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

29 August 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 had left the home and there was no manager at the service at the time of this visit. There is no deputy manager at the service.

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

We carried out an early inspection in response to a concern from a visiting professional and another concern that the appointed interim manager had left the service and there was no deputy manager in post. The staffing levels and the overall leadership and management of the service was inadequate. Since our previous inspection in May 2018 there has been little progress in meeting outstanding non compliance and protecting residents from harm.

We (CIW) found that residents continue to be 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. Improvements are needed to ensure that adequate arrangements have been made to protect people from the risk of harm. Staffing levels need to be reviewed to ensure there is sufficient staff, including ancillary staff, available at all times and comply with the conditions set out in the registration. There have been some improvements made to facilities provided and to improve the outdoor space.

2. Improvements

- Although in the early stages some improvements had been made relating to care planning.
- Improvements have been made in tidying the outdoor area and rubbish had been removed from the car park.

3. Requirements and recommendations

Section five of this report sets out our recommendations to improve the service and areas where the registered person is not meeting legal requirements. The following was identified at the last inspection and no improvements were seen at this inspection.

These include:

- Effective leadership and management.
- Responsible individual's oversight of the service.
- Management of the service. This was identified as an issue at the previous inspections.
- Staff supervision and training: This was identified as an issue at the previous inspection.
- Risks to the health or safety of service users. This was identified as an issue at the previous inspection.
- On call procedures.
- The environment.
- Care plan reviews.
- Lack of notifications to CIW.
- Safe storage of nursing equipment and other items within the home.

1. Well-being

Summary
Due to insufficient staff on duty people do not always experience well-being because their needs are not catered for in a timely way. People do not always receive the right care and support to meet their assessed needs. People have positive relationships with care staff and others in the home.

Our findings

People with complex needs do not experience adequate monitoring from staff. We identified that this was an area for improvement during our February and May 2018 inspections and staffing levels required improvement to ensure all peoples needs were met in a timely way . During this inspection we could not see that improvements had been made and staffing levels had not increased. We saw one person's daily fluid intake over a seven day period fluctuated from 150mls to 800mls. Another person who had a chest infection received 190mls over a twenty four period. None of the people had received the daily amounts of fluid required as per their 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 to ensure that people's poor fluid intake was addressed. We saw that fluid amounts had been entered at set times on charts but the drinks were not always consumed as they were out of peoples' reach or they were unable to assist themselves. We saw that seven people were in bed at 10.35am waiting for assistance form staff to attend to their care needs. One person said "*staff are very busy, they will come to me when they have time*". Of the twenty people living in the home, we found that in several of people's rooms, people did not have a call bell within reach. 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 15 hours despite requiring to be turned to alternate positions to minimise the risk of developing pressure sores. We saw care staff had recorded this person's pressure areas were red. We saw another person had not been repositioned for 9 hours and staff had documented this person had red pressure areas. We saw that four people had been repositioned at the same time by the same care staff. 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. A non-compliance notice was issued at a previous inspection for similar failings and action ad not been taken to address this. People's ability to exercise choice and control is sometimes restricted by lack of planning and inadequate deployment of staff at key times. People do not always experience enhanced wellbeing from the support received.

People feel included in the home and have warm relationships with the staff. Many of the staff have been employed in the home for a long period of time and have established good relationships with the residents. Despite there not being sufficient staff on duty to care for people in a timely way, staff treated people with patience and respect which enabled their dignity. We observed staff talking with people in a warm, friendly manner. A person using the service told us, *"I'm comfortable and content, I'm treated with dignity and respect."* Another person told us, *"They look after me well, they don't stop all day."* We spoke to a person's relative who said, "*I can't fault it, staff go above and beyond"* and "*I have faith that*

the staff will look after her when I'm not here." Relatives told us that they felt welcome at the home and could visit at any time. People are treated with dignity and respect.

2. Care and Support

Summary
Risk assessments are not adequately robust to ensure that people are kept as safe as they can be. Record keeping requires improvement to ensure care plans reflect peoples care needs and updated and reflective of people's current needs so they receive appropriate care.

Our findings
Measures are not in place to ensure staff are provided with adequate information to enable them to meet people's needs. At the previous inspections, we identified deficiencies in care documents such as a lack of up to date and accurate information and a non compliance notice was issued to the provider. The time scale for achieving compliance had not expired at this inspection but some improvements had been made and will be looked at during future inspections. The previous interim manager had started to re-write care documentation before leaving the home. It was the responsibility of the nurses employed in the home to continue updating the care records. We reviewed a number of peoples' 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 changed or to take into account advice from other healthcare professionals. In some cases, we found that there was no care plan in place, where there should have been, to meet assessed needs. 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. Old care plans and documentation remained in the care file along with new care plans which gave confusing information. People do not always receive the right care and support because staff are not always provided with an up to date care plan.

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 identified that this was an area for improvement during our May 2018 inspection. At this inspection we did not see any improvements. We also saw that a person was at a high risk of aspirating and was prescribed Textured C diet and thickened fluids and required supervision with all diet and fluids. We saw an incident form which documented a near miss of aspirating with this person. This person had been left with a half filled beaker and had fallen asleep with the tip of the beaker in their mouth. This incident should have been reported through safeguarding procedures but was not. We brought this to the attention of the Director (and former responsible individual) but no action was taken by him. We reported, at the last inspection, that one person was at high risk of falling and had attempted to leave the home on several occasions. This person also required regular monitoring of their blood pressure. Regular checks every 15 minutes were documented in their care records as being required to ensure their safety. We saw documented in their notes that this person received 15 minute checks for two days only and they were receiving weekly blood pressure checks. We later received a notification advising that this person had suffered an unwitnessed fall and had fractured their hip three weeks after staff had stopped carrying out 15 minute checks. We could not evidence why the recording of the observations had stopped. There was no updated risk assessment in place to demonstrate the checks were no longer needed and why. People are not supported to be as safe and healthy as they can be.

3. Environment

Summary

Improvements are required in relation to the safe storage of equipment. Investment is required in some areas of the home. Parts of the home require refurbishment.

Our findings

People are mainly confident that they are cared for in an improving environment. We identified that this was an area for improvement during our February and May 2018 inspections. At this inspection we saw that the outside area had been tidied and the grass had been cut, flowers had been placed in tubs in the enclosed garden and the general appearance of the gardens had improved. We did not see people enjoying the outside areas during the inspection. All furniture placed in the car park had been removed and a rubbish skip had been hired. However, storage of furniture and nursing equipment and general investment required in the home remains an area for improvement. We reported at the last inspection that a bathroom and a bedroom was used to store furniture and equipment. The carpet in the main corridor required attention as it was stained, heavily worn and looked unsightly. 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. At this inspection we saw that no improvements had been made in improving these areas.

We concluded there are some improvements to hazards in the home generally but attention needs to be given to other environmental issues to promote people’s wellbeing at all times.

4. Leadership and Management

Summary

The service is not being carried on or managed with sufficient care, competence and skill. Staff training is inconsistent and is impacting upon the care and support people receive. Staffing levels are not always sufficient to effectively meet people's needs. The service is breach of three of the conditions imposed on their registration. The responsible individual had failed to inform CIW they had instructed an insolvency company to assist them in placing Penisarwaun Care Home Ltd in to voluntary liquidation.

Our findings

People cannot always be sure that the business is well run, with due care and attention to minimum standards and regulations. The responsible individual's lack of working knowledge of the regulations is impacting upon their ability to oversee the safe and effective running of the service. On the 10th July 2018, after this inspection but prior to publication of this report, CIW received an email from an Insolvency Practitioner advising they have been engaged to assist placing Penisarwaun Care Home Ltd into liquidation. During a provider meeting on 23rd May 2018 the provider advised CIW that regarding financial viability there was no problem for the service to continue for another 2 years and no concerns were raised during the meeting. There have been significant changes to the management team since our last inspection visit in May 2018. We had previously reported that the home has been without a manager since 2010 and a number of managers had been appointed since and left for various reasons. We were informed prior to this inspection, by commissioners that the appointed manager had left the home and the deputy manager had been demoted. We also received a concern that there was no manager or deputy and that the home was being run by staff. Prior to this inspection, we (CIW) had issued an Urgent Notice of Decision to impose a condition on the registered persons' registration that the registered person must ensure at all times that a manager is in day to day charge of Penisarwaun Care Home. The responsible individual confirmed that this was the case on 4 July 2018 and he had failed to inform CIW of the absence of a manager. He advised us he was actively trying to recruit a suitable manager but had been unsuccessful and was currently still advertising through various methods. During this inspection we spoke with a director who was the previous responsible individual in the home. He acknowledged that he had failed to inform us of the lack of management in the home. We reminded him of the seriousness of the situation and of the breach of conditions of registration. We also reminded him that it was the responsibility of the current responsible individual to inform CIW of the changes in the management situation.

During the afternoon a staff nurse had informed us that the director had "*just told her*" that she would take on the managerial responsibilities for the next two weeks and asked admin staff to write a letter to her immediately to make it official. We were later informed by the responsible individual that he was not aware of this arrangement and had not been consulted by the director in making this decision. We have informed the registered persons of their breach of regulations in respect of this matter in our last seven inspection reports and in meeting with the registered provider held under our Service of Concern process. However, they have failed to take action to address this breach of Regulation 8 (1) (a). The

repetitive nature of this issue and the inability to learn from previous advice shared and the ongoing non compliance in other areas, demonstrates evidence of a breach of Regulation 10(1) which sets out that the home must be carried on or managed with sufficient care, competence and skill. This means people cannot be confident there are effective and robust arrangements in place to safely oversee the smooth running of the service in compliance with the legislation.

Staffing levels do not always reflect the needs and numbers of the people using the service. Prior to this inspection, we (CIW) had issued an Urgent Notice of Decision to impose a condition on the registration. The registered person must ensure, at all times, that nurses appointed to work at the home must be sufficient in number to provide the required level of individual direct nursing care to service users according to their individual assessed needs. To also undertake the supervision and support of other staff in providing direct care to individual service users until such time as we were confident that the quality of care provision had improved. In addition a separate condition was issued in that the registered person must ensure consistency in the use of agency staff to provide continuity of care to service users.

During this inspection we saw that the home employs five permanent nurses and one bank nurse. Two nurses work 8am until 2pm then one nurse is employed 2pm until 8pm. One of these nurses, who used to be the appointed manager, had handed in their notice and would be leaving at the beginning of August. This is the person who was told to take on the managerial responsibilities during this inspection. The additional responsibility had added increased pressure on top of her day to day clinical duties and leaving one less nurse to work on the floor. Staff and relatives told us that this has caused a great deal of worry and uncertainty in the home. We saw one nurse, who should have finished at 2pm, was still working after 4pm to catch up on paperwork. Since the last inspection we saw care staff levels had decreased. Staff rotas we examined at this inspection, showed that levels of care staff had decreased from six to five staff in the morning and from five to four in the afternoon. This left insufficient staff to ensure peoples' needs were being met. For example, we saw that improvements required in the previous inspections relating to the oversight of peoples fluid and food input had not been addressed. We also identified that one person who required increased supervision due to high risk of falling was not being supervised. We also identified that another person required supervision with their meals and drinks due to high risk of choking was not always supervised. We saw a near miss incident form had been completed by a nurse who raised concerns that this person had been left with a drink. Staff rotas we examined at this inspection did not evidence consistency in agency staff on duty. We saw fourteen different agency staff were being used over a three week period to cover day and night shifts. This included care staff and nurses. The service uses three different agencies to cover shifts. We saw on the 1st July four agency care staff from different agencies were used and worked with one permanent care staff employed by the home. In addition an agency nurse worked 8am until 2pm also that day. People do not benefit from a service where best use is made of staffing resource and continuity in care is given priority.

Leadership and management of the service are not effective. We found a significant number of areas where the registered provider was not complying with the legal requirements. Staff views of the new responsible individual were negative; four staff members said they had not seen him. Two relatives who visit regularly were unaware there was a new responsible individual. Staff members felt that there was no leadership in the

home but felt they could approach the nurses with any concerns. We saw evidence that staff had not been kept aware of changes to the management team and we were told that an urgent staff meeting had been requested verbally over a six week period to address concerns in the home. This request has been ignored on all occasions by the Director. We were told that five staff members had left the home for various reasons. We found morale within the home was low and the lack of communication and presence from the new responsible individual had only added to their concerns. The responsible individual told us he visits monthly as he was told that is what is required of him. Discussions were held with him prior to the inspection regarding visiting the home more frequently in the absence of a manager to ensure the overall day to day management of the home is carried out in a safe effective manner. We were told that he would visit fortnightly. At the last inspection we saw that there was no on call system in place and advised immediate improvement was required. During this inspection no improvements had been made due to the lack of manager. A nurse informed us that staff could ring her anytime if needed, but this was not official. The home uses agency staff and this arrangement requires clarification, should advice or any concerns that need addressing arise, to ensure the safety of the people in the home. The previous interim manager had undertaken some monthly quality assurance audits to drive forward quality standards and practice in the home and also some staff supervisions had taken place. These have not continued due to the lack of manager and no information was available as to who would continue to conduct these audits. Concerns were also raised as who would be completing the staff rota. We were told the administrator would complete the next two weeks rota but after that period it was unclear who would take charge of ensuring adequate and skilled staff were on duty. People do not benefit from a service which is well managed and meets their needs.

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) The service remains non compliant
• We found evidence that the registered persons were not 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 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
• The registered person must ensure that comprehensive care plans are completed reflecting all the individual's care needs and detailing clearly what action needs to be taken in order to meet these needs. Associated risk assessments must also be completed.	15(1) The service remains non compliant
• 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.	13(4)(c) The service remains non compliant
• 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	18(1)(a) The service remains non compliant

	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 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.**	**18 (1) (c) (i)** **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.

6. How we undertook this inspection

This was an early unannounced inspection conducted in response to concerns we received regarding the responsible individual's running of the service and the absence of a manager and deputy manager in the home. We visited the premises on the 06 July 2018 between 08:15 am and 4:10 pm.

The following inspection methods were used:

- We undertook a tour of the building viewing all communal areas, bathrooms, laundry room and most bedrooms.
- We spoke with the director, two nurses, three residents, three staff and two visiting relatives.
- We saw the staff rota, training records and supervision documents.
- We saw four people's care plans and associated documents.
- We used the Short Observational Framework for Inspection (SOFI 2) tool. The SOFI tool enables inspectors to observe and record care to help us understand the experience of people who cannot communicate with us.
- We spoke with the responsible individual after the inspection.
- Information received prior and after the inspection.

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	**09,11 and 14/05/2018**
Dates of this Inspection visit(s)	**06/07/2018**
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:	