

The Gables (Northumberland) Ltd

# The Gables Care Home

## Inspection report

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Bedlington  
Northumberland  
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## Ratings

Overall rating for this service

Inspected but not rated

Is the service safe?

**Inspected but not rated**

# Summary of findings

## Overall summary

### About the service

The Gables is a residential care home providing personal care for up to 10 people with mental health issues, including both younger and older adults. At the time of the inspection there were 10 people using the service.

The home is a converted house in Bedlington Station. It has accommodation on the ground and first floor. There is no lift or stair lift to access the upper floor. There is a lounge area on the ground floor and a small dining room. People have access to shared bathroom and washing facilities and a shared laundry area.

### People's experience of using this service and what we found

People were not always supported in a safe environment and staff were not following infection control guidance. Infection control issues that we had found at the previous inspection had not been fully addressed. Some staff continued not to follow the correct guidance on the use of personal protective equipment (PPE). Whilst some training on the use of PPE had been offered, there were no competency checks to ensure procedures were understood and being followed. Disposal of used PPE was not always carried out safely and in line with national guidance. The manager told us additional cleaning had been put in place to prevent the spread of COVID-19, including extra cleaning of high risk areas. However, records documenting this cleaning were not well completed and we were not assured that thorough cleaning was being undertaken. The provider had engaged a company to undertake a deep clean of the premises, although both people and staff said this clean had not been thorough.

For more details, please see the full report which is on the CQC website at [www.cqc.org.uk](http://www.cqc.org.uk)

### Rating at last inspection.

The last rating for this service was requires improvement (published 19 November 2020).

The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was still in breach of regulations.

### Why we inspected

The inspection was prompted due to continued concerns received about infection control practices at the home. A decision was made for us to inspect and examine those risks.

We undertook this targeted inspection to check on a specific concern we had about infection control. The overall rating for the service has not changed following this targeted inspection and remains requires improvement.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns.

They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Gables Care Home on our website at [www.cqc.org.uk](http://www.cqc.org.uk).

### Enforcement

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

We have identified a breach in relation to Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Effective practices to keep people and staff safe during the current COVID-19 pandemic were not being followed. There continued to be concerns about cleanliness and infection control overall at the home.

Full information about CQC's regulatory response to the more serious concerns found during inspections can be found in the enforcement section at the end of this report.

### Follow up

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### **Is the service safe?**

Further information is in the detailed findings below.

**Inspected but not rated**

# The Gables Care Home

## Detailed findings

### Background to this inspection

#### The 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.

This was a targeted inspection to check on specific concerns we had about infection control procedures at the home. We received information of concern about infection control and prevention measures at the service.

#### Inspection team

The inspection was undertaken by one inspector.

#### Service and service type

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

The service did not have a manager registered with the Care Quality Commission. This meant at the time of our inspection the provider alone was legally responsible for how the service is run and for the quality and safety of the care provided. There was an acting manager in charge of the home on a day-to-day basis.

#### Notice of inspection

We gave a short period notice on the morning of the inspection to ascertain the situation at the home with regard to Covid-19 infections and to allow staff to prepare for the inspection to be carried out safely, with minimal risk to people living at the home.

#### What we did before the inspection

We reviewed information we had received about the service since the previous inspection. We sought feedback from the local authority and professionals who work with the service. The service is in organisational safeguarding. Organisational safeguarding is a process employed by the local authority

where there are multiple concerns about a service. We attended an organisational safeguarding meeting and reviewed the information presented.

During the inspection

We spoke with one person who used the service. We spoke with three members of staff including the manager and two care workers. We reviewed a range of records relating to infection control systems, the management of the service and policies and procedures.

After the inspection

We continued to seek clarification from the provider to validate evidence found.

# Is the service safe?

## Our findings

S5□ How well are people protected by the prevention and control of infection?

- Robust infection control measures were not always in place and people were not always protected against the risks associated with the spread of infection.
- Staff members were not always following national guidance on the safe and effective use of PPE. We witnessed one member of staff wearing their face mask below their chin or under their nose on four occasions.
- PPE was not stored safely. Rolls of aprons had been left out in a number of rooms, including toilet areas. This meant they were potentially exposed to contaminations by touch or when someone used the toilet area.
- Used PPE was discarded in bins that did not have appropriate clinical waste bags in them. This meant used PPE was not disposed of in line with national guidance.
- At the last inspection we found communal cloth towels were in use in bathroom and toilet areas. We advised the provider that this posed an infection control risk. At this inspection, whilst paper towels were available, we found communal cloth towels were still in use in some areas.
- Systems to maintain effective cleanliness at the home and limit the spread of the COVID-19 virus were not robust. Records relating to the cleaning of high-risk areas, such as door handles and light switches were not well completed and we could not be assured this cleaning had been thoroughly undertaken.
- Following the last inspection in October 2020, the provider told us they would employ a company to carry out weekly or fortnightly deep cleans of the home. At this inspection we found only one deep clean of the home had taken place, in February 2021. We found the home still in need of further cleaning. People at the home and staff told us the deep clean had not been thorough. One person told us, "They did not move the furniture. After they cleaned I still had to sweep under my bed and wardrobe."
- Cleaning products were not stored safely. We found a cupboard in the laundry area that contained bleach had been left unlocked. A cupboard in the kitchen area was also unlocked and this contained other cleaning products and turpentine. This presented a risk to people who lived at the home as potentially hazardous chemicals were not stored securely.

People were not always protected from the risk of infection because staff were not following official guidance and robust control measures were not in place. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People and staff at the home were subject to regular testing for COVID-19 in line with national guidance.
- The majority of people and staff had received their first COVID-19 vaccination.

This section is primarily information for the provider

## Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment  Robust systems were not in place to effectively manage and mitigate the risks associated with infection. Staff actions and service processes were not in line with current government guidance on COVID-19. Regulation 12(1)(2)(h).

### **The enforcement action we took:**

We have imposed an urgent condition on the provider to ensure that infection control practices are in line with current guidance.