Marton Care Homes Ltd

Wansbeck Care Home

Inspection report

Church Avenue
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Choppington
Northumberland
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Tel: 01670817173

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Wansbeck Care Home is a residential care home providing accommodation and personal care to up to 40 older people some of whom are living with a dementia related condition. At the time of our inspection 34 people were living at the home. The home is separated into four units across two floors.

People's experience of using this service and what we found
People were not always protected from the risk of harm. Infection prevention and control procedures did not follow government guidance. People were receiving medicines as prescribed but some records for 'as required' medicines were not fully completed.
Systems were in place to safeguard people from the risk of abuse. We observed there were enough staff available to meet people's needs and staff were recruited safely.

We have made a recommendation about the governance of the service. Quality monitoring systems had failed to identify the shortfalls in infection control practices we observed. The provider was committed to delivering service improvements.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 31 January 2020).

Why we inspected
We undertook this targeted inspection to follow up on specific concerns which we had received about the infection control practices of staff. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with infection control practices, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment at this inspection. In particular, with infection control practices.

Please see the action we have told the provider to take at the end of this report.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Wansbeck 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 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was conducted by two inspectors.

Service and service type
Wansbeck 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. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
We gave the service very short notice of the inspection.

What we did before the inspection
We reviewed information we held about the service, including the statutory notifications we had received from the provider. Statutory notifications are reports about changes, events or incidents the provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams to request feedback.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with the relatives of six people who used the service about their experience of the care provided and observed staff interactions with people. We spoke with eight members of staff including the home manager and quality manager.

We reviewed a range of records. This included care records for seven people. We looked at recruitment records and a variety of records relating to the management of the service, including policies and procedures.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested further information to be sent when the inspection process was extended from targeted to focused. We spoke with a health professional to share details of our inspection observations.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection
• Staff did not follow the correct procedure for wearing and removing Personal Protective Equipment (PPE). Staff were observed wearing their face masks under their nose or chin or removed their masks to take drinks. They failed to replace facemasks with a new mask after each incident where they had been contaminated in line with government guidance.
• The home's social media Facebook page showed photographs and videos which demonstrated staff were not following government guidance in relation to infection control practices. Staff were seen to be touching people without wearing gloves and aprons and were not following social distancing guidance.
• Cleaning was not always taking place in line with the requirements identified by the provider.
• PPE was not stored appropriately around the service. For example, aprons were draped across trolleys and handrails in bathrooms and corridors meaning they were at risk of contamination.
• Some feedback from staff indicated additional training in relation to infection prevention and control was required. One staff said, "In all honesty some staff could do with additional training. Things like infection prevention and control and keeping it up to date; knowing what PPE to use and when."

The provider's failure to ensure infection control policies and procedures were followed by staff was a breach of regulation 12(1) (2)(h) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
• Emergency plans were in place to ensure people were supported in certain events, such as fire.
• Risk assessments were in place for people. Since our last inspection the home was being managed by a new provider. A plan was in place to update risk assessment documentation in line with the current providers policies.
• Premises checks had been completed to help ensure the safety of the building.

Staffing and recruitment
• There were enough staff deployed to meet the needs of people during the inspection. The provider used a dependency tool to assess the staffing requirements for the home.
• Additional staff including domestic staff had recently been recruited. The staff we spoke with understood the needs of the people they supported.
• Procedures were in place to ensure staff were recruited safely.

Systems and processes to safeguard people from the risk of abuse

• Systems were in place to safeguard people from the risk of abuse. A relative told us, "[Name of staff] contacted us about a safeguarding issue. I felt [staff] had assessed [relative] really well, they reassured me they could meet [relatives] needs and continue to do so."
• One relative shared information of a safeguarding nature with us. We passed this feedback to the local authority safeguarding team. The provider responded to this feedback immediately and commenced an investigation into the concerns.
• Staff understood their role in how to protect people and told us they would be confident to raise any concerns if they suspected any form of abuse.

Using medicines safely
• Systems were in place to ensure medicines were managed safely.
• Protocols were in place for people who needed 'as required' medicines. Records were not fully completed to show they had recorded the outcome for these medicine administrations. In addition, staff were not following the providers policy in relation to recording the administration of 'as required' medicines in the daily records for people.

Learning lessons when things go wrong
• Systems were in place to review accidents or incidents. Accidents and incidents were reviewed to identify if there were any trends or if lessons could be learned and whether improvement actions could be taken to minimise future risks.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• There had been several recent managerial changes within the home. A new home manager had been recruited. Their first day of employment was the day of our inspection visit.
• A range of quality assurance audits were completed. The provider had not identified the issues we found in relation to the infection prevention and control practices within the home.
• There were gaps in the recording on care records for some people. For example, a falls risk assessment for one person was not fully completed which meant you could not identify how the assessed risk had been determined.

We recommend the provider reviews their governance systems to ensure they are robust and capable of monitoring quality across the whole service.

• The provider was responsive and an action plan was implemented to address the issues we identified during this inspection.
• The service was working through a transition period of changing documentation in line with the new providers policies.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
• The management team were aware of their regulatory responsibilities. Any statutory notifications the provider was required to submit to CQC had been done in a timely way.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care; Working in partnership with others
• Surveys were used to gather the views of people, staff and relatives. The provider told us action was taken to respond to any feedback they received.
• Non-essential visiting had been suspended due to the Covid-19 pandemic. Systems had been introduced to support people to maintain contact with their relatives. This included window visits, video and phone calls. Relatives provided feedback there had been some difficulties with video calls due to the equipment not always being charged. The provider was assessing options for how to introduce indoor visits in line with

government guidance.
• The home had received infection control support and guidance from external health professionals and the provider was committed to ensuring staff always followed government guidance.
• We received mixed feedback from relatives regarding the communication systems in place. One relative told us, "The new manager sends an email on a Friday to give updates, this didn't happen previously." Another relative said, "They [staff] offered a weekly update call but I've only had two phone calls from them, there is very limited information that they share."
• Links had been established within the local community. Children from a local school were sending letters and pictures to people.

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 Infections prevention and control procedures were not robust. Regulation 12, (1)(2)(h)

The enforcement action we took:

We issued a warning notice.