Inspection Report

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

Wansbeck Care Home

Church Avenue, West Sleekburn, Choppington,
NE62 5XE

Date of Inspection: 13 March 2014

Date of Publication: April 2014

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

Cleanliness and infection control	✖	Enforcement action taken
Safety and suitability of premises	✖	Action needed
Safety, availability and suitability of equipment	✖	Action needed
Staffing	✖	Action needed

Details about this location

Registered Provider	Four Seasons (Bamford) Limited
Overview of the service	Wansbeck Care Home is situated in West Sleekburn, Choppington. It provides personal care and accommodation for up to 40 people, most of whom have dementia.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

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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 13 March 2014, talked with people who use the service and talked with staff. We reviewed information given to us by the provider and talked with other authorities.

What people told us and what we found

We carried out this inspection since we had received information of concern about infection control procedures and the condition of the premises.

We were assisted during our inspection by the manager who had been in post since December 2013. Her name does not appear within this report, because she is not yet registered with the Care Quality Commission.

Some people who lived there were not able to communicate with us verbally because of their condition. We spoke with three people who informed us that staff looked after them well and the home was kept clean.

However, we had concerns about infection control and the cleanliness of the home. In addition, we found that maintenance had not always been carried out in a timely manner. Paint was peeling off in certain areas of the home and some of the ceiling tiles were stained.

We had not planned to look at staffing levels or equipment at the home. However we had concerns about these two essential standards. We considered that there were not enough domestic staff on duty to ensure that relevant standards such as those relating to infection control and the environment were met. We also found that some equipment was used inappropriately, broken or out of use.

We passed our concerns to the local authority contracts and commissioning team, safeguarding team, environmental health and the fire safety officer.

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 15 May 2014, setting out the action

they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Environmental Health, Local Authority: Commissioning, Local Authority: Safeguarding and Fire Safety Assessor. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Wansbeck Care Home to protect the health, safety and welfare of people using this service.

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

Cleanliness and infection control ✖ Enforcement action taken

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 protected not protected from the risk of infection because appropriate guidance had not been followed. People were not cared for in a clean environment.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Prior to our inspection, we received information of concern about infection control issues at the home. We therefore carried out an inspection to look at this regulation.

All providers of health and social care have to comply with the Code of Practice for health and social care on the prevention and control of infections, and related guidance. We found that criterion two of this code, which requires the service to provide and maintain a clean and appropriate environment was not being fully met.

We spent time looking around the home. We looked inside the laundry room on the ground floor. We saw that some clean, ironed items of clothing were lying on the floor in close proximity to soiled clothing. The manager told us that there was no system in place to ensure that clean and soiled clothes were stored separately. We concluded that there was a risk of cross contamination from soiled or infected linen. Paint was peeling off in various places around the laundry room. This meant that the room could not easily be cleaned.

We checked communal bathrooms and shower rooms. We noted that the bases of some of the shower chairs had not been cleaned and there were brown stains evident. We observed that many of the hot and cold water tap inserts were missing in bedrooms and bathrooms which meant that the taps could not easily be cleaned nor differentiated. In addition, areas of bathroom and shower room floors had not been cleaned, particularly in the corners where there was a build-up of dirt and debris.

We went into one person's room and noticed that his wheelchair had not been cleaned and was covered in food particles. We asked the manager whether there was a system in

place to ensure that wheelchairs were cleaned regularly. The manager confirmed that a system for cleaning wheelchairs was currently not in place. We also noticed that the person's call alarm handset was thick with food particles and grime.

The home had a sluice room for the disposal of bodily waste. A sluice machine had been fitted which cleaned the continence equipment such as commode pots and urine bottles. The manager explained that this machine was currently out of use and had not worked since the 7 March 2014. The manager confirmed that this issue had been reported to their maintenance department. We noticed that some continence equipment was stored on the floor. The floor was unclean and covered with stains and debris. In addition, there was no rack to dry and store the continence equipment hygienically. We considered that this was an infection control risk. We asked staff how continence equipment was cleaned. They told us that they manually washed this equipment in a bathroom or shower room. This was an infection control risk because bacteria could be transferred during the manual cleaning process

We considered that effective systems to reduce the risk and spread of infection, were not fully in place.

We spoke with both the manager and area manager about our concerns. They told us that they were already aware of many of the issues we raised and had immediately started to address these. In addition, they were working with the local NHS Trust's infection control team. This team visited the home during our inspection and confirmed that some improvements from their last visit had been made.

Safety and suitability of premises ✖ Action needed

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was not meeting this standard.

People who used the service, staff and visitors were not fully protected against the risks of unsafe or unsuitable premises.

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

Prior to our inspection, we received information of concern about the condition of the premises. We therefore carried out an inspection to look at this regulation.

We spent time looking around the home. We noticed that plaster was damaged in certain areas. We checked the kitchen and noticed that an area of wall was covered by black bin bag lining following plaster damage.

An area of piping and wires was exposed in one area of the home at ceiling height. The manager explained that a boiler had been fitted and the piping and wires had not been boxed in yet.

The hairdressing room, which was in use, was also used as a storage area for a fridge, freezer and hot trolley as well as other equipment such as ladders and wood. We noticed that paintwork was peeling in various places and a damaged piece of wood had been used to box in underneath the sink.

We noticed that many of the ceiling tiles were brown and discoloured. These looked unsightly. In one downstairs bathroom, we saw that some ceiling tiles were bulging and damaged. We considered that this was a health and safety risk.

We checked the laundry room on the ground floor. We noticed that there was a lack of shelving and storage areas to ensure that laundry was stored appropriately. We also checked the lounge areas. In one of the lounges we visited, part of the carpet strip had come off which left a raised edge of carpet which we considered was a trip hazard.

We saw many instances where paint and plaster was peeling. In addition, some of the silicone sealant in the bathrooms and hairdressing room was mouldy or grimy. This issue had already started to be addressed. During our visit, the maintenance man had renewed the silicone in the ground floor bathroom.

When we visited people in their rooms we noted that there were several maintenance issues which needed addressing. We noticed that one person's en-suite door handle was loose and the tops of the screws were revealed. This was a health and safety risk. Two people's en-suite taps were not working; one person's hot tap and another person's cold tap.

We saw that fire extinguishers were stored on the walls at various locations around the home. The manager explained that these were serviced annually. We noticed that these had last been serviced in February 2013. The manager explained that they were aware of this and were in the process of organising annual testing.

We considered that the provider had not taken steps to provide care in an environment that was adequately maintained.

We spoke with the manager and regional manager about our concerns. They informed us that they were already aware of many of the issues we raised. They also informed us of their plans to refurbish and redecorate the home.

Safety, availability and suitability of equipment ✖ Action needed

People should be safe from harm from unsafe or unsuitable equipment

Our judgement

The provider was not meeting this standard.

People were not fully protected from unsafe or unsuitable equipment.

We have judged that this has a minor 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

We did not plan to inspect this essential standard. However, we identified concerns with equipment during our inspection which led us to look at this regulation.

We spent time looking around the home and checking people's bedrooms. We noticed that two people had been sleeping on beds that had overlay mattresses on. These are pressure relieving mattresses which are designed to be placed on top of an existing mattress. We observed that there was no existing mattress in place. This was a pressure sore risk. Staff immediately ensured that the correct mattresses were put on these beds. We also saw that two people's armchair cushions were missing. The manager informed us that these cushions had probably been lost.

We went into the laundry room. We noticed that some soiled clothing was stored on the floor. The manager explained that there was a lack of laundry baskets and trollies. In one bathroom we visited, the laundry basket was cracked. This was a health and safety risk. At the end of our inspection, the manager explained that more laundry storage equipment had been ordered.

We checked the kitchen and noticed that the dishwasher was out of use. Kitchen staff had to wash the dishes by hand. The manager explained that the non-functioning dishwasher had been reported to their maintenance department.

Staff informed us that the bath hoist in the ground floor bathroom was not working. The manager explained that this had also been reported to the maintenance department. Staff informed us and our own observations confirmed that other bathing facilities were available.

We concluded that people were not fully protected from unsafe or unsuitable equipment.

We spoke with the manager and regional manager. They informed us that they were already aware of many of the concerns we had raised and were in the process of addressing them immediately.

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 staff employed to ensure that relevant standards such as those relating to infection control and the environment were met.

We have judged that this has a minor 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

We did not plan to inspect this essential standard. However, we identified concerns with domestic staffing levels during our inspection which made us look at this regulation.

Staff did not raise any concerns about the number of care workers on duty and we observed that care workers carried out their care duties in a calm unhurried manner.

We spoke with the manager about the number of domestic staff on duty. She explained that there were two domestic staff on duty three days a week and one four days a week. We spoke with a member of staff from this team. He explained that it was difficult to clean the home adequately when there was only one domestic on duty. He informed us that most of the people at the home had dementia and required assistance with their toileting needs. He said that extra care was required to ensure that the home was clean because of people's toileting issues. This was confirmed by the manager.

The general appearance of certain areas in the home, including some people's bedrooms, communal toilets and bathrooms gave us cause for concern. We concluded that there were not enough staff employed to ensure that relevant standards such as those relating to infection control and the environment were met.

We spoke with the manager and regional manager about our concerns. They said that they were going to look at the domestic staffing rota immediately.

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 activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety and suitability of premises**
	How the regulation was not being met: People who used the service, staff and visitors were not fully protected against the risks of unsafe or unsuitable premises. Regulation 15 (1)(c).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010** **Safety, availability and suitability of equipment**
	How the regulation was not being met: People were not fully protected from unsafe or unsuitable equipment. Regulation 16 (1)(a)(b)(2)(3)(4)(a).
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing**
	How the regulation was not being met:

This section is primarily information for the provider

	There were not enough staff employed to ensure that relevant standards such as those relating to infection control and the environment were met. Regulation 22.

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 15 May 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.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 05 May 2014 This action has been taken in relation to:	
Regulated activity	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010** **Cleanliness and infection control**
	How the regulation was not being met: People were not protected from the risk of infection because appropriate guidance had not been followed. People were not cared for in a clean environment. Regulation 12 (1)(a)(b)(c)(2)(a)(c)(i)(ii).

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

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