Bethesda Care Homes Ltd

Pinglenook Residential Home

Inspection report

229 Sileby Road
Barrow Upon Soar
Loughborough
Leicestershire
LE12 8LP

Tel: 01509813071

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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 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 10 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
Governance systems and processes had failed to make improvements to the quality and safety of the service since the last inspection.

People were not kept safe from known risks. Action had not been taken to reduce fire risks. Quality monitoring systems were not in place to reduce risks to people following incidents.

People were not protected from abuse. A person was unlawfully deprived of their liberty, and this had caused them distress. Staff did not always know how to spot the signs of abuse.

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.

Care was not person-centred. Care plans were not always reflective of people's needs. Staff did not always engage people or respond to people's preferences. People's and relatives' input was not used to improve the care provided.

People were not always administered medicines safely. People were not always supported to eat enough and were not always offered food they preferred. Staff were not recruited safely, and staffing levels were not calculated safely. Up to date staff training was not always in place.

Some improvement had been made to the service environment since the last inspection and work was ongoing. People were protected from the risk of infection. Staff supported people with their mobility safely. Some people were happy with staff and felt safe.

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 (13 December 2022). The service remains rated inadequate. 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. However, due to concerns found with consent and deprivation of people's liberty, this inspection was also opened to the key question of effective.

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.

Enforcement
We have identified breaches in relation to people's health and safety, protecting people from abuse, consent, 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 therefore 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 two inspectors.

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 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. There was also a manager in post who

was at the service on the day to day basis. This manager had also submitted an application to register.

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 5 people who used the service and 3 relatives about their experience of the care provided. We spoke with 6 members of staff including the manager, an operations manager, the cook and 3 care staff members. We looked at a range of records including 4 people's care plans. We also observed staff practices while at the service.

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.

- Risks to people were not managed safely.
- A person at risk of malnutrition was recorded as losing a significant amount of weight within a week. Food intake charts showed the person was eating small amounts and not being offered snacks as specified in their nutrition care plan. A relative told us they had informed the service the person preferred to eat a certain type of food, but the person's nutrition care plan did not reflect this, and intake charts showed this type of food was not being offered. This put the person at increased risk of harm.
- Risks to people were not always mitigated following incidents. A person had several recorded falls. While action had been taken following some of these incidents, 2 fall records included no actions to reduce further falls. Behaviour monitoring charts (ABCs) also failed to record appropriate actions to support people expressing their needs or emotional reactions. For example, a person was recorded to be throwing items and the action recorded was, "Told [person's name] to stop what they were doing". No further actions were recorded to support them to reduce any anxiety and distress.
- Fire safety risks were not always mitigated. A fire risk assessment completed in June 2022 outlined several actions to reduce risks to people, but these were not completed. For example, the provider had not replaced a foam fire extinguisher for a CO2 fire extinguisher as this was identified to be more appropriate in the event of a fire. CO2 fire extinguishers are used for electrical fires, and some typed of liquid fires. Some staff had not attended any fire drill training and had not been shown how to use the fire sledge for evacuation in the event of a fire.
- Environmental risks were not always managed safely. A side door remained unlocked throughout the inspection which allowed entry and exit to the service. This risked people leaving the building without staff knowledge. A basin hot tap in a communal bathroom had a temperature of over 60 degrees Celsius which left people at risk of scalding. A previous check by the provider showed this tap to have a high temperature, but action had not been taken to ensure this remained safe. Health and Safety Executive guidelines state hot water output should not exceed 44 degrees Celsius in care homes.

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.

● We saw examples of people being supported with their mobility safely.
● Following the inspection, the provider took action to rectify some concerns identified by inspectors around the failure to follow recommendations in their fire risk assessment.

Systems and processes to safeguard people from the risk of abuse
● One person did not feel safe because they were being unlawfully deprived of their liberty. The provider and staff were not aware of the affect and impact this had had on the person. This meant this person experienced degrading treatment which significantly disregarded their rights and needs.
● Up to date safeguarding training was not always in place. A staff member had not received safeguarding training despite being employed for over 6 months. This was not in line with National Institute for Health and Care Excellence (NICE) best practice guidelines. Another staff member had failed a knowledge check following a safeguarding refresher training, but no action had been taken to support them to pass this training. Staff we spoke with were also not able to fully explain how they would recognise the signs of abuse such as changes in behaviour or low mood.
● The provider was unable to provide records of safeguarding incidents for review, so it was not clear how these were being responded to or investigated. There was therefore no evidence of people being protected from avoidable harm following safeguarding incidents.

People were not always protected from abuse of improper treatment. This was a breach of regulation 13(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff we spoke with knew how and who to report safeguarding concerns to.

Using medicines safely
● Medicines were not always managed safely. Some people were prescribed medicines to manage distressed behaviour on an as required basis. The protocols for when this medicine should be given were not sufficiently detailed. When these medicines were used staff failed to detail specifically why the medicine was given or of the outcome. This meant there was a risk people may be given this medicine unnecessarily or before attempting to reduce any distress or agitation through communication or a change in environment.
● Medicines prescribed for a person's short-term illness had not been reviewed. One person was prescribed a medicine to manage distressed behaviour on an as required basis while they were ill but they had since recovered. The medicine prescription had not been reviewed and although it had not been administered, there was a risk staff could give this medicine which could result in significant harm to the person.
● Although medicines were stored securely, the room temperature in the medicine room was not monitored or recorded. This room was found to be very warm and may have been above the safe temperature limits for the storage of medicines.
● The provider had not sought advice from a pharmacist to confirm it was safe for a person to have their prescribed medicine in a drink. However, in response to these concerns the acting manager contacted the pharmacist as soon as we pointed this out and established it was safe to give this medicine in a drink.
● Two people told us they were given medicine by staff but did not know what they were for or why they had been prescribed.

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.

Staffing and recruitment

● Safe recruitment processes were not always in place.

● One staff member did not have evidence of an enhanced Disclosure and Barring Service check in place or references for their conduct in previous roles being sought. This staff member, along with 2 other staff members, had unexplained gaps in their employment history. This put people at risk of not being supported safely. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

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

● Staffing levels were safe during the day but staffing levels at night put people at risk. Two staff members were on shift each night, but there were 2 people who required 2 staff members to support them. At times when these people were supported, the rest of the service was not supervised sufficiently to ensure people were supported to remain safe. The provider failed to document how these staffing levels had been calculated. This is outlined further in the well-led key question.

Preventing and controlling infection

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was supporting people living at the service to minimise the spread of infection.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was responding effectively to risks and signs of infection.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

● People were supported to have visits from relatives and friends. We observed people being visited by relatives in both communal areas and their rooms. People and relatives did not raise any concerns about being supported to be visited.

Inadequate

Is the service effective?

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 requires improvement. At this inspection the rating has changed to 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
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.

● Where people had lawful authorisations in place to deprive them of their liberty, not all restrictions had been included in this information. Decision specific mental capacity assessments or best interest decisions were also not always recorded. For example, this was not in place for the use of covert medicines (where the person is not aware they have been given the medicine), and other care and support practices which restricted freedom.
● There was not always evidence of consultation or best interest decisions made regarding the use of CCTV in communal areas where people lacked mental capacity to consent. This meant lawful consent had not been obtained for this practice.
● Not all staff were aware of who had a deprivation of liberty authorisation in place or who had capacity to make decisions about their care and support. This meant there was a risk staff may not provide care and support in the least restrictive way.

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

● One person was unlawfully deprived of their liberty. We have reported on this in under the safe key question section of this report.

Supporting people to eat and drink enough to maintain a balanced diet

● One person's care plan did not reflect their food and meal preferences. This person had lost weight and frequently had very little amounts to eat. While staff had consulted with the person's GP and a dietician, they were not offering the person's preferred food as outlined by a relative. This was a missed opportunity to ensure they had enough to eat and were provided with meals they were known to enjoy.

● People had their risk of malnutrition assessed. Where risks were identified, care plans were put in place and food intake was monitored.

● People and relatives we spoke with said they liked the meals provided. The cook had a good relationship with people and was stated they were developing the menu based on people's likes and dislikes.

● All meals were fortified to increase calorie intake. In addition, special diets for people with diabetes or swallowing difficulties were provided. One person had a restrictive diet due to the medicine they were prescribed. They told us the cook worked hard to provide alternatives to restricted items and said this had a very positive impact on their health.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People's needs were not always effectively assessed on admission to the service. One person had arrived at the service the day before the inspection, but the provider's pre-admission assessment had not been fully completed and was missing key information about their care and support needs. The person's care plan only included a discharge assessment provided by the hospital, which risked staff not knowing this person's needs. The manager stated they were due to complete an initial assessment of the person's needs on the day of inspection and had completed a verbal handover to staff about this person's needs.

● People's mobility needs were not always assessed and documented. For example, a person did not have a care plan in place for the use of the hoist to support them with their mobility. The manager told us that the community therapist had advised the hoist could be used to support this person when needed, but their care plan did not include information to support staff to do this safely. This put the person at risk of injury if the hoist was not used correctly. Following the inspection, information around use of the hoist was added to this person's care plan and risk assessment.

Staff support: induction, training, skills and experience

● Staff were being supported to receive online and practical training relevant to their roles, but training was not always up to date. For example, two staff members had not completed training or refresher training in safeguarding.

● The manager did not have full oversight of staff training due to an ongoing system error. This limited the manager's ability to track when staff training was completed or due. This is detailed further under the well-led key question.

● Staff received an induction and were supported to complete the care certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.

● The provider completed supervisions and competencies for staff. Staff received competencies in areas such as medicines and moving and handling.

Adapting service, design, decoration to meet people's needs

● Improvements had been made to the service environment since the last inspection. Several people's bedrooms had been refurbished with new flooring and vanity units. There were also new areas of the building which were going to be used by staff when staff needed to complete documentation rather than use the lounge area.

● Some adaptations were in place to support the needs of people living at the service. Most people's rooms

had signs with their name and photo on it to support people to find their room. People's rooms also had personal items and photos of loved ones. An access ramp had also been installed to aid people using wheelchairs to enter and exit the service.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

● There was some evidence of the staff team working with other agencies to support people's care. For example, people were supported to access the GP and the community nurse team where needed. However, as already outlined under the safe and effective key questions, agencies such as the local authority DoLS team and the pharmacist were not always contacted when required.

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. At this inspection the rating 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.

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The provider has consistently failed to ensure systems and processes are in place to achieve regulatory compliance. The service has been rated inadequate at the last two inspections and had failed to improve the quality of the service at this inspection.
- Systems and processes had failed to improve the safety of the service. Known risks in the environment had been identified, such as fire risks, but the provider had not acted to ensure these risks were reduced. Further to this, there was no documented maintenance plan with timescales. The manager and operations manager told us of planned works to further improve the service environment but had not documented this with timescales.
- Processes outlined in provider policies had not been followed. The admission policy stated that a pre-assessment of a person's needs should be completed by the manager prior to admission to the service. This had not been completed for a person who arrived at the service the day prior to the inspection, so this risked staff being unaware of their care and support needs. The provider also failed to follow processes outlined in their medicines, recruitment, and Mental Capacity Act (2005) policies to ensure regulatory compliance.
- The provider failed to ensure quality monitoring systems were in place. Accident and incident audits had not been completed for over 3 months. Further to this, there was no system in place to review behaviour monitoring charts (ABCs). This left people at continued risk of harm as the provider was not identifying themes or consistently learning from these incidents.
- There was no system in place to determine safe staffing levels. There were two staff members on the rota each night but there were two people who required two staff to support them. This left the service unsupervised when these people were being supported and left other people at risk. The provider had failed to consider people's needs when determining the number of staff needed.
- The manager failed to have a clear oversight of staff training. The manager told us there had been a system error for over 2 months which meant they could not load a training matrix which showed all staff training records. At the time of the inspection the manager was therefore not aware of the training needs of

staff. Following the inspection, the provider sent a copy of a training matrix which showed an overview of staff training records.

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 continued breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the manager provided a copy of the training matrix to show oversight of staff training but this was not provided at the time of the inspection.

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.
● Care was not always person-centred and did not reflect people's preferences. For example, we observed a staff member supporting a person with their lunch. The person repeatedly told the staff member they did not like their meal, but the staff member did not offer any alternative and instead continued to support them to eat their meal.
● People and relatives told us they were not involved in or aware of their care plans. There was no evidence people's or relatives' feedback was used to improve the quality of care and support. Two people also stated staff treated them as though they were a child.
● As outlined in the effective key question, the provider had failed to ensure people's needs were fully assessed to support staff in their role. A person did not have an assessment in place for use of the hoist, despite the manager telling inspectors this was used when the person's mobility was reduced.
● There was very limited evidence people's social or cultural need were met. During our inspection people were unoccupied for most of the time. Two people told us they were bored. One person repeatedly told staff they were bored and wanted something to do.

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

● Staff meetings were held but meeting minutes had not been distributed to all staff.
● Staff told us they felt supported. They told us the manager and operations manager were accessible and approachable.
● One person told us their care and support met their needs and preferences. They said, "I am as happy as I could be, I couldn't wish for better care."
● The provider had recorded information around people's religious needs in their care plans. The manager stated that ministers also visited to help meet people's religious needs.

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; Working in partnership with others
● There was some evidence of relatives being informed following incidents, but this was inconsistent. A relative was not aware of a person's weight loss and had not been consulted about a medicine being stopped.
● The manager was candid during the inspection and accepted that improvements to the service were needed.
● As outlined in the safe key question, there was some evidence of the provider working with other agencies to support people, but this was inconsistent.

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 9 HSCA RA Regulations 2014 Person-centred care The provider failed to ensure people were provided with person-centred care.

The enforcement action we took:

We have served a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider failed to act in line with the Mental Capacity Act (2005) where people were unable to consent to care and treatment.

The enforcement action we took:

We have served a Notice of Decision to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risks relating to the helath, safety and wellbeing of people were mitigated.

The enforcement action we took:

We have served a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider failed to protect people from the risk of harm or abuse.

The enforcement action we took:

We have served a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to ensure effective governance systems and processes were in place to improve the qulity and safety of the service.

The enforcement action we took:

We have served a Notice of Proposal to cancel the provider's registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure staff were recruited safely.

The enforcement action we took:

We have served a Notice of Proposal to cancel the provider's registration.