Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Penisarwaun Care Home

Penisarwaun
Caernarfon
LL55 3DB

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date of Publication

27 June 2018

Description of the service

Penisarwaun is a large care home providing nursing and personal care for up to 33 older persons over the age of 65 years. The registered provider for the home is Penisarwaun Care Home Ltd. The home is situated in a rural area on the outskirts of Caernarfon, close to the village of Penisarwaun. Accommodation is offered on one level and provides spacious communal areas for people to spend their time.

The company has nominated an individual to oversee the service and Care Inspectorate Wales (CIW) recognises this person as the Responsible Individual (RI). There has not been a registered manager at the service since 2010. The recently appointed interim manager does not possess the necessary qualification to register with Social Care Wales (SCW). The manager says that she will stay in post until a suitable person can be employed.

Penisarwaun Care Home Ltd was designated as a Service of Concern by CIW on 15th May 2018. Enforcement action was taken to prevent further admissions to the home on 23rd May 2018 until CIW was satisfied that the unacceptable risks to people's health and welfare were fully addressed.

Summary of our findings

1. Overall assessment

Since our previous inspection on 9 February 2018 there has been little progress in meeting regulatory requirements and protecting residents from harm. The new interim manager has identified improvements needed to improve the quality of care and is taking actions to address these issues. This inspection was carried out over three visits in May 2018. During all three visits to the home, we found that people were not receiving care and support that meet their assessed needs. We identified concerns about the peoples' weight loss, pressure care, swallowing, falls and dignity. The staffing levels and the overall leadership and management of the service was inadequate.

We (CIW) found that residents are supported by kind and caring staff. Some residents do not have a sufficiently comprehensive assessment of their needs. We found deficits in some residents' care plans and risk assessments. This had resulted in poor outcomes for people. Whilst people are cared for in a homely environment, improvements are needed to ensure that adequate arrangements have been made to protect people from the risk of harm. People are cared for by staff who are familiar to them. However, staffing arrangements mean that people can not rely on receiving the level of care and supervision they require. Whilst generally people enjoy appropriate healthy and nutritious meals and drinks, improvements are needed to support those people who are dependent on assistance to eat and drink. Improvements are required in the environment that are detailed later in this report.

2. Improvements

An interim manager has been appointed to address the current concerns in the home.

3. Requirements and recommendations

Section five of this report sets out our recommendations and legal requirements to improve the service and areas where the registered person is not meeting legal requirements. These include:

- Medication management is not effective.
- Effective leadership and management.
- Fluid/intake charts should be totalled and deficits acted upon to evidence nursing oversight. This was identified as an issue at the previous inspections.
- Staff supervision and training: This was identified as an issue at the previous inspection. Further improvements are required to ensure that staff are supervised appropriately.
- Risks to the health or safety of service users: There is the potential for a risk of significant injury and serious harm to residents.
- On call procedures need to be implemented.
- Improvements are required in the environment.
- Not all care and welfare plans had been reviewed to reflect the changes in peoples' care needs so that care workers are properly informed as to how to deliver care. This was identified as an issue at the previous inspections.
- Consideration should be given to the safe storage of nursing equipment and other items within the home.

1. Well-being

Summary
People living at Penisarwaun Care home are generally happy and have opportunities to take part in activities which they enjoy. Most of the people that we saw were well presented and were relaxed and content. The home is working towards an active offer of Welsh.

Our findings

People with complex needs do not experience adequate monitoring from staff.
Rounding sheets detailing planned time periods when people needed assistance with turning, toileting, fluids, and mouth care needs, were seen to have excessive gaps between care episodes. One person who required regular repositioning due to high risk of developing pressure damage remained in the same position for 12 hours despite requiring to be turned to alternate positions to minimise the risk of developing pressure sores. We saw that staff were not accurately recording the times people had been re-positioned. We saw staff had documented that this person's pressure area was red. The records were not counter- signed by nurses to show there was an oversight of the care and if any further action needed to be taken. People cannot be assured of adequate hydration and fluid balance monitoring. We looked at the fluid balance charts being maintained by staff (a tool used to calculate the amount of fluids a person has drank within a 24 hour period). Not all charts were totalled at the end of the day; the fluids levels recorded were inadequate and indicated that many people in the home would be dehydrated. There was no evidence of nursing intervention to ensure people were receiving adequate fluids. We saw a family member had raised concerns with nursing staff on that their relative was not receiving adequate fluids. We looked at fluid input charts for this time period and found that records did not show that the person was receiving adequate fluids. We looked at the daily records and staff handover records for this time period and found that the nurses had not followed this through despite the matter being drawn to their attention. We saw documented in the minutes of a staff meeting on 2 May 2018 that people's fluid input requires improvements. Similar failings were also identified at a previous inspection and the notice issued remains in place. In light of our findings we conclude people cannot be confident they will receive the right care at the right time.

People mainly are encouraged to be involved in activities and have opportunities to socialise and follow interests. Although we did not evidence any activities taking place during our visits there was a range of activities and events available for people to join in. Staff told us that people who are cared for in their own rooms are offered activities including; use of sensory equipment, manicures, adapted games, chats and reading books and newspapers. Records are kept by the activity co-ordinators around the activities held and a description of how people had interacted and responded to the activity. We also saw a photograph album in the main reception that had many pictures of people participating in a range of activities. However, we told by the interim manager and from the minutes seen in recent relatives meeting that a Director had cancelled the Easter entertainment and that they were planning to celebrate the forthcoming royal wedding. A Director had told staff if this went ahead then the entertainment in June would have to be cancelled. We had reassurance from the manager that no entertainment will be cancelled and will go ahead as planned. We can conclude that some people are mainly feeling fulfilled and have opportunities to live an active life of their choice.

The home is working towards an active offer of Welsh. We heard several members of staff conversing with people in Welsh. Many people spoken with were locals who told us that they appreciated being able to speak in their first language. A person living in the home and a visiting relative told us that they would like to see more entertainments offered in Welsh. We saw documented in the minutes of a relatives meeting that one person would like their care plans written in Welsh. The deputy manager informed the relative that this was not possible due to legal requirements and all information had to be written in English. It is advised that the management familiarise themselves with The Welsh Language (Wales) Measure 2011. Not all signs and documents in the home were also available in Welsh. The telephone is not always answered in a bi-lingual manner in the service. Not all care records seen acknowledged people's first language choices. We also recommend the registered persons read Welsh Government's "More than just words- follow on strategy guidance for Welsh language in social care". Further work is required to achieve the active offer of Welsh.

2. Care and Support

Summary
People living in the home told us that staff were kind and very helpful but very busy. Staff numbers and deployment affects the timeliness of the care provided and safety of people. Risk assessment and care planning processes are not adequately robust to ensure that people are kept as safe as they can be.

Our findings

People cannot be confident that risks to their safety and well-being are identified and that care plans and risk assessments are updated appropriately to ensure that their health and safety. We examined care documentation for a sample of residents and found that risk assessments were not reviewed appropriately or not immediately actioned.
We saw that one person had sustained 7 unwitnessed falls over a four month period. We could no see that their falls risk assessment had been updated which is required after a fall. We saw that this person had sustained two head injuries. The nurse failed to ensure that appropriate observations were undertaken in light of the head injury. We also saw that this person was at a high risk of aspirating and was prescribed Textured C diet and thickened fluids and found that they were left unsupervised and struggling to eat their meal. We saw on the second visit that they had been given the wrong diet which placed them at a high risk of choking. We saw that one person was at a high risk of absconding from the home. We looked at the care and daily records and found staff had documented this person had exited the home via the fire escape six times. Staff were alerted immediately as the fire alarm had been activated. Furthermore, we also saw staff had documented on six other separate occasions that this person had been "*Wondering*" around the home and entering other people rooms during the night. Staff had documented that they had found this person feeding another resident crisps. We saw staff had documented that this person should be checked regularly every two hours. The manager stated it should be every 10-15 minutes. This person had no written care plan or risk assessment in place and no strategies were in place to ensure this persons safety.

We saw that another person had lost 6Kg in weight over a short period of time and staff had weighing this person for six weeks. A referral to the dietician was completed the same day as the person was weighed. We also heard one person shout out "I'm in pain, I'm in pain". The nurse told the person that she had only just changed their pain relief patch and to wait 20 minutes or so for it to take effect. The manger told the nurse to administer Paracetamol. The nurse replied that they were not prescribed Paracetamol so could not give it she also said that "*she's been in a bad mood all morning; I don't know what's wrong with her*". The manger told the nurse to give the Paracetamol under the homily remedy policy. The nurse said she would do so after she had finished what she was doing. We looked at the medication administration charts for this person on out third visit on 15 May 2018. We could not evidence that the pain relief Paracetamol had been given on that day as instructed by the manager. We could not evidence in the care records that this person had been assessed as to whether the current prescribed pain relief remained sufficient for their pain control needs. This deficit had led either to poor outcomes or a risk of poor outcomes for residents. Furthermore, where risk assessments are undertaken, and measures identified, these should be actioned immediately. The registered persons need to improve the

timeliness of reviews and risk assessments to ensure that people are supported to be as safe and healthy as they can be. Further details can be found in the attached notices.

Staff do not always have access to comprehensive documentation that informs them about people's needs and the care that should be provided. At the previous inspections, we identified deficiencies in care documents such as a lack of up to date and accurate information. These same failings were also identified at this inspection. We reviewed a number of resident care files. We found that care plans did not always contain the necessary advice and guidance for staff as to how they should assist people and they were not updated when peoples' needs change or to take into account advice from other healthcare professionals. Some care plans were missing. People were not involved in determining the content of their care plans so important information about their wishes and preferences was not always apparent. Plans were not person-centred and were lacking detail about the person and their life history. The interim manager has also identified this as an area for improvement and has recently started to implement changes. As a result, people are not involved in making important decisions about their care and peoples' individual needs and preferences are not always understood or anticipated.

Staff numbers and deployment means that care is not timely. The home currently has 23 people of which ten people receive continuing health care and thirteen people are in receipt of funded nursing care. The interim manager and staff expressed concerns that there was not enough staff on duty to meet the needs of people living in the home. Staff and families have highlighted many examples of how the needs of people are not met. People do not receive baths and showers. There is insufficient staffing to safely observe and support people who are walking. Meal times are long with insufficient intervals between meals. People us told that staff are kind and helpful but staffing is insufficient to meet peoples needs. People are happy with the care given; staff deployment needs further consideration to best fit in with people's care needs.

3. Environment

Summary

The home is warm, clean and tidy with no offensive odours. Improvements are required in relation to the safe storage of equipment and outside area. Investment is required in some area of the home. Parts of the home require refurbishment.

Our findings

People are mainly confident that they are cared for in an uplifting environment. Most bedrooms are spacious and have essential furniture and facilities. The home is warm, clean and tidy with no offensive odours. At the last inspection we identified that improvements were required in relation to the laundry room. Parts of the home require refurbishment. We identified at the previous inspection that the carpet in the main corridor required attention as it was stained, heavily worn and looked unsightly. At this inspection we did not see any improvements. We saw a bedroom wardrobe mirror was cracked and we saw holes in two bedroom doors. We saw several chairs in the main lounge were worn and faded. We saw that some of the specialist nursing equipment was being stored in two communal bathrooms. We could not enter one bathroom as the equipment and furniture had been placed up the door. We also saw that two empty bedrooms were also being used to store unused furniture and equipment. The maintenance person told us that he had placed these items in the bathrooms as he had nowhere else to store them. He also advised us that he has spoken with the responsible individual on many occasions regarding the lack of storage facilities in the home and to date no action has been taken. We advised improvements were required in the outside garden area at a previous inspection in 2017. At the last inspection in February 2018 we saw some improvements had been made. At this inspection we saw these improvements had not been sustained. We saw the grass had overgrown and generally required tidying up. We saw old furniture and other items were left at the front of the property in the car park. We discussed these issues with the responsible individual who said it was difficult to find someone to attend to the outside area and reassurance was given that the rubbish would be removed.

4. Leadership and Management

Summary

Overall we found that the service was not well led and managed. The quality of the service people were receiving was not improving. Although action plans had been provided to CIW, insufficient action had been taken to prioritise and address the issues raised at the previous inspections. The registered provider had repeatedly failed to make or sustain the necessary improvements. Not all staff are adequately trained or supervised to make sure that people receive good outcomes. Staffing levels remain inadequate. There has been no registered manager in the service since June 2010.

Our findings

People do not benefit from a service which is well run with a suitably qualified manager in post. The home has not had a registered manager since 2010. Since that date, several managers have been appointed but had since left for various reasons. A new interim manager had been appointed to oversee the service until a suitable manager can be appointed. The new manager currently works 3 days a week and the deputy manager works two nights per week. We have since been informed since the inspection visit that the deputy will now be working days. The interim manager is experienced, proactive and has been at the service for a short period of time. She has identified numerous failings in the home and has expressed concerns relating to staffing levels, documentation and medication management. The responsible individual told us that he continues to have difficulties in recruiting a suitable manager. An area manager visits the home every month to support staff. We found insufficient evidence of adequate oversight and effective management of significant health issues which may have impacted upon the well being of individuals. Additionally, CIW were concerned that there is no suitable arrangements for on call when the manager is not present in the home. During the first inspection visit the nurses on duty were not aware that the manager was on a day off and went to find her in the home. The admin assistant and handyman informed the inspector that the manager was not on duty and would be returning the following day.

The management continues to lack commitment to continuously drive improvements in the standard of care at the home.

- People with kidney disease and other health conditions are not receiving adequate fluids.
- There is inadequate care of one person with unstable diabetes
- There is no management of falls.
- People who are at high risk of aspirating receiving the wrong textured diet and no supervision of these people.
- There is insufficient staff training. During this inspection nurses told the inspector that they had not had training to care for people with certain health conditions such as the person with unstable diabetes and another with an indwelling catheter.

We found no evidence of action by the responsible individual which served to improve the quality or safety of the service and we found evidence of poor outcomes and evidence of unacceptable risks to some people. Therefore, all the areas of non compliance issued at the last inspection remain unmet and new areas of non-compliance have been identified at this inspection in relation to unnecessary risks, care planning, training and staffing.

The home does not have a full compliment of nursing staff and relies heavily on agency nursing staff to cover night shifts. During an inspection on 9 February 2018 we saw that some improvements had been made in relation to staffing levels. The appointed manager at time informed us that she increases staffing levels accordingly during busy times to ensure people receive the right care. During this inspection we saw that this improvement had not been sustained. Records indicate that the agency staff are not consistent, highlighting that different staff are being used each night resulting in care in a lack of continuity of care. We found at a previous inspection in April 2017 that systems were not in place to measure the quality of the service provided to make sure it is constantly improving and meets people's needs and expectations. A dependency tool should be used to determine the number of staff required to meet assessed needs. The provider should review staffing levels further, especially at night, linking this to their individual behavioural traits to ensure that the needs of all residents are met appropriately. The interim manager at the time of the inspection had stopped all admissions into the home as she had concerns regarding the staffing levels. Further details can be found in the attached notice.

We found that the service does not always ensure that people receive care from appropriately supervised and trained staff. A training matrix which was dated 2018 provided an overview of the training completed by all members of staff. We saw that a majority of staff had completed mandatory and service specific training including; fire, health and safety, dementia, safeguarding and moving and handling. Most staff had completed training in dignity in care in 2015. We saw additional training such as food hygiene, pressure area care, dysphagia, diabetes, infection control training, COSSH and first aid had not been completed. The interim manager was in the process of handing out work books to staff in relation to dementia care and challenging behaviours. The gaps in staff members' training may result in staff not feeling confident in the support that they offer. We identified at the last inspection that improvements were required in the supervision of staff. At this inspection we did not see any improvements. The interim manager told us she had just completed group supervision with most staff which was in response to a safeguarding concern. We saw from staff records that staff supervision had not been carried every two months. Further details can be found in the attached notice. From our findings, we consider that people do not always benefit from a service where staff are appropriately trained and improvements are required in this area. Further details can be found in the attached notices.

Overall, the registered provider has failed to give due care and attention to the areas identified at the last inspection in relation to health and welfare, safety, documentation, staffing, training and supervision. It remains CIW's view that the non compliance in relation to the registered provider has not been carrying on the service with sufficient care, competence or skill remains in place.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

• **The registered person must appoint a person to manage the home.**	**8 (1)**
• **We found evidence that the registered persons were carrying on and managing the care home with sufficient care, competency and skill. The registered person should provide evidence that the home is managed so as to safeguard and promote people's welfare.**	**10 (1)** **The service remains non compliant**
• **The registered person(s) must establish and maintain a system for reviewing and improving the quality of care at the home. This must include seeking the views of people who live at the home.**	**25 (1)** **The service remains non compliant**
• **The registered persons must ensure that there are effective systems in place so that staff are responsible and take appropriate action to seek the necessary health care for people when required.**	**12 (1) (a)** **The service remains non compliant**

5.2 Recommendations for improvement

Some parts of the environment require maintenance and updating. The carpet in the main corridor required attention due to some stains and some areas were worn and faded. The outside area requires attention and rubbish placed in car park needs removing.

Care plans require updating to ensure that they reflect the person-centred approach to care, are regularly reviewed. Care plans need to be prepared for all people living in the home, in conjunction with the person and give more detail.

Qualified nurses must ensure that there is oversight regarding the care that is given and that it is documented.

6. How we undertook this inspection

We undertook an unannounced baseline inspection on 9, 11 and 14 May 2018 in response to outstanding areas of non compliance issued by CIW at the last inspection.

- We used the following sources of information to formulate our report:
- Observations of daily routines and care practices at the home
- Conversations with three residents
- Information provided by the responsible individual, interim manager and discussions with six members of staff.
- Examination of documentation stored at the home including care files and a selection of care intervention charts
- Observation of breakfast and lunch being served
- Consideration of information provided in relation to staff training and staff supervision
- Consideration of the home's quality assurance and auditing systems and accident file
- The staff rota
- Consideration of minutes from staff and relatives meeting held in May 2018
- We used the Short Observational Framework for Inspection (SOFI). The SOFI tool enables inspectors to observe and record care to help us understand the experience of people who cannot communicate with us.

Further information about what we do can be found on our website:
www.careinspectorate.wales

About the service

Type of care provided	**Adult Care Home - Older**
Registered Person	**Penisarwaun Care Home Ltd**
Registered Manager(s)	**There has been no registered manager since 2010**
Registered maximum number of places	**33**
Date of previous Care Inspectorate Wales inspection	**9/2/2018**
Dates of this Inspection visit(s)	**09,11 and 14/05/2018**
Operating Language of the service	**Both**
Does this service provide the Welsh Language active offer?	**The service is working towards an active offer of the Welsh language.**
Additional Information:	

Care Inspectorate Wales

Care Standards Act 2000

Non Compliance Notice

Adult Care Home - Older

This notice sets out where your service is not compliant 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 notice is a serious matter. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.careinspectorate.wales

Penisarwaun Care Home

Penisarwaun
Caernarfon
LL55 3DB

Date of publication:
27 June 2018

Care and Support	Our Ref: NONCO-00005948-BQTY
Non-compliance identified at this inspection	
Timescale for completion	**20/08/18**
Description of non-compliance/Action to be taken	**Regulation number**
The service is not compliant with Regulation 15(1) of The Care Homes (Wales) Regulations 2002	

Evidence

The service is not compliant with Regulation 15(1) of The Care Homes (Wales) Regulations 2002

This is because care plans and associated risk assessments do not contain sufficient detail to assist and instruct staff in providing anticipated, responsive and appropriate care. Care plans have not been implemented for all needs. Tools and or strategies must be implemented to assist staff in providing appropriate care and completed comprehensively to accurately reflect the care given and any changing needs.

The evidence includes:

- We found the documentation was poor for one person who suffers from swallowing difficulties. There was no guidance for staff in assisting with meals safely.

- We saw that care plans did not contain sufficient detail to assist and instruct staff in providing appropriate care. For example, a care plan in relation to managing a person's diabetes did not reflect a person centred approach to care; an acceptable range in terms of their blood sugar monitoring was not given, the care plan did not stipulate how often to monitor blood glucose levels. Signs and symptoms of diabetic ketoacidosis (high blood glucose readings) were not identified to assist staff in recognising this. Conversely there was no information recorded in respect of hypoglycaemia (low blood sugars). It was recorded 'to maintain stable BM's' but there was no information regarding the acceptable levels for this individual.

- This area has also been identified by the area manager as an area that requires improvement in the Regulation 27 visit dated 15/1/18. It was documented that time was a restriction in implementing care plan improvements. The interim manager has also identified this as area that requires improvement and is currently in the process of developing new care documentation.

- We identified that this was an area for improvement on the 15 February 2018 and 25 April 2017 inspection and that every person living in the home needed to have a comprehensive care plan that contained sufficient detail to instruct and assist staff in providing the right care in the way people want it.

- We saw that care plans in relation to managing person 'A's diabetes did not contain sufficient detail to assist and instruct staff in providing appropriate care. Managing person's 'A' type 2 diabetes did not reflect a person centred approach to care; an acceptable range in terms of their blood sugar monitoring was not given, the care plan stipulated to monitor blood glucose levels as often as requested by the general practitioner but this is not prescriptive enough. Signs and symptoms of diabetic ketoacidosis (high blood glucose readings) were not identified to assist staff in recognising this.

- People were not involved in determining the content of their care plans so important information about their wishes and preferences was not always apparent. We saw that wording such as 'consider likes and dislike' and consider using food charts' were used within the care plan when in fact people where actually receiving increased monitoring due to weight loss and food charts where in use.

- The care files seen in relation to personal care were basic and lacked detail. They did not give an accurate description of the actual needs of the person such as what the persons strengths and weaknesses are.

- We saw that in one of the care files viewed one person did not have a pain assessment chart or the care plan had been updated, despite this person being nursed in bed due to limb contractures. Their Maelor score assessment chart indicated that they had moderate pain.

- We saw a person had a history of re-occurring urine infections. We cold not see that a care plan had been implemented to instruct staff what the signs and symptoms were or actions to take to help prevent further infections.

- We saw that it was documented in one persons care file that they had dementia at risk of absconding from the home. We looked at the care and daily records and found staff had documented this person had exited the home via the fire escape six times. Although staff were alerted immediately as the fire alarm had been activated, this person is not actively supervised when moving around the home due to insufficient staff. We also saw staff had documented on six separate occasions that this person had been "wandering" around the home and entering other people rooms during the night. We could not see that a risk assessment or care plan had been implemented in this persons file.

This evidence indicates that people living in the home cannot be assured of having their care adequately assessed, planned, and evaluated.

The impact of this is that the care planning for people using the service is inadequate which affects their health and welfare.

Care and Support	Our Ref: NONCO-00005949-FBYM
Non-compliance identified at this inspection	
Timescale for completion	**31/05/18**
Description of non-compliance/Action to be taken	**Regulation number**
Regulation 13(4)(c) – The registered person shall ensure that unnecessary risks to the health or safety of the service users are identified and so far as possible eliminated.	

Evidence

Regulation 13(4)(c) – The registered person shall ensure that unnecessary risks to the health or safety of the service users are identified and so far as possible eliminated.

The registered person is non compliant with this regulation

The evidence is as follows:

- Care records seen during the inspection visits on 9, 11 and 14 May 2018 evidenced that risk management strategies for people identified as being at risk of falls and/or pressure sore development and/or nutritional deficit/weight loss and fluid intake were not implemented as per risk assessment and care plan instructions.

- In relation to four people's increasing needs, the records evidenced that the care plans and risk assessments were not updated to reflect the increasing risks and additional care needs. This is in relation to falls management, pain management, weight management and one person's safety relating to absconding from the home.

- We identified at previous inspections on 09/05/2017, 05/06/2017 and 9/2/ 2018 that improvements were required in the management of people receiving adequate fluids. We did not see improvements at this inspection. Fluid balance charts for eight people were seen during the three inspection visits on 9,11and 14 May 2018. None of the people had received the daily amounts as required by their individual care plan instructions.

- There was no countersignature to demonstrate that the nurse in charge was aware of the deficits and there was no evidence of any strategies in place or action taken by nursing staff to ensure people's poor fluid intake was addressed.

- The Inspector observed that fluid amounts had been entered onto charts but the drinks were not consumed because people could not reach them or because they had not received assistance from staff where required.

- We saw a record in the minutes of a staff meeting on 2 May 2018 that people's fluid input required improvements. Staff had sought clarification from the management as to who was responsible for the fluids charts. The deputy manager explained that it was the care staffs'

responsibility to write down this information. The manager explained that she has seen staff write 250mls given a lot but is not necessarily the amount of fluid which had been consumed.

- We saw a family member had raised concerns with nursing staff on 25/4/2018 that their mother was not receiving adequate fluids. We saw that this person had been diagnosed with Stage 3 Kidney failure and had a history of urine infections. We looked at fluid input charts for this time period and found that that the concerns raised were valid and the previous day their mother had drunk 660mls of fluid. We looked at the daily records and staff handover records for this time period and found that the nurses had not followed this through and risk to people from dehydration has not been addressed and was still present during this most recent inspection.

- We saw in the records that one person had lost 3.7kg in weight between June and August 2017. Inspectors saw that staff had documented “not weighed at present as unsafe to do so”. There was no explanation as to why it was unsafe and this instruction had not been reviewed. Therefore this person had not been weighed since August 2017. We also saw that this person had been discharged from the dietician and staff were instructed to re-refer if any concerns arose. As staff have not been weighing this person, they do not know if a dietician visit is required. There were no instructions in this person’s care plan to offer snacks throughout the day in-between meals.

- The food charts for this person evidenced that staff were not offering additional snacks/meals in between set meal times despite the dietary intake being poor. Inspectors could not find evidence that nursing staff had oversight of this person’s diet or that they had put strategies in place to manage this. This person is at risk of malnutrition.

- We also saw that this person was at a high risk of aspirating and was prescribed Textured C diet and thickened fluids. Their nutritional care plan stated this person required assistance and observation. During our first visit on 9 May 2018 we saw that staff had left this person’s meal in front of them and saw that they were struggling to eat. A member of staff did go into their room and asked the person if they had finished. When the care staff called this person ‘Darling” this person became extremely angry and shouted at the carer and told not to call her ‘Darling’. The carer quickly left the room. The carer did not offer any assistance to the person.

- During our second visit on the 11 May 2018 the inspector and interim manager found this person’s door was shut. The manager opened the door and saw that this person was once again eating their food unsupervised. We saw that a member of staff had given this person eggs which placed them at high risk of aspirating. The manager asked the nurse assigned to that area who had left the meal. The nurse replied it must have been the carer. The manager later identified afterwards that the kitchen porter had handed the meal to this nurse and she had given the meal to the person.

- The Inspectors observed the care of three people who had been identified as being at high risk of pressure sore development. We looked at the repositioning charts for one person and found that they had been sat up in bed from 11.30am to 05.05hrs the following day. We saw that care staff had documented that this person’s sacrum was red.

- The inspector and manager heard one person shout out “I’m in pain, I’m in pain”. The nurse

told the person that she had only just changed their pain relief patch and to wait 20 minutes or so for it to take effect. The manager told the nurse to administer Paracetamol. We looked at the medication administration charts for this person on our third visit on 15 May 2018. We could not evidence that the pain relief Paracetamol had been given on that day as instructed by the manager.

- We observed that a person, who was at a high risk of falling did not have a suitable risk assessment in their care records. We saw that this person had sustained five unwitnessed fall since January 2018. We could not evidence that that any risk assessment had been reviewed after each fall. However, the evidence of continued unwitnessed falls indicates that the risk assessment was not implemented in practice and the risk assessment was not always reviewed following a fall. We also saw that in two of the falls, this person had hit their head. We could not evidence that the nurses had completed head injury observations after these falls.

- We saw that one person was at risk of absconding from the home. We looked at the care and daily records and found staff had documented this person had exited the home via the fire escape six times. Although staff were alerted immediately as the fire alarm had been activated, this person is not actively supervised when moving around the home due to insufficient staff. We also saw staff had documented on six separate occasions that this person had been “wandering” around the home and entering other people rooms during the night. Staff had documented that they had found this person feeding another resident crisps – which could have been dangerous had the person been at risk of choking.

- We saw staff had documented that this person should be checked regularly every two hours. The manager stated it should be every 10-15 minutes but there was no risk assessment or care plan evident in the person’s notes and no evidence to demonstrate the person was being supervised as required.

- We saw, documented in this person’s mobility care plan, that a floor sensor mat was in place in their room. This would alert staff when this person left the room. We looked in this person’s room and could not see a sensor mat in place. The manager advised the inspector she thought that there was one in place and would ensure that there would be one by the end of the day. It is not likely this would have been identified if the inspector had not intervened.

- We saw that the same person was at high risk of falling and on the 5 April 2018 staff had found them on the floor. Emergency services were contacted and this person was taken to Hospital. Staff were advised that this person was suffering from low blood pressure and they require monitoring. We could not evidence that nursing staff had been monitoring this person’s blood pressure since discharge from hospital or that the failure to do so had been identified by the management of the service.

- We saw that the same person weighed 56Kg on 16 February 2018. This person was admitted to the home on 28 March 2018. This person’s first weight was carried out by home on 11 May 2018. This person weighed 50Kg. A dietician referral was completed on the same day. We looked at this person’s daily food and fluid charts and saw that this person had a very poor appetite and had very poor fluid intake. We could not evidence that staff had been offering snacks or other nutritional meals in-between meals or that nursing staff had oversight of this.

- We saw that home had recently admitted a person with unstable diabetes. We looked at their records and found that they had been admitted to hospital twice with low blood sugars. An agency nurse was on duty during one hypoglycaemic attack and they had documented that had given orange juice and sugar. We saw that care records in relation to this person's management of unstable diabetes was inadequate and we were informed by one nurse that she had implemented instructions in the care file to instruct staff of what to do in the event of a hypo/hyperglycaemic event only after this person was admitted in to hospital. We spoke with two nurses who admitted that they had not received training the management of diabetes and they were concerned that the home had agreed to accept this person as they could not confidently meet this persons needs without adequate training.

The impact for people using the service is that they were put at significant risk as a consequence of staff and management not meeting their needs appropriately.

Leadership and Management	Our Ref: NONCO-00005988-MKNG
Non-compliance identified at this inspection	
Timescale for completion	**31/05/18**
Description of non-compliance/Action to be taken	**Regulation number**
Regulation 18(1)(a) -The registered person shall, having regard to the size of the care home, the statement of purpose and the number and needs of service users ensure that at all times suitably qualified, competent, skilled and experienced persons are working in the home in such numbers as are appropriate for the health and welfare of service users.	

Evidence

Regulation 18(1)(a) – The registered person shall, having regard to the size of the care home, the statement of purpose and the number and needs of service users ensure that at all times suitably qualified, competent, skilled and experienced persons are working in the home in such numbers as are appropriate for the health and welfare of service users.

The registered person is non compliant with this regulation

The evidence is as follows:

- The home provides personal and general nursing care for up to 33 people. The home currently accommodates 23 people of whom, ten people have complex nursing needs and receive continuing health care and thirteen people are in receipt of funded nursing care.

- The interim manager and staff expressed concerns that there was not enough staff on duty to meet the needs of people living in the home. We were told that 23 people require some level of assistance and supervision with their meals of which several are at high risk of aspiration. Staff expressed concerns that breakfast starts at 0630hrs. On some days breakfast does not normally finish until 11am and lunch is the then served at 12.15pm. Which often means that people miss lunch because they have just had breakfast.

- The manager confirmed that people have a bed bath everyday and do not have regular baths/showers as there are so many dependant people in the home. We saw that two bathrooms were used to store furniture and nursing equipment and were clearly not in use. In addition, we checked the wet room, during all three visits of this inspection, and it had not been used. People are not being offered a bath or a shower because of insufficient staff.

- We saw the minutes of a staff meeting held on 2 May 2018 It is recorded that one staff member raised a concern that it is the mobile residents which can cause problems because there is no-one to supervise them and keep them safe. Other concerns raised in the meeting included that there is a “problem” with one mobile resident as he pulled a plug out

and deflated another resident's pressure relieving mattress and this was not discovered for some time. Staff also stated that mobile residents take more time as staff have to keep a closer watch on them. We saw the minutes of a relatives' meeting held on 25 April 2018 during which a relative expressed a concern that every time she visits her mother its very quiet in the home and it's because there is no staff on duty.

- The home does not have a full compliment of nursing staff permanently employed and relies heavily on agency nursing staff to cover night shifts. Records indicate that the agency staff are not consistent, highlighting that different staff are being used each night. The manager raised concerns during the inspection that there was no continuity in the care given to people in the home.

- We found at a previous inspection in April 2017 and at this inspection, that systems are not in place to measure the quality of the service provided to make sure it is constantly improving and meets people's needs and expectations. There is no dependency tool to determine the number of staff required to meet assessed needs. The manager has not accepted any recent admissions into the home as she had concerns regarding the staffing levels.

- During an inspection on 9 February 2018 we saw that some improvements had been made in relation to staffing levels. The manager at the time, informed us that she increased staffing levels accordingly during busy times to ensure people receive the right care. During this inspection we saw that this had not been sustained and staffing is not increased in line with peoples' changing needs.

- The failures in care identified in this notice had not been identified by the home's own nurses or by the agency nurses employed by the home. It is of concern that their lack of competence and skill to ensure people are safeguarded from harm to their health and welfare is not in place.

- The numbers of nurses on duty does not allow for the oversight and supervision of care delivery leading to people being placed at risk as evidenced by the incidents identified in this notice.

The impact for people using the service is that they will not always receive appropriate care to meet their individual needs placing them at risk of harm.

Leadership and Management	Our Ref: NONCO-00005995-FXVY
Non-compliance identified at this inspection	
Timescale for completion	**13/08/18**
Description of non-compliance/Action to be taken	**Regulation number**
The service is not compliant with Regulation 18 (1) (c) (i) of the Care Homes (Wales) Regulations 2002.	

Evidence

Regulation 18(1)(c) (i)-The registered person shall, having regard to the size of the care home, the statement of purpose and the number and needs of service users ensure that at all times suitably qualified, competent, skilled and experienced persons are working in the home in such numbers as are appropriate for the health and welfare of service users.

The evidence includes:

- We viewed a training matrix dated 2018 which included both mandatory and specialist training which had been undertaken by some staff between 2015 and 2018. The service employs a total of 30 employees of which 8 are qualified nurses. The interim manager is included in these numbers.

- There was no evidence that care staff had received had received training in tissue viability, dysphagia, diabetes management, catheter care, falls prevention, risk assessments and epilepsy.

- We saw that three out of the eight qualified nurses were up to date with their clinical training. Five qualified nurses had not received training in medication management, diabetes, catheter care, tissue viability, dysphagia, health and safety, infection control, falls prevention and manual handling. Two nurses expressed concerns that they required training and were concerned that the home had recently admitted one person who was an unstable diabetic and another person who had an indwelling catheter.

- There was no evidence that staff have undertaken training in respect of communication and how to engage with people who have communication Difficulties.

- The training record showed that no staff have received training in Control of Substances Hazardous to Health (COSHH).

- Two staff have undertaken training in respect of Deprivation of Liberty Safeguarding (DoLS) in 2017. No staff have undertaken training in respect of the Mental Capacity Act.

The evidence indicates that the registered person does not offer staff the opportunity to gain skills and experience through training or provide them with the knowledge and skills for the work

they are to perform.

The impact of this is that people cannot be assured that they are being cared for by staff who are competent and have the skills necessary to meet all their care needs. This places people who use the service at risk of harm as people do not always receive the appropriate care.