Bethesda Care Homes Ltd

Pinglenook Residential Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Pinglenook Residential home is a care home, providing personal care for up to 16 people aged 65 and over who may also be living with dementia. At the time of the inspection 13 people were using the service. Accommodation is provided over the ground and first floors with communal lounges and dining areas.

People's experience of using this service and what we found
Risk was not identified or managed. Care plans and risk assessments were not always reflective of people's needs or risks. This exposed people to risk of significant harm.

Staffing numbers were not sufficient to meet people's needs or keep them safe. Staff did not always have time to spend with people or to monitor people when they displayed risky behaviours.

People were not protected from the risk of avoidable harm. There were a number of unwitnessed falls and opportunities to learn from accidents and incidents were missed.

Quality assurance systems and processes failed to identify concerns relating to safe care. Opportunities for people to follow their hobbies and interests were very limited and some staff were not aware of people's unique life and social histories. This information is important when supporting people with communication difficulties.

Infection prevention and control procedures mostly followed expected government guidance and requirements.

People received their prescribed medicines at the right time. Medicine administration records were accurate and up to date.

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

Rating at last inspection (and update)
The last rating for this service was Good (Published 15 July 2020). The rating for the service has deteriorated to Inadequate. This is based on the findings at this inspection.

Why we inspected
We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The inspection was prompted in part due to concerns received about care and support provided to people at Pinglenook Residential Home. A decision was made for us to inspect and examine those risks. We

undertook a focused inspection to review the key questions of safe and well-led. We reviewed all the information we held about the service.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this report. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Pinglenook Residential Home on our website at 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 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, staffing and good governance.

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

Follow up
The overall rating for this service is 'inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this time-frame and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well led findings below.

Pinglenook Residential 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 carried out by one inspector and one assistant inspector.

Service and service type
Pinglenook Residential 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 had a manager registered with the Care Quality Commission.

Notice of inspection
This inspection was unannounced. We gave the provider five minutes notice because we needed to check the current COVID 19 status for people and staff in the service.

What we did before the inspection
We reviewed information we had received about the service since the last inspection on 14 and 30 January 2020. We sought feedback from the local authority. We used all of this information to plan our inspection.

During the inspection we spoke with two people who used the service about their experience of the care provided. We spoke with five members of staff including the registered manager, care workers and catering staff. We reviewed a range of records. This included care records of five people at the service and multiple medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection we continued to seek clarification from the provider to validate evidence found. This included, but was not limited to care plans, risk assessments staff rota's, dependency tools and audits.

Inadequate

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 deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Risks to service users were not appropriately managed. One person had complex mental health needs and two other people were living with advanced dementia and associated behaviours which caused risk of harm. There were several recorded incidents which resulted in harm or risk of harm to the person, or to other people who used the service. Despite these known risks, care plans and risk management plans did not protect people from avoidable harm.
- We saw one person who was disorientated to time and place approaching and touching other people and staff throughout the inspection. This put the person and others at risk of harm, including the potential increased risk of transmission of Covid 19.
- Some staff did not have the knowledge, skills or experience to meet the needs of people with complex mental health needs. In particular they did not have sufficient training about mental health, self-harm and managing distressed or risky behaviours.
- Some staff had not received any practical training about moving and handling or use of mobility equipment such as hoists. There was no information for staff about the type of sling they should use or how this should be measured to ensure it was the correct fit and safe for the individual.
- Care plans and risk assessments for nutritional risk and risk of developing pressure sores had not been updated for five months, this was despite known changes to two people's health and wellbeing such as pressure sores and weight loss recorded by staff in daily records. Two people were identified as at risk of developing pressure sores or had a pressure sore. Staff were instructed to carry out two hourly positional changes in order to reduce the risk. Records showed this was not always carried out two hourly.
- There was contradictory information about a medicine allergy in one person's records. The care plan recorded 'no allergies' yet they had a known allergy to an antibiotic. This put the person at risk of avoidable harm.
- One person had been identified as at risk of accessing the stairs unsupervised and was at risk of falling. A stairgate had been fitted to minimise the risk. However, this had been removed two days prior to our inspection because the stairlift had broken and was in need of repair. There were no alternative risk management plans in place and therefore the person remained at risk of accessing the stairs and falling because of their mobility difficulties..
- Staff had not received appropriate training about fire evacuation procedures and did not know how to use fire evacuation equipment. We saw a fire door on the first floor was blocked with a mobility hoist. Some people's fire evacuation plans were not reflective of their current needs. One person's fire evacuation plan stated they could walk with prompting, but they could not mobilise at all. This meant emergency evacuation information was inaccurate and staff were not clear about how to evacuate people in the event of a fire or emergency. We contacted the fire and rescue service who spoke with the provider about action they should take.

Due to this lack of risk assessment and risk management, people were placed at risk of harm. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing

● Staffing numbers were calculated based on people's dependency needs. However, when we looked at how this tool was used, we found it did not accurately reflect the actual and current needs for two people. This meant staffing numbers may not be sufficient to meet people's needs and keep them safe.

● At the time of our inspection, two people were at risk of harm without close staff supervision, another person frequently became distressed and required a staff member to be with them to offer reassurance and another person was frequently up at night and known to be at risk of falling. Two people had mobility problems and required two staff to attend to their needs for transfers and personal care.

● Staff were not able to provide the monitoring or support people required to meet their needs or keep them safe. In particular, at night when there were only two staff on duty. There were six unwitnessed falls recorded in accident records in July and August 2020.

● Call bell audits and event reports showed that during August 2020 there were two occasions at night when call bells were not answered for more than 13 minutes and one occasion when the call bell was not answered for more than five minutes. Staff recorded in the event report, they did not hear the call bell until they came out of the room of the person they were attending to. This meant both staff were attending to one person and there were no other staff available to attend to or supervise other people using the service.

● There was a mixed response from staff about staffing numbers. Some staff felt there were not enough staff to meet people's needs or keep them safe. In particular when staff called in absent with short notice, they were not replaced or there was a delay in replacing them.

Due to this lack of sufficient numbers of suitably skilled and experienced staff, people were placed at risk of harm. This is a breach of Regulation 18 (1) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Learning lessons when things go wrong

●There were six unwitnessed falls recorded in July and August 2020. There was no analyses or audit or consideration of action to reduce further risk.

Preventing and controlling infection

● Staff were mostly following expected guidance regarding infection prevention and control.

● Staff were following cleaning schedules including increased cleaning of high touch areas. However, one person's room had an unpleasant odour and staff reported this was an ongoing issue.

● Signage was displayed about hand washing and use of personal protective equipment (PPE) for staff and visitors.

● Staff had access to and used (PPE) such as gloves and aprons. However, there was a delay on staff putting on their masks. They did not do this on immediate entry to the building. We saw staff frequently touching their masks and not changing them as they should once the mask had been touched.

● Visiting was restricted in order to reduce the risk of infection during Covid 19. An area in the garden had been developed for people to see their relatives for socially distanced visits.

● There was a designated staff lead for infection prevention and control. They had received additional training from the local authority.

● Regular Covid 19 testing for people and staff was taking place.

Staff recruitment

● Staff were recruited in a safe way. Appropriate checks were carried out such as references and criminal records checks. This meant that so far as possible, only staff with suitable qualities and skills were employed.

Systems and processes to safeguard people from the risk of abuse

● Staff had received on line training about protecting people from abuse. There was a mixed response from staff about systems for reporting abuse. Staff understood their responsibilities to report suspected abuse but not all staff confidence that their concerns would be listened to and acted on.

● Staff did not have all the training they required about managing risky behaviour which could result in harm to the person or to others.

Using medicines safely

● People told us staff managed their medicines in the right way and their got their prescribed medicines at the right time.

● Staff had received training about managing people's medicines and had their competency assessed.

● Peoples medicines were stored securely and in line with manufacturers requirements.

● Medicine records we looked at were accurate and up to date.

Inadequate

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 good. At this inspection this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Systems for identifying, capturing and managing risks and issues were ineffective. Audits had not been carried out or had not identified the deficiencies we found at this inspection.
- People's care plans and risk assessments were not up to date and were not reflective of people's current needs. One person's needs had changed significantly following an accident and hospital admission, but their care plan had not been updated.
- Staff had not received all the training they required to meet people's needs or keep them safe. For example, the management of risky or self-harming behaviour and mental health. Use of mobility equipment and fire safety evacuation procedures.
- There was limited analyses and limited action taken in response to accidents or incidents in order to reduce further risk. Despite a number of unwitnessed falls and other incidents where people were put at risk of harm, action was not taken to reduce these risks for people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was very limited evidence of involving people or seeking their feedback about the care and support they received. Although care plans recorded a monthly review or evaluation, there was no record of involvement of the person or changes made to reflect people's wishes and preferences.
- There was no system in place to ensure people could have a bath or shower at a time of their choosing. Records for two people showed they had not had a bath or shower within the last 20 days.
- Staff we spoke with were not familiar with people's life histories or significant details such as past occupation, hobbies or interests. This information is important when people have communication difficulties because they are living with dementia and supports staff to communicate with people effectively and to find out their views, likes and dislikes.
- Staff had used 'listening forms' to seek people's views. However, none had been completed since July 2020 and there was little evidence of changes being made to reflect people's preferences.

Continuous learning and improving care. 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

- Quality monitoring systems and processes were not effective in identifying areas requiring improvement. Audits did not always identify ongoing risks so that accidents and incidents could be used to learn and

improve.

These matters were a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● The registered manager told us they spoke with people daily. They also told us they were about to send a satisfaction questionnaire to people's relatives in order to seek their views.
● Staff meetings were held. The registered manager told us changes had been made as a result of staff suggestions. For example, a person's rooms had been changed for a room with more space to enable staff to use mobility aids.

Working in partnership with others
● People had access to healthcare professionals such as GP's, community nurses

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 There was a lack of risk assessment and risk management, this put people were placed at risk of harm.

The enforcement action we took:

Urgent imposing conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems and processes failed to identify concerns relating to safe care or to mitigate risk.

The enforcement action we took:

Urgent imposing conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing numbers were not sufficient to meet people's needs or keep them safe.

The enforcement action we took:

Urgent imposing conditions.