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

Summary of findings

Overall summary

About the service
Pinglenook Residential Home is a residential care home providing accommodation and personal care to up to 16 people. The service provides support to people aged 65 and over who may also be living with dementia. At the time of our inspection there were 12 people using the service.

People's experience of using this service and what we found
People were not kept safe from known risks. Where risks were identified there was not always guidance to inform staff how to support people safely and consistently. Medicines were not managed safely which exposed people to the risk of harm. Infection prevention and control measures were not robust, and people were placed at risk of Legionella. The provider did not ensure recruitment checks were carried out in line with the regulations.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People's care was not always personalised. The home environment did not reflect dementia friendly best practice to best meet people's needs.

Systems and processes to ensure good oversight of the service were ineffective. People were at risk of receiving care that did not meet their needs or wishes. Records were either inaccurate or lacked detail to provide staff with guidance on how to support people appropriately. A robust system was not in place to ensure accidents and incidents were appropriately recorded and responded to.

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 inadequate (published 6 June 2023). This service has been rated inadequate for the last 4 consecutive inspections. At this inspection we found the provider remained in breach of regulations.

Why we inspected
This focused inspection was carried out to follow up on action we told the provider to take at the last inspection. This focused inspection was initially carried out to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can see what action we have asked the provider to take at the end of this full 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 and Recommendations
We have identified breaches in relation to consent, safe care and treatment, protecting people from abuse, staff recruitment, person-centred care and governance at this inspection.

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
The overall rating for this service is 'Inadequate' and the service remains 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 timeframe 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 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective 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.

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 2 inspectors. An Expert by Experience also supported the inspection remotely by making telephone calls to relatives. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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 provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager 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 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
Not everyone who lived at the home was able to share their views with us. As a result of this, we spent time observing interactions between people and the staff supporting them. We spoke with 2 people who used the service and 5 relatives about their experience of the care provided.

We spoke with 7 members of staff including the registered manager/nominated individual, manager, 4 care staff members, and cook. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We looked at a range of documents including people's care plans and risk assessments, staff recruitment records, training records, DoLS records and mental capacity assessments. We also reviewed audits and governance, medicines records and observed medicine administration. We conducted checks of the building, grounds, and equipment.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection risk was not managed effectively, and people were not protected from avoidable harm. This was a breach of regulation 12(1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People were placed at risk of harm because of unsafe moving and handling practice. We observed a person being moved by staff who used the incorrect equipment. This placed the person at significant risk of injury.
- Where people required support from staff with complex healthcare needs, the provider failed to develop robust accompanying care plans to guide staff how to safely support people with this aspect of their care. This meant people were at risk of staff providing unsafe care and not identifying signs of deterioration in their health condition.
- People that required support when they were anxious or distressed did not have clear guidelines in place. For example, we saw 1 person's records demonstrated they had experienced multiple episodes of distress. However, the person did not have a care plan in place to provide guidance for staff on known triggers, and ways to support the person when they were in an agitated state.
- Episodes of anxiety or distress were not always recorded. There were no monitoring or analysis tools used to manage, monitor or learn from these records to help identify how staff could change or develop their approach in future to better meet people's needs. This put people at risk of unauthorised restrictive practices.
- People were at increased risk of harm as staff failed to record and report incident and accidents. This meant the provider could not effectively monitor accidents and incidents to learn from them and reduce the risk of them happening again.
- Risks to people's health and wellbeing were not always assessed, monitored and managed. This included risks associated with skin integrity and moving and handling. Some people did not have appropriate care plans and risk assessments in place.
- Records of fluid intake for people at risk of dehydration were not regularly completed. Where records had been kept there was no oversight of these.

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

Regulations 2014.

● Some improvements had been made to environmental risks. For example, the provider had now completed a fire risk assessment at the service. Also, water temperatures were now within a safe range and being regularly monitored.

Using medicines safely

At our last inspection the provider failed to ensure medicines were managed safely. This was a breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines were not managed safely. This placed people at risk of harm because staff were not consistently administering all prescribed medicines in line with national guidelines.
● Transdermal patch (medicines applied directly to the skin through an adhesive patch) records were not completed consistently. Records were not always completed to confirm the location of the new patch or that the old patches were removed. This placed people at risk of over absorption and potential overdose. There were also no daily checks to ensure the patches remained in place. This is important because if a patch is removed or becomes detached, then the person would stop receiving the dose of medicine.
● Where people were supported with PRN (as required) medicines, staff did not consistently record the outcome of administration. This information is required for monitoring a person, determining the effectiveness of the medicine and deciding if they needed reviewing by the doctor.
● PRN guidance was inconsistent and did not always reflect the prescriber's instructions. For example, a PRN protocol for a person's prescribed laxative stated, 'maximum dose in 24 hours: 1 sachet', however the Medicines Administration Record (MAR) stated 'take 1 or 2 sachets if required'. This put the person at risk of not receiving their medicines as prescribed.
● Handwritten medicine records were not always countersigned by another member of staff. This meant information had not been checked to ensure it was accurate and matched the prescriber's instructions, which placed people at risk of their medicines being administered incorrectly.

The provider failed to ensure medicines were managed safely. This was a continued breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● People were not protected from water borne infections. We found a build-up of limescale on multiple taps and a shower head around the service. Limescale deposits can be a breeding ground for dangerous bacteria including Legionella bacteria which causes Legionnaires' disease. The provider was unable to provide evidence descaling was being completed at the service.
● We were not fully assured that the provider was promoting safety through hygiene practices of the premises. We identified multiple pressure relieving cushions and a mattress cover were stained. Records demonstrated these had not been checked since August 2023.
● The provider's infection prevention and control policy was not up to date as it still contained guidance staff should be wearing face masks and did not reflect updated government guidance which stated masks only needed to be worn in an outbreak. Staff were following the new guidance as they were not wearing face masks. However, this lack of update to the guidance could be confusing to staff.

The provider had failed to protect people from the risk of infection. This was a breach of Regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection the provider had failed to undertake robust recruitment procedures. This was a breach of regulation 19(1) (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 19.

● Staff were not recruited safely. Recruitment checks were not always carried out in line with the regulations or the provider's recruitment policy. The provider failed to check proof of identity documents for 2 newly recruited members of staff. This put people at risk of receiving care and support from unsuitable staff.

The provider had failed to undertake robust recruitment procedures. This was a continued breach of regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were not assured there were enough staff available in the service to keep people safe and provide timely support where required. On the first day of inspection only 3 staff members were allocated during the day, however there were multiple people who required the assistance of 2 staff members to support them. This meant at times when these people were supported, other people were not supervised sufficiently to ensure they remained safe. This was addressed with the provider and staffing levels were increased on the second day of our inspection.
● We received mixed feedback regarding staffing levels. Staff told us they felt the service was short staffed. However, 1 relative said, "There always seem enough staff on duty."
● The provider was using a dependency tool to determine how many staff should be in place to support people based on their needs.

Systems and processes to safeguard people from the risk of abuse

At our last inspection people were not always protected from abuse of improper treatment. This was a breach of regulation 13(1) (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 13. This is further detailed in the effective section of the report.

● People and relatives felt they/their family member were safe using the service. One person told us, "I get on with them [staff] alright and I feel safe here", and a relative said, "I know [relative] is safer there."
● Most staff had completed training to help them identify and respond to any safeguarding concerns.

Visiting in care homes
● The provider's approach to visitors in the care home was in line with government guidance and people were supported to have visitors. One relative said, "We can visit anytime."

Inadequate

Is the service effective?

Our findings

Our findings
Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question inadequate. The rating for this key question has remained inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Ensuring consent to care and treatment in line with law and guidance

At our last inspection care and support was not always provided with people's consent. This was a breach of regulation 11 (1) (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 11.

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 MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA , whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- We found the provider was not working within the principles of the MCA. Where a person had restrictions in place such as a pressure mat which enabled staff to monitor the person's movements there had been no assessment of their capacity to consent to these and no decisions made in their best interest. This meant people had restrictions in place which may not have been in their best interests.
- There was not always evidence of best interest decisions made regarding the use of closed-circuit television (CCTV) in communal areas where people lacked mental capacity to consent. This remained an ongoing concern from the last inspection. Failing to document the continual surveillance was in people's best interests and put them at risk of their privacy and human rights not being protected.
- The manager confirmed to us no action had been taken in relation to MCA since the last inspection.

Care and support was not always provided with people's consent. This was a continued breach of regulation 11 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had made appropriate DoLS applications which had been authorised. Some authorisations contained conditions which the provider must meet. However, authorisation paperwork for 1 person was not readily available at the service during the inspection. This meant the provider did not have full oversight of DoLS and did not have a record of what conditions were in place for all people.
● Where people's DoLS authorisations contained conditions the provider must meet, these were not met. For example, 1 person's conditions required the provider to review and update MCA assessments, to ensure the questions asked were reflective of the decision that needed to be made within 2 weeks of the authorisation. This had not been completed. This meant we were not assured this person's human rights in relation to their DoLS condition were being respected.
● At this inspection we continued to find not all staff had awareness of who had a deprivation of liberty authorisation in place. This meant there was a continued risk staff may not provide care and support in the least restrictive way.

Systems and processes in place to protect people's human rights in relation to their DoLS were not effective. This was a continued breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet; Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● We couldn't be fully assured that people's needs had been completely and holistically assessed. This was because the care records did not demonstrate this. For example, there was not always sufficient guidance in place to prevent risks as far as possible.
● Nutritional care records did not always contain consistent information about modifications to people's food, using the recognised International Dysphagia Diet Standardisation Initiatives (IDDSI). This is important so all staff supporting people to eat, and drink would know what the level was to reduce risks of choking.
● For example, 1 person's care records contained contradictory information regarding their modified diet. An 'At a glance' document detailed the person required their food to be cut up, whereas their care plan detailed they required a 'minced and moist' diet. This contradictory guidance for staff put the person at risk of choking through receiving an incorrect diet.
● Where changes in people's needs or conditions were identified, prompt and appropriate referrals to external professionals had not always been made. For example, 1 person's mobility had recently declined but staff failed to ensure a referral was made to assess the equipment being used was safe and appropriate.

The failure to monitor and mitigate risks relating to people's nutritional and care needs was a continued breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● We received mixed feedback about the meals provided at the service. One person told us, "The food portions could be bigger, we have a choice every day except on a Sunday when it's the standard roast." Another person said, "The food could be better and the quality of it, we had pasta the other day and there was only a small bit of meat."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider failed to assess people's needs before using the service. This had been identified as a concern at the last inspection. While the manager reported to us, they carried out a face-to-face visit with

the person, they relied upon the local authority's assessment.
● People's needs were not always clearly reflected within their care plans. Information contained in people's care plans was not always clear and some information was contradictory. This placed people at risk of not having their needs met.

Adapting service, design, decoration to meet people's needs
● The bath chair remained unusable at this inspection, and the provider failed to provide a date for its repair. This restricted people's bathing preferences.
● There was a lack of way-finding signage in place to support people living with dementia at the service. This meant people living with dementia did not have access to an environment designed to meet their specific needs.
● While some improvements had been made to the service, access to outside space was still lacking. We received mixed feedback from relatives including, "They have worked hard to get the place up to scratch, although some communal areas are still a bit shabby and the garden could do with some work so it's more usable", and "The owner probably needs to spend a bit more money on the communal areas and a bit of modernising."

Staff support: induction, training, skills and experience
● Staff were positive about the training and support they received. One member of staff told us, "[The manager] is good, friendly and helpful."
● Staff were being supported to receive online and practical training relevant to their roles, but training was not always up to date. For example, some staff had not received training in equality and diversity, end of life care and falls prevention.

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 our last inspection we rated this key question inadequate. The rating for this key question has remained 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; Continuous learning and improving care

At our last inspection, 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) (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● This is the fourth consecutive inspection where the provider has failed to meet the regulations. There have been repeated breaches in relation to safe care and treatment, and good governance across all 4 inspections.
● The governance systems in place continued to be ineffective. Issues found at the last inspection remained and further issues were identified as requiring attention. The provider's systems and processes were not robust, effective or embedded, with a lack of oversight that failed to identify significant gaps in the quality of the service people received.
● Audits had failed to identify shortfalls we found in relation to the safe administration of people's medicines. For example, the provider's medication audit failed to prompt the check of transdermal patch locations, therefore the concerns we outlined in safe were not identified.
● Accurate, complete and contemporaneous records were not reliably maintained. For example, risk assessments and care plans did not consistently contain enough detail and MCA records did not adhere to the associated legislation. The care records did not always guide staff in the current way of providing support to people.
● There was a lack of oversight of accidents and incidents. This meant risks to people's safety and wellbeing had not been appropriately reviewed, assessed, and learned from to reduce the risk of them happening again. The provider had not ensured all accidents and incidents were recorded and reported by staff.
● People were at increased risk from the spread of infection because infection prevention and control measures were not always implemented. For example, the provider's audits on the environment failed to identify the build up of limescale on the showerhead and taps around the service.

The failure to operate effective systems to assess, monitor and improve the service and to maintain an accurate, complete record in respect of each service user was a continued breach of regulation 17(1) of the

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People gave generally positive feedback about the manager and the changes they were trying to make. One relative told us, "The management seem upfront and want things to be better."

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

At our last inspection the provider failed to ensure care and support reflected people's needs and preferences. This was a breach of regulation 9(1) (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● People did not always receive person-centred care. This was because staff failed to understand or recognise people's emotional support and communication needs. For example, 1 person with dementia was observed to be in distress, however staff failed to respond in an appropriate manner to alleviate this. This meant the person remained in distress and did not receive care which met their needs.
● People were not always involved in decisions about their care. We found people's care to be task focused. For example, we observed staff failing to communicate with people when supporting them with moving and handling. This meant people's voice in respect of their care wishes were not always heard.
● At the last inspection relatives reported they were not involved with care planning. This remained an ongoing issue at this inspection. One relative told us, "I haven't ever seen [Person's] care plan, but when I asked about it 2 weeks ago, I was told they were just working it out."
● The provider had not sought feedback from relatives. Relatives told us, "I have never been asked for feedback", and "I haven't been asked for any input or feedback yet and I haven't seen a note of any meetings being held."

The provider failed to ensure care and support reflected people's needs and preferences. This was a continued breach of regulation 9(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Equality, diversity and inclusion training was in place for staff, but at the time of inspection only 60% of staff had completed this training in the last 12 months. The provider could therefore not be assured people's individual diverse needs would be respected in line with their protected characteristics.
● The provider held meetings with people to source their feedback. Meetings offered an opportunity to give feedback on areas of care including food quality and level of activities. However, 2 people we spoke with reported they had not attended any meetings. One person told us, "I don't remember a resident's meeting."

Working in partnership with others
● Records confirmed a range of healthcare professionals had been involved with people's care. However, as detailed in effective, where changes in people's needs or conditions were identified, prompt and appropriate referrals to external professionals had not always been made.

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 provider understood their responsibilities in relation to the duty of candour and communication with people when things went wrong.
● Relatives told us they were generally informed when things went wrong. One relative said, "They do call me if anything happens or there are any changes."