

Bethesda Care Homes Ltd

Pinglenook Residential Home

Inspection report

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Date of inspection visit:

25 April 2022

29 April 2022

13 May 2022

Date of publication:

17 January 2024

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 accommodation and personal care for up to 16 people aged 65 and over who may also be living with dementia. At the time of the inspection thirteen people were using the service. Accommodation is provided over the ground and first floor with communal lounges and dining areas.

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

People were not safe because risk was not managed effectively. Care plans and risk assessments did not provide enough information about what staff should do to meet people's needs and keep them safe. Staff did not always identify when people at risk of malnutrition and dehydration had not had enough to eat or drink and did not take action when this was the case.

Leadership and governance was not effective and did not identify risk, drive sustainable improvement or seek and act on feedback from people and staff. There were ongoing issues with the environment requiring general maintenance and redecoration. Deficiencies identified by the fire service and by the local authority had not been addressed.

The majority of the service's environment was clean and fresh and staff followed infection prevention and control and government guidance about the control of COVID-19.

There were enough staff on duty to meet people's needs and staff were recruited in a safe way. Staff were kind and caring and had developed positive relationships with people.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

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 requires improvement (28 May 2021).

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 COVID-19 and other infection outbreaks effectively.

This inspection was prompted by a review of the information we held about this 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 full report.

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 will take further action if needed.

We have identified breaches in regulations in relation to safe care and treatment and leadership and quality monitoring.

We have taken enforcement action and cancelled the provider's registration.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

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 Health and Social Care Act 2008.

Inspection team

The inspection was carried out by one inspector.

Service and service type

Pinglenook Residential Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Pinglenook Residential Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there were three registered managers in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection

We spoke with three people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including a registered manager, deputy manager and three care workers.

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- One person had an identified risk of developing a pressure sore. They required a special airwave alternating pressure mattress to reduce the risk of pressure sores developing. The provider failed to ensure this mattress was replaced when it failed safety checks and was removed.
- This put the person at risk of avoidable harm because they were without the required mattress for a period of more than three weeks. As well as this, records showed the required support from staff with positional changes had not been offered at the required intervals to reduce the risk of the person developing pressure sores. This resulted in the person developing a pressure sore.
- Food and fluid charts recorded four people did not have enough to eat and drink each day. Despite people having lost weight, staff had not offered additional meals or snacks or provided fortified meals or drinks. Specialist advice had not been sought in a timely manner.
- Four people identified at risk of dehydration and malnutrition had care plans and risk assessments in place but these did not specify the amount of fluid people should have each day or the most effective way staff could encourage people to have enough to eat.
- One person's care plan for nutrition required a specific diet assessed by a speech and language therapist. However, records showed meals and snacks provided did not follow this required diet and this put the person at risk of choking.
- Risk assessments were not effective because they did not provide enough information and instruction for staff to follow to keep people safe.

Risk was not managed effectively, and people were not protected from avoidable harm. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- Although staff had training and understood their responsibilities to protect people from abuse, we found they did not always recognise or report issues they were dealing with. When they did recognise concerns and escalated to management, management did not always act on the safeguarding matters and take appropriate actions.
- People said they felt safe and could speak with staff if they had any concerns.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Staff had consulted with the community mental health team for advice and support regarding people's best interests.

Preventing and controlling infection

- The service was mainly clean and fresh. However, there were unpleasant odours in one bedroom and in the downstairs shower room. The waste outlet in the hand basins in two people's rooms were tarnished and may be difficult to keep clean. There was a rusty shower chair which was difficult to clean. The registered manager took action after our inspection and replaced the shower chair with a new one.
- The outstanding general maintenance deficiencies and redecoration such as peeling plaster and scratched and dirty paintwork made thorough cleaning difficult.
- Staff were following infection control procedures and government guidance for the management of COVID-19.

Visiting in care homes

- There were no visiting restrictions. Staff supported people to receive visits from their friends and family in a safe way.
- The provider was preventing visitors from catching and spreading infections.

Learning lessons when things go wrong

- Action was not always taken when things went wrong to prevent further risk. Issues identified by the local authority contract team in February 2022 had not been addressed and this meant people continued to be at risk. For example care plans and risk assessments did not highlight what should be done when risk was identified and food and fluid charts were not being checked each day. These issues were again identified at our inspection.
- Procedures were changed following a lost prescription to ensure a copy of each prescription was available. Staff received further training following a medicines error to prevent any further errors and improve safety.

Staffing and recruitment

- The registered manager used a dependency tool to calculate how many staff were required to meet people's needs.
- Some people had complex physical and mental health needs. During our visit, staff were available and were able to effectively provide reassurance when people became distressed and required support.
- Staff were recruited in a safe way. Checks and references were carried out before staff were offered employment. This meant so far as possible, only staff with the right skills and experience were employed.

Using medicines safely

- Protocols were in place where medicine was prescribed on an 'as required' basis. These required more detail and the registered manager took immediate action to address this. This meant staff knew when this medicine should be offered.
- People's medicines were managed in a safe way. Staff had training and had their competency assessed.
- Records were accurate and up to date and audits were carried out to make sure people had their medicines at the right time and in a safe way.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed 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; 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

- Risk management was not effective. Identified risks such as risk of malnutrition, dehydration and risk of developing pressure sores were not managed.
- Food and fluid charts were not checked each day and no action was taken when people had insufficient amounts to eat and drink. A weekly care records audit failed to identify any of these issues.
- A mattress required to prevent the development of pressure sores had been not replaced following failure. This was despite requests made by the registered manager to the provider. Staff did not carry out repositioning at the required frequency. This resulted in a person developing a pressure sore requiring hospital treatment.
- The premises and environment required general maintenance and redecoration. Despite these issues being identified by the registered manager, action had not been taken and there was no plan in place to address the ongoing maintenance and décor deficiencies. These included; peeling plaster, dirty and scratched paintwork, broken furniture, unsafe access to the garden area and a broken gate. The hand wash basin waste outlets in some people's rooms were old and tarnished. There was an unpleasant damp odour in the ground floor shower room.
- A fire safety inspection carried out in April 2022 had identified a number of areas requiring improvement including the fire risk assessment, emergency procedures and drills and deficiencies found in fire doors. At the time of this inspection, these matters had not been addressed by the provider.
- The fire risk assessment had been completed in 2015 before the provider owned and operated Pinglenook Residential Home. Any reviews of the fire risk assessment carried out had not sufficiently identified fire safety maintenance such as fire doors and compartmentation deficiencies.
- The providers systems and processes were not effective in identifying these risks and deficiencies.

Systems and processes were not effective to assess, monitor and mitigate risk or to assess, monitor and improve the quality of the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

- Leadership at provider level was not always effective because staff did not always feel listened to and were

not given information or timescales about when identified deficiencies would be addressed or if action would be taken.

- People were not involved in the care planning process and had limited opportunities to feedback their views and experiences so that these could be acted on.
- Staff did not have the physical space required to complete paperwork and care planning. This resulted in staff using the dining room for administrative tasks when this space was intended for people who use the service. While a small number of people continued to use the dining room, most people had their meals in the lounge. It was not clear if this arrangement had developed because staff were using this area and tables were piled high with paperwork.
- The provider's compliance history since registration with the CQC was poor and demonstrated ongoing failures to make and sustain improvements and to ensure people were safe.

Systems and processes were not effective to assess, monitor and mitigate risk or to assess, monitor and improve the quality of the service. This was a breach of regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

- The registered manager was working to an action plan to address non-compliance identified at the local authority's contract monitoring visit.
- The provider had taken action to remedy deficiencies identified at the last food hygiene inspection by the local authority and were awaiting a further visit and rating.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- Residents meetings were held, and people were asked about activities they liked and meals on the menu. However, people's care plans were not sufficiently detailed about people's needs and preferences and where people's preferences were identified these were not provided. For example, where a favourite food choice was recorded there was no record of this being provided. There was very limited evidence of people being able to follow their chosen interests and hobbies.
- Staff were respectful and had positive relationships and interactions with people who used the service. People were able to make choices about how they spent their day.

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 Risks were not identified or managed and people were not protected from avoidable harm.

The enforcement action we took:

We cancelled the provider's registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Leadership and governance were ineffective and did not identify or mitigate risk or drive improvement

The enforcement action we took:

We cancelled the provider's registration