



Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017

Priority Action Report

Pangea Healthcare Ltd

in respect of

Plas Newydd Care Home

Pwllheli Road
Criccieth
LL52 0RR

This report contains notices where priority action must be taken by the registered person in respect of identified non-compliance with the regulations. You, as the registered person, are required to take action to ensure compliance is achieved in the timescales specified.

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Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 3 October 2023
Our Ref: NONCO-00017283-KKWX

Ongoing non-compliance has been identified with Regulation 58
The specific sub-regulatory failures relate to: 58(1)

The storage of controlled drugs is inadequate. The service provider must have arrangements in place to ensure that medications are stored safely.

Regulatory Failings

58(1) The service provider must have arrangements in place to ensure that medicines are stored and administered safely.

Evidence

On 17 August 2023 we visited the service and looked at the storage of medication, including controlled drugs.

[REDACTED]

[REDACTED] We saw a medication weekly dispense box containing medication in this area. The box did not state the person's name, medication or date prescribed so it was unclear to whom the medication box belonged, which could result in medication errors.

[REDACTED]

On 03 October we conducted an unannounced inspection to the service to check compliance. We found the following:

The medication room has been redecorated with new flooring.

[REDACTED]

Impact on and / or risk to the health and well-being of people:

We have assessed the potential risk and / or impact on people's health and well-being as

a result of this non-compliance as Moderate and there is likely reoccurrence.

Outcomes for People

People are at risk of not receiving the correct medication in a safe way because the systems for storing and handling controlled drugs are not robust.

Timescale for completion

30 November 2023

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Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 3 October 2023
Our Ref: NONCO-00015363-XYGK-3

Ongoing non-compliance has been identified with Regulation 56
The specific sub-regulatory failures relate to: 56(1)

The provider has not ensured the home meets reasonable standards of hygiene in some areas.

Regulatory Failings

56(1) The service provider must have arrangements in place to ensure -
(a) satisfactory standards of hygiene in the delivery of the service;
(b) the appropriate disposal of general and clinical waste.

Evidence

The evidence is collated following an unannounced inspection to the service on 11 April 2023. A second announced visit was conducted on 9 May 2023. We found the following;

We saw during inspection, the toilets on the ground floor are not in a good state of repair.

Ground floor shower room – the grab rails, pedal bin and skirting around the room is dirty. Drill holes are left in wall covering.

A toilet on the first floor also has a gap in the lino flooring around the base of the toilet and we saw dirt and grime in the gap.

Staff/visitors toilet – ground floor – Tiles around the sink are broken and not replaced. Wallpaper is peeling from the wall. The radiator is rusty, flooring and skirting around the room is dirty.

First floor bathroom – the lino flooring is not fitting up to the sink unit. Wall paper is flaking/peeling from wall. The bath seat need replacing. The flooring needs replacing.

Top floor bathroom – the lino flooring does not fit around toilet and wall tiles have not been replaced around toilet cistern. The open top bin needs replacing and dirt removed from around the shower units.

Bedroom ■ -the carpet needs replacing as the area around new sink has been patched up with different carpet covering. The carpet is also stained.

We saw the wallpaper is loose in room ■. There is thick dust on picture frames and on top of the tv. Bedroom ■ has peeling wallpaper. There is a stain on the carpet in room ■.

This does not present a dignified, well cared for environment for people living in the home.

We saw in one wardrobe clothes stored on the floor of the wardrobe.

New boiler – the wall cover at the right side of the cooker has been removed to fit/repair the boiler but has not been put back, leaving torn insulation covers exposed over the cooker. The insulation covers appear to have a fibre filling which could result in fibres dropping into food prepared on the cooker top.

The tiled walls are stained with grease particles. The cooker was left uncleaned following the lunch period. The coving rail around the kitchen is dirty. We saw no evidence of cleaning schedule in place. This poses a food hygiene risk for people.

Bin in kitchen area has no lid as it is broken.

The serving area needs deep cleaning, flooring, skirtings and plinths are dirty/dusty. The dishwasher needs cleaning and put in a secure position as it is leaning to the left towards the sink. The floor beneath the dishwasher is black with dirt and grime. The walls surrounding the dishwasher are stained and dirty. The dishwasher itself is stained. The tap sink in the serving area is continually dripping and must be replaced or repaired. This poses a food hygiene risk for people.

The evidence is collated following an unannounced inspection to the service to check compliance. Improvements were seen, however this continues to be evidence of non compliance.

We found the following during the unannounced inspection visit on 17 August 2023:

Ground floor shower room – the grab rails, pedal bin and skirting around the room are dirty. Drill holes are left in laminated wall coverings.

A toilet on the first floor has a gap in the lino flooring around the base of the toilet and we saw dirt and grime in the gap.

Staff/visitors toilet – ground floor – This has received attention but the work is not complete. The walls need decorating and a new blind/window covering is required to stop people looking in from outside when passing the window. The radiator is rusty and the flooring and skirting around the room are dirty.

First floor bathroom – the lino flooring is not fitting up to the sink unit and needs replacing. The wall paper is flaking/peeling from wall. The bath seat needs replacing as it is worn.

Top floor bathroom – the lino flooring does not fit around toilet and wall tiles have not been replaced around the toilet cistern.

Bedroom ■ The flooring has been replaced in this room.

We saw the wallpaper has been repasted to the wall. The mattress is too big for the bed base in this room which is a health and safety hazard. The bed needs replacing as the mattress is too big for the bed.

Bedroom ■ The wallpaper has been repasted to the wall. The ceiling needs attention where damp patches are visible.

Bedroom ■ We were unable to view this room during this inspection as the person accommodating the room was resting in the bedroom. At the previous inspection in May 2023 there was a stain on the carpet in this room. We could not evidence if this had received attention.

The piping around the top of the kitchen walls is dirty and needs cleaning. Part of this was cleaned during the inspection. Other areas in the kitchen and serving area need cleaning.

Relatives and staff told us they feel the home should be cleaned. We informed the RI that the home is unclean in places and would benefit from deep cleaning.

The tap in the serving area has been replaced, which is an improvement.

The evidence is collated following an unannounced inspection to the service to check compliance. Improvements were seen, however this continues to be evidence of non compliance.

We found the following during the unannounced inspection visit on 03 October 2023:

Ground floor shower room – this area has not received any further work. The grab rails, pedal bin and skirting around the room are dirty. Drill holes are left in laminated wall coverings.

A toilet on the first floor has a gap in the lino flooring around the base of the toilet and we saw dirt and grime in the gap.

Staff/visitors toilet – ground floor – This area has not received work since the previous inspection. The walls need decorating, and a new blind/window covering is required to stop people looking in from outside when passing the window. The radiator is rusty and the flooring and skirting around the room are dirty.

First floor bathroom – new lino flooring has been fitted and walls have been painted. The bath seat needs replacing as it is worn.

Top floor bathroom – new lino flooring has been fitted and wall tiles have not been replaced around the toilet cistern.

Bedroom ■ There are damp patches in this room which does not preserve the person's welfare or dignity. The person in this room told us they wanted the ceiling painting.

Bedroom ■ The bed has not been replaced. The mattress is too big for the bed base in this room which is a health and safety hazard. The bed needs replacing as the mattress is too big for the bed.

Bedroom ■ The wallpaper has been re-pasted to the wall. The ceiling needs attention where damp patches are visible.

New flooring has been installed on the second-floor corridor. This has not been completed and poses a risk to people and staff as it poses a trip hazard.

The venetian blinds in the conservatory are broken and need fixing / replacing.

There continues to be areas in the kitchen which need cleaning, the electrical sockets and piping are dirty and need cleaning. Other areas in the kitchen and serving area are unclean and need cleaning.

Impact on and / or risk to the health and well-being of people:

We have assessed the potential risk and / or impact on people's health and well-being as a result of this non-compliance as Major and there is likely reoccurrence.

Outcomes for People

People cannot always be assured of certain areas in the home being clean and hygienic, which places them at risk of infection.

Timescale for completion

18 August 2023

Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 3 October 2023
Our Ref: NONCO-00015362-TFMB-3

Ongoing non-compliance has been identified with Regulation 57
The specific sub-regulatory failures relate to: 57

People cannot always be assured of all practicable risks to their person being mitigated as far as is possible.

Regulatory Failings

57 The service provider must ensure that any risks to the health and safety of individuals are identified and reduced so far as reasonably practicable.

Evidence

The evidence is collated following an unannounced inspection to the service on 11 April 2023. A second announced visit to the service was conducted on 9 May 2023. We found the following:

At the last inspection in December 2022 new flooring in the downstairs corridor had started to lift in places. There is an obvious slope from the corridor to the kitchen area which could pose a hazard for people with balance issues. One area of flooring between the corridor and dining room is slightly higher than the other, posing a trip hazard, but there is no threshold strip to mitigate against trips and falls. The manager could not confirm if this has been fully rectified.

At the last inspection in December 2022 we found a store room on the first floor was full of equipment which was piled on top of each other in a haphazard manner. This poses a risk of injury should equipment fall on a person or staff member, especially when accessing that equipment.

At the inspection on 11 April and 9 May 2023 we continued to find vinyl gloves stored within reach of people living in the home. This poses a choking risk should people without capacity, ingest them.

Several bins in bathrooms and toilets are not pedal bins. This poses an infection control risk if used PPE and soiled materials are disposed in bins. Bins should be foot operated in order to minimise contact with potentially unhygienic waste and surfaces.

At the inspection on 11 April and 9 May 2023 we found a store room on the first floor was full of equipment which was piled on top of each other in a haphazard manner. A broken clothes hanger was left on the radiator and a blue disposable glove was seen on the floor.

The freezer in the [REDACTED] was overstocked which resulted in the freezer lid not closing tightly leaving a build up of ice between the freezer chest and lid.

The evidence is collated following an unannounced inspection to the service on 17 August 2023.

We found the following at this inspection:

We were unable to view the storage room as [REDACTED] herefore, we were unable to confirm whether the necessary improvements had been made.

Vinyl gloves were still left out within easy reach to people. The RI must demonstrate vinyl gloves are being stored safely in the home, to mitigate risk of choking.

We found bins which were not pedal bins are still being used. The RI must ensure appropriate bins are used in the home to mitigate against the risk of infection. Bins used should be foot operated "pedal" bins to avoid the risk of cross-contamination by means of contact with potentially unhygienic waste and surfaces.

We looked at the freezers in the [REDACTED] and found they had been cleared of stock and the build up of ice removed enabling the lid to close.

The evidence is collated following an unannounced inspection to the service on 03 October 2023. We found the following at this inspection:

The storeroom has been cleared with a bed installed. The room is currently used as a sleep-in room for staff following recommendations made by the fire officer to have 3 carers on the premises during the night, whilst the lift is out of order.

Vinyl gloves are still left out within easy reach to people. The RI must demonstrate vinyl gloves are being stored safely in the home, to mitigate risk of choking and to ensure people's safety.

Bins, which are not pedal bins, are still being used. The RI must ensure appropriate bins are used in the home to mitigate against the risk of infection. Bins used should be foot operated "pedal" bins to avoid the risk of cross-contamination by means of contact with potentially unhygienic waste and surfaces to ensure people's health and safety as far as is reasonably practicable.

We looked at the freezers in the [REDACTED] and found a build up of ice in two chest freezers. The lid on one chest freezer would not stay in an open position causing risk of injury for staff who access the freezer.

We found random items piled in the [REDACTED] making access to food-shelves and freezers difficult. This also makes the food storage area difficult to clean which contravenes food safety guidance and needs to be addressed to ensure people's health.

The following issues and information have come to CIW's attending during September/ October 2023:

The lift at the home has been out of order since 24 September 2023. People were stuck on the ground floor as they had difficulty accessing their rooms via the staircase [REDACTED]

The fire service conducted a fire safety inspection at the end of September 2023. Many concerns were raised, and a report with time dated actions has been sent to the RI. Two rooms containing fire escapes were to be emptied, the RI assured CIW and authorities this had been achieved at the end of September. We found a [REDACTED] during the October 2023 inspection, and a bed remained in the other room. The fire officer has asked a structural engineer to assess the fire escape stairs as they have not been maintained. Fire risk assessments were found to be poor, and not fit for purpose.

Impact on and / or risk to the health and well-being of people:

We have assessed the potential risk and / or impact on people's health and well-being as a result of this non-compliance as Major and there is likely reoccurrence.

Outcomes for People

People's health and safety are at risk because they cannot be assured that environmental risks are assessed and action taken to mitigate those risks.

Timescale for completion

06 February 2023

Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 3 October 2023
Our Ref: NONCO-00013659-SMKH-4

Ongoing non-compliance has been identified with Regulation 66
The specific sub-regulatory failures relate to: 66

The provider has not supervised the management of the service sufficiently to ensure the proper management, quality, safety and effectiveness of the service.

Regulatory Failings

66 The responsible individual must supervise the management of the service, which includes taking the steps described in regulations 64, 72 and 73.

Evidence

The evidence is collated following an unannounced inspection to the service on 11 April 2023. The evidence is as follows:

The Responsible Individual (RI) must visit the service in person and meet with staff and individuals at least every three months. The RI visited the home in person in late July 2022. They visited again in January 2023 and was present at a site visit on 9 May 2023. This does not meet with the requirements of the regulations and does not provide adequate oversight of the service and does not ensure essential improvements are being made in a timely way. The provider visited in January 2023 and was present at the site meeting with CIW on 9 May 2023.

We saw evidence on the manager's phone that communication between RI and manager is via e-mail. This does not support clear communication and explanation which can be provided in face to face communication.

We looked in the manager's personnel file and in training documents and saw that no specific training has been offered to the manager to support them in their role and to carry out their managerial duties. Some of the management functions in the home are not being completed.

██████████ The RI told us he provides business, development and management training for manager. The manager was scheduled to attend mandatory training in April 2023.

There is a lack of a robust managerial structure in the home and the manager / RI gave us conflicting information as to who is responsible for which aspects of the service.

There were 14 people at the service with one admission planned for ██████████. There were 3 care staff on duty between 8:00 – 20:00 with two night care workers covering the night shift. The manager stated ██████████ is satisfied that the current staffing levels to meet the needs of the people currently using the service. During the site visit on 09 May 2023 the staffing levels were low with the manager and senior carer assisting with personal care. In addition the cook was working and the RI was at the home.

The manager told us they do not have access to the CIW notifications system, as the RI has not set them up on the system. The RI is the only person who has access to this system but we saw from people's personal plans they have not reported all incidents to CIW as required by Regulation 60.

The manager told us the RI has not requested they provide monthly reports on quality markers such as infection control, sores, falls rates, safeguarding cases and staffing issues. An analysis of these quality markers is, therefore, missing from the RI's 6-monthly quality of care review reports which are required by Regulation 80. The RI has not asked the opinion of staff working in the home, or people visiting the home for feedback about the service in order to inform the review and the development of the service. The 6 Monthly quality of care report for October 2022 to March 2023 is overdue.

There is no documented evidence of a robust discussion following recommendations from the professional fire safety and hygiene visits and reports completed at the service. The delegation of tasks and responsibilities regarding actions required as a result of these reports is unclear, so some of the actions have not been completed.

Manager is now recorded as on line assistant with CIW, however is experiencing difficulties submitting on line notifications.

The updated evidence is collated following an unannounced inspection to the service on 17 August 2023. The evidence is as follows:

The RI told us the manager and deputy manager have resigned. The RI told us he is staying at the service, providing daily support for staff and undertaking management responsibilities. The RI is actively attempting to recruit a new manager. [REDACTED]

[REDACTED]. A recruitment process, including obtaining references and a satisfactory DBS is being followed for the manager.

Staff told us there is a better working relationship with the RI since he has been at the service. They said staff morale has improved and staff are supporting the RI by taking on management responsibilities, these include weekly rotas and medication orders.

The RI said he is arranging training and supervision. Staff last received supervision from the previous manager. We saw no evidence of recent formal recorded supervision.

[REDACTED] We informed the RI they must not allow any other person to work at the service in a position in which he or she may in the course of his or her duties have regular contact with individuals who are receiving care and support or with persons who are vulnerable unless that person is fit to do so. [REDACTED]

[REDACTED] The RI must produce a robust risk assessment and risk management plan should they consider the worker is suitable to work in an environment with vulnerable people.

The RI told us staff have received training on safeguarding provided by an external provider and

the RI also provides training on the subject. The training matrix we saw shows all staff received safeguarding training in April 2023 and five staff received safeguarding training by the RI in August 2023. The RI has not attended train the trainer training in order to be able to provide this training. The new manager told us they will contact the Local Authority for training schedules and nominate staff to attend.

[REDACTED]

This evidence is collated following an unannounced inspection to the service on 03 October 2023. The evidence is as follows:

On 25 September 2023 the Local Authority (LA) informed us that the passenger lift had been out of order since 22 September 2023, [REDACTED]

[REDACTED] The lift was still out of order at the time of the unannounced visit on 3 October 2023. The lift has previously been out of order in the previous summer and despite assurances from the RI that a new lift would be installed in August 2022, this had not been actioned placing people and staff's safety at risk. The lift remains out of order at the time of writing this report.

On 26 September 2023 the North Wales Fire Service contacted CIW with their concerns regarding fire safety at the service. There are two bedrooms located on the first (bedroom [REDACTED]) and second floors (bedroom [REDACTED]) which are fire exits. The RI told the fire safety officer that all people are mobile and self-caring and would be able to leave the building independently. On the day of the inspection staff told us one person is cared for in their bedroom by two carers and one person on the first floor requires care and support from two carers. Due to the passenger lift being out of order the fire safety officer also stated there should be 3 care workers on night duty for the safety of people should a fire break out. This was actioned on 27 September 2023. On the day of inspection one person was accommodated in bedroom [REDACTED]. Bedroom [REDACTED] still had furniture contained in it and fire triggers, with the exits blocked with small items of furniture, despite the advice from North Wales Fire Service.

On [REDACTED] there were two carers, one domestic, one cook and the manager working. The cook finishes work at [REDACTED], leaving the responsibilities of preparing and serving afternoon and evening meals to the care workers. The manager was attending various meetings leaving, two carers to care and support nine people over three floors with no working lift. Two people were confined to their bedrooms as they could not get downstairs to the lounge due to their mobility and support needs. People were sat in the lounge or bedroom with no one to one or small group activities. The manager told us staff did spend time chatting to people in their bedrooms. One person at the service is assessed as needing 2 carers for personal care, leaving no other carers available to assist others, if needed.

The new manager was working at the home and confirmed [REDACTED] [REDACTED] been processed. During the inspection we asked the manager for the application pack, including references and DBS check for a recently appointed staff member who had previously worked at

the home. The manager did not have this information. During the inspection feedback meeting with the manager and RI on 04 October 2023 the RI told us as the person had previously worked at the home a new recruitment process was not followed. The person had previously worked at the home until [REDACTED] During the feedback meeting the RI requested the manager complete a recruitment process for the new carer but this should have been done prior to the staff member starting in post.

[REDACTED]

On 04 October 2023 CIW sent the RI requests for additional information and documents in relation to the inspection of the service via the CIW direct messaging service, to be returned to CIW by 10 October 2023. The RI responded to two requests on 04 October 2023. The remaining 6 sets of documentation are outstanding at the time of writing this report.

[REDACTED]

The RI has failed to address the issues identified at the last inspections so the PANs are to be re-issued. This indicates a lack of oversight and failure to supervise the management of the service sufficiently to make the improvements necessary to ensure the health, safety and welfare of people living in the home.

Impact on and / or risk to the health and well-being of people:

We have assessed the potential risk and / or impact on people's health and well-being as a result of this non-compliance as Major and there is likely reoccurrence.

Outcomes for People

People cannot be assured the provider has proper oversight of the management, quality, safety and effectiveness of the service.

Timescale for completion

06 February 2023

Sensitif Swyddogol / Official Sensitive