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

Cherish Care Homes (Wales) Ltd

in respect of

The Hollins Care Centre

Hollins Wood Nursing Home
The Hollins
Neath
SA11 3BQ

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.

The issuing of this report is a serious matter. The notices contained within the report have been issued in accordance with our Securing Improvement and Enforcement Policy. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with this policy.

A copy of the Securing Improvement and Enforcement Policy is available on our website

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Priority Action Notice Identified at this inspection dated: 13 October 2023 Our Ref: NONCO-00017601-RGFS
Non-compliance has been identified with Regulation 6 The specific sub-regulatory failures relate to: 6
The service is not being delivered in accordance with the statement of purpose. Staffing levels at the service is not always appropriate ans staff do not feel supported or receive adequate supervision in the their roles. We also found multiple failings around health and safety in the service and poor infection control programmes. The provider must take action to ensure that people are safe and risks of infection minimised as far as reasonably possible. Safe staffing levels must also be maintained during this transitional period to ensure that people receive the care and support that they need.

Regulatory Failings

6 The service provider must ensure that the service is provided with sufficient care, competence and skill, having regard to the statement of purpose.

Evidence

The RI has failed to ensure that the service is provided with sufficient care, competence, and skill, having regard to the statement of purpose.
We saw failings in the assessment and monitoring to support individuals to achieve their personal outcomes:
- We looked at skin bundle documentation in both Hollins Park and Hollins Wood. In Hollins Park we looked at skin bundle documentation for three people and saw good documentary evidence of frequent turns and skin checks were in place, however in Hollins Wood on most skin bundles viewed, there was minimum evidence of the skin integrity being checked routinely on people with high risk of skin breakdown. Many records stated 'snacks', 'lunch given' on the skin bundle where evidence of skin checks should have been noted. We looked at documentation for food and fluid intake and saw most days were completed effectively. However, there were still evidence of gaps seen and on one occasion, all that was noted for one person was 200 ml of fluid all day and a few biscuits. Daily evaluations written to document oversight of individuals presentations were not clear to read, handwriting was illegible on many documents. Therefore, not adequate.

The provider does not always ensure that safe staffing arrangements, underpinned by professional development is in place to meet the care and support needs of individuals using the service.
- We did not see evidence of any medication competency test of staff on the training matrix, the last dated training for medication was on 05/01/22, [redacted].
- The Medication management team have visited the service and noted improvements are required. They have given the service a three-month timescale for these to be achieved.
The SOP states "All care staff complete mandatory training which includes but is not limited to: Safe moving and handling, all Wales passports. Health and safety, Safeguarding of vulnerable adults. COSHH, Dementia awareness. Medication training for senior carers. Fire safety, Infection Control, First Aid awareness, MCA/DOLS"

- The provider did not forward the training matrix for Hollins Wood despite reminders. Therefore, no training could be evidenced for the Hollins Wood staff as training matrix seen in personnel files were not up to date.
- We spoke with 6 care staff [redacted] We were told that agency staff were only authorised as a last resort, and they would have to use staff from the other side of the service first which often resulted in shortfalls elsewhere. During the inspection there was only one domestic on duty in Hollins Wood and one laundry person. We looked at staff rota's and saw in Hollins Wood for the month of September there were 13 occasions where the optimal staffing ratio of 5 in the morning and 4 in the afternoon were not in place. On the day of the inspection, [redacted] there were only two nurses left in the service to cover 7 days and 7 nights which is not manageable or sustainable.
- The rotas in Hollins Park had not been updated to reflect the recent resignations so there was a high risk of there being low staffing issues in forthcoming weeks.
- Feedback from staff overall was negative due to the increased pressure they felt at the time because of increased scrutiny from external agencies and poor communication management. We were told that many staff had already left the service to seek other employment as they did not feel secure there. We saw that staffing numbers since the last inspection in June have fallen and the use of agency staff increased. [redacted]

The statement of purpose states: "All staff have regular supervision. For care staff and nurses this is every 3 months"
- We looked at the supervision matrix and saw substantial gaps in supervision for most staff. Staff meetings were duplicated and logged as group supervisions which does not give staff the opportunity to have one to one discussion about their workload, personal development, and well-being.

The SOP states "The home employs a full-time activities co-ordinator who discusses their wishes with residents and provides access to activity and entertainment and trips out for those who wish to be involved. The home also has 2 volunteers who attend regularly to chat with and support residents with socialising".
- We were in the service for two days and the only activity we saw was a care worker blowing bubbles as a one-to-one activity. The individual was looking down and not engaged at the time of the observation. People sat in the perimeter of the communal lounges and TVs were on. One relative told us there are limited activities that just aren't suitable for their relative at all.

"The Home operates a locked door policy with the main entrance locked at night but operated by a keypad code during the day".

We found failures by the provider to ensure the premises, facilities and equipment are suitable and accessible and that policies and procedures are adhered to in order to meet the aims and objectives of the statement of purpose.

The statement of purpose states… "The Home is kept clean with the housekeeping team and Maintenance Officer ensures that all maintenance is completed in a timely manner and meets all H&S requirements."

We found people's health and safety were compromised due to numerous environmental hazards:

[redacted]

- [redacted] we found a [redacted] storeroom in Hollins Wood to be unlocked with the door partially open. The room was generally untidy and contained numerous office chairs, moving and handling equipment and other items. We prompted staff to keep this room locked when not in use due to the risk of people experiencing trips, falls and other injuries should they access the room unsupervised. However, when leaving Hollins Wood [redacted] we once again observed the room to be unlocked with the door slightly ajar.
- We found the first-floor sluice room in Hollins Wood to be unlocked. Although a keypad was fitted to the door, the door would not close properly and could therefore not be locked. Within this room was a bottle of cleaning spray that should be stored securely under Control of Substances Hazardous to Health (COSHH) Regulations 2002. This presented a risk to people ingesting a potentially harmful chemical.
- During a walk around Hollins Park on 13 October 2023, we found an unused bathroom being used as a storage room. The room was untidy and contained numerous furniture and boxes that were stacked on top of each other. There was no lock on the door to prevent people accessing this room and being exposed to trip hazards that may cause them injury.
- On the first floor of Hollins Park, we observed a large light hanging by its electrical cable from the ceiling in one of the corridors. Part of the ceiling looked to have recently been replaced due to water damage. As the light was not fixed securely, there was an increased risk of it falling and injuring anybody in the area and/or causing an electrical fault that could affect people's safety and well-being.
- We observed a call bell lead in one of the first-floor bathrooms in Hollins Park to be tangled and tied up out of immediate reach. This could prevent people from calling for staff assistance should they need it when using the bathroom.
- We observed damage to various furnishings that could cause injury. For example, a light switch had a hole in its centre where it was missing its switch and there was a ragged hole in the centre of the door handle to bedroom [redacted] in Hollins Wood where the lock mechanism was missing.
- A social care and health professional told us they had intervened on two separate occasions to prevent staff members using unsafe moving and handling techniques when assisting residents.
- There were gaps in records for environmental checks in the premises, with nothing recorded for July, September or October this includes hot and cold water, call bell, bed rails and window restrictor checks, all which are scheduled to be checked monthly.

In addition, we found that the service was not being provided in line with the national infection control policy as poor standards of hygiene and infection control were observed.
The infection control policy was requested however not submitted for us to view.
However, we made the following observations:

- Furniture, furnishings and other equipment were visibly dirty:
- The legs of a hoist staff were using in Hollins Wood had multiple brown smears on them.
- The base of a stand aid in the storeroom in Hollins Wood had dirty black marks on it.
- There were multiple dirty marks and a piece of torn apron on the floor of the storeroom in Hollins Wood.
- The footrest of a stand aid in room [redacted] was heavily soiled with debris gathered in its corners. A staff member told us the room had been unoccupied for approximately three weeks.
- Two urine bottles were lying on the floor in one of the communal toilets opposite the lounge in Hollins Wood.
- There were crumbs and stains on a chest of drawers in room [redacted].
- There were drip stains down the wall in room [redacted]. The tube of denture adhesive in the en suite bathroom did not have a lid.
- There were brown drip stains on the paddles of a stand aid being stored in a vacant room

on the first floor in Hollins Wood.
- A tub containing catheter stands and some stained commode pot lids had been left on the floor by the bath in the first-floor communal bathroom in Hollins Wood.
- The toilet brush in one of the communal toilets on the ground floor of Hollins Park had brown staining on it.
- The material on a shower chair in the first-floor communal shower room in Hollins Park was stained.
- Several pieces of furniture were in poor condition or permeable, making them difficult to adequately clean and sanitise in order to reduce cross contamination and infection risks:
- There was wooden panelling around the standard bath and some of the pipework in the communal bathroom in the basement of Hollins Wood.
- Parts of the frame around the toilet seat in one of the communal toilets opposite the lounge in Hollins Wood was rusty.
- The cantilever table in room [redacted] was damaged and the armchair was heavily worn and ripped.
- The cantilever table in room [redacted] was damaged.
- There was rust stained water around the base of the toilet in the first-floor communal bathroom in Hollins Wood. It appears this was caused by a small leak. The sealant along the skirting board by the shower was dirty and stained and the wall panelling was cracked in places.
- The bedrail bumper pads and bedframe in room [redacted] were heavily scratched.
- There were gaps in the flooring around the toilet bowl in the sluice room on the first floor in Hollins Park. Items were also being stored in this room inappropriately. For example, a resident's cardigan and coat hanger were hanging off the edge of a linen trolley.
- The flooring in a second communal toilet on the ground floor of Hollins Park was damaged.
- The clinical waste bin in the communal bathroom of the first floor of Hollins Wood had a rusted frame.
- We found toiletries and prescribed creams within communal bathrooms, posing a risk of people sharing items intended for personal use:
- A bottle of Dermol prescribed for a resident who was no longer living in the home was observed in a cabinet in one of the bathrooms in the basement of Hollins Wood. The prescription label was barely visible, and the lotion had an expiry date of March 2023.
- A basket containing a hairbrush, bottles of lotion, some dry wipes and other items was found in the first-floor communal bathroom in Hollins Wood.
- An 'unused' bathroom was being used as a storage room on the ground floor of Hollins Park. The room was untidy and contained numerous boxes and furniture, including moving and handling equipment. There was no lock on the door to prevent people using the bathroom facilities in this room.
- Several bins did not have lids:
- The bin in a communal toilet opposite one of the lounges in Hollins Wood
- The bin in the communal bathroom on the first floor in Hollins Wood.
- The bin in the communal shower room on the first floor in Hollins Park.
- The bin in the communal bathroom on the first floor in Hollins Park.

Prior to this inspection, we were made aware of the poor condition of mattresses in the service following an infection control audit by Swansea Bay university Health Board. During the inspection we saw many mattresses did not have an adequate waterproof outer cover which meant that the inner layer and foam material was heavily stained with bodily fluids. These mattresses were malodorous. We were made aware that the RI had informed commissioners that he would not be able to provide new mattresses [redacted], resulting in commissioners agreeing to source and replace these, where possible.

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	
The RI has failed to ensure that staffing arrangements, premises, facilities and equipment are suitable and accessible and that policies and procedures are adhered to in order to meet the aims and objectives of the statement of purpose. as a result of these failings, people are at risk of infection, harm and neglect.	
Timescale for completion	22 January 2024