that staff focused on the task and were seen to ignore people who were calling out for assistance.

We saw that there were staff employed to stimulate the people. We saw people who lived with dementia were unable to engage with the quiz. We observed that staff played a game of throwing a large ball at people. We saw one person appeared frightened by a large ball coming towards them.

The housekeeping staff we spoke with told us that they had not had any training or induction, specifically around the prevention of cross infection.

We saw that the care staff on duty were very busy and at times left people unattended, as they were assisting other people in their rooms.

We were told that people who were awake were offered a drink by the night staff. We found evidence that they may have been offered a cold drink and not offered a hot drink. We saw that people were assisted to the dining room at 08.30 for breakfast and people told us that this was the first time they were offered a drink since they woke.

Some staff told us that they spend time with residents but were unable to tell us the last time they sat down with a person and chatted to them or offered them comfort. We saw one person had been left unattended and alone in a room for over an hour. During that time the person showed visible and verbal signs of distress. Other staff said that they would like to spend time with the people but had too many tasks to complete.

We saw one person who was walking in the corridor wore heavily stained clothing: one carer asked him to wait a minute as they were assisting another person. It took ten minutes for carers to attend to this person.

During the morning, we saw that for over twenty minutes in the lounge area of Sunflower unit, four people appeared to be withdrawn and had no engagement from staff to stimulate them or to offer them comfort. We saw that staff were present but they were engaged in writing up notes.

During our lunchtime observation on the Sunflower unit, there were insufficient staff present to ensure the safety and welfare of the people. We saw a person get agitated and upset another person, this incident escalated as there was not a staff member to intervene.. We saw that one member of the care staff had to serve lunch to 14 people. The lack of effectively trained staff present during lunch meant that people were not served meals in a dignified way and that there were risks that people's needs were not being met.

One staff member we spoke said they had not had formal health and safety and infection control training since they started work at the home recently. The home had not supported staff to have the right skills to carry out effective cleaning routines.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare.
Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not cared for in a clean, hygienic environment as there were not effective systems in place to reduce the risk and spread of infection.

This section is primarily information for the provider

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met: There were not sufficiently trained staff on duty to meet the people's needs in a person centred manner.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 10 January 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk