Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Meddyg Care Nursing Home (Porthmadog)

Garth Road,
Porthmadog
LL49 9BN

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

06/02/2020

Description of the service

Meddyg Care Nursing Home (Porthmadog) is situated on an elevated position in Porthmadog overlooking the Cob and the mountains beyond. The home is close to local amenities and transport links. The service is provided by Meddyg Care (Porthmadog) Ltd. The Responsible Individual (RI), registered with Care Inspectorate Wales (CIW), is Kevin Edwards. At the time of the inspection, the manager was not in work and the responsible individual had brought in the manager from a sister home to oversee the running of the service. The home is registered to provide personal and/or nursing care for 44 adults.

Summary of our findings

1. Overall assessment

We found the staff at Meddyg Care Porthmadog to be friendly and observed that they treated people with dignity and respect. However, we found the quality of the care provided at the home to be inconsistent due to insufficient staffing numbers present on several shifts and especially at night time. We found this had a negative impact on the well-being of people living in the home. We saw a lack of managerial oversight for the service, which impacted on the smooth running of the home and led to staff feeling unsupported. The provider has invested in the refurbishment of the home making it a pleasant environment to live in and care planning documentation is more comprehensive and informative to staff.

2. Improvements

We found there was an improvement to people's personal plans, they included more detail and instruction for staff regarding people's care. We saw the plans reflected individual people's needs and included their preferred routines, likes and dislikes.

3. Requirements and recommendations

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

Areas where the care home is not meeting legal requirements:

- Regulation 34- staff numbers.
- Regulation 60- notifiable events.
- Regulation 66- lack of over-sight.

Recommendations made to improve the service:

- Active offer of the Welsh language.
- Activities.
- Varied diet.

1. Well-being

People have some choice and influence over some aspects of their daily lives but preferences regarding care are not always met due to lack of staff capacity to accommodate them. There was an insufficient number of staff to meet all peoples needs all of the time, particularly at night. People and family members told us staff were kind to them and were helpful but that staffing numbers were too few at times. Many staff were new to the service or were agency staff and people lacked confidence their needs could be met well by unfamiliar staff. Care giving was task orientated and staff could not always accommodate any requests that deviated from routine. We found not everyone had their preferences met for example in relation to frequency of bathing. Health monitoring was not always effective.

People could personalise their rooms with objects of importance to them and make the room homely and so could influence their environment in that way. Family and friends could visit as they wished and were given privacy in the person's room. Some staff are Welsh speakers and can meet people's first language and ethnicity choices; depending on availability of Welsh speaking staff, they can sometimes provide activities in Welsh. People had limited choices regarding meals and snacks, they commented they were frequently offered the same choices and the menu does not offer sufficient variety. People's personal plans were detailed and personalised, describing people's needs and preferences.

The quality of care provided is inconsistent. A planned programme of activities was in place in the home but further one to one work and some dementia friendly activities would be of benefit for some people. The care planning documentation provided staff with good information about meeting people's needs but daily recording and monitoring of how people's basic needs were to be met was poor in some instances.

Processes in place to protect people are not fully utilised and implemented. We found that CIW had not been notified of reportable incidents impacting upon people's health and safety. Some incidents had not been reported to the relevant local authority safeguarding and monitoring teams presenting a risk they would not be investigated independently and promptly. Staff supervision was not as frequent as it should be; staff reported feeling anxious and insecure following the last manager's departure and were unsure of plans for the service. Some residents told us they were concerned regarding the lack of staff, management, and continuation of care. We spoke with agency staff who were new to the service and unsure as to local policies and procedures. People cannot be assured of consistent care from a stable staff team who are aware of local safeguarding policies and procedures.

2. Care and Support

People cannot always influence their day to day care. We observed staff treating people with dignity and respect. Staff who could speak Welsh were happy to support people in their language of choice although Welsh speaking staff are not always available. A resident told us there were many instances when there were no Welsh-speaking staff available. They were sometimes unable to converse with or discuss the local community and events, which they missed. We observed care giving was rushed at times. People commented that staff were too busy to chat and they frequently had to wait a long time for assistance. Activity staff held group activities in the dining /lounge area, we saw a notice board with activities such as a harpist coming to play and events such as people's birthdays were on it. We recommended to the provider that more inclusive and dementia friendly activities would be of benefit to some people. People told us menu choices were very limited and they frequently had the same options on offer. People said they would appreciate more choice of meals and more variety of fruit and vegetables. We fed this information back to the provider for consideration. Care staff were not always able to meet people's personal preferences, such as the frequency of baths or showers. People do not always have their choices catered for.

People who are able to do more for themselves reported good satisfaction with the care provided. People that are more dependent told us care is not always timely. People and families told us of incidents which had occurred due to a lack of staff to assist them with basic needs such as going to the toilet and how this had impacted on their well-being. Residents told us their night time routines took longer due to staff being constantly called away to help others. We found people who required monitoring, due to their dementia diagnosis and other care needs, were not assisted consistently and some of their needs had not been met in a robust and timely manner. We saw monitoring of people's health indicators such as food and fluids taken and the health of people's bowels was poor in some instances. Some people, who required assistance with eating and drinking, had very poor intake recorded on several days. We found medications administration and ordering was not always timely which resulted in medication dosages sometimes being missed. People told us staff were friendly and helpful but felt they were over-stretched. People reported they noticed a rapid turnover of staff and management, and were not always familiar with the staff caring for them. People cannot be confident they will have all their care needs met by sufficient numbers of staff who know them well.

The protection of people is not promoted as fully as it could be. CIW and the local safeguarding authorities were not always appropriately notified of reportable incidents, which prevented independent investigation and the promotion of people's health, safety and well-being. This is a serious matter, which breaches legal requirements, and the provider has been notified. We saw the provider had acted to protect people who lacked capacity to make decisions on their own by ensuring Deprivation of Liberty Safeguards (DoLS). People

who were unable to make their own care decisions could also access an independent advocate via social services.

3. Environment

This was a focused inspection to look at non-compliances identified in the previous inspection. These did not involve the environment, which will be inspected in future inspections. However, we did observe a number of improvements had been made to the environment and that improvement work was continuing for the benefit of staff and people living in the home. The provider has invested in the conservatory, the home was clean and tidy and the staff office was being refurbished.

4. Leadership and Management

Oversight and governance of the service needs to be improved. Processes to monitor, review and improve the quality of the service are required to be more robust. Key staff members have departed from the service. People living in the home and staff were unsure of the managerial structure of the home and reported feeling anxious regarding the situation; they wanted improved communication regarding this. The provider will also need to ensure the new structure is detailed in the Statement of Purpose document so that people can understand the governance available. Our findings relating to care and support indicated oversight of the service is not effective and does not ensure a consistent quality of care is provided. This is a serious breach of regulations and the provider must address this. Although there is a list of senior staff posted in the home, staff were unsure who to contact in an emergency or to help with staffing issues. These issues need to be addressed quickly to ensure people receive a safe, appropriate service.

The provider recruits staff safely, with proper vetting arrangements in place. They have recently recruited staff who are in the process of being trained for their role. Insufficient numbers of staff recruited and deployed on each shift affects standards of care offered, so additional recruitment will be advantageous. The provider reported it was difficult to recruit staff in the local area, especially Welsh speakers. We saw retention of staff was challenging for the service. Staff told us they felt unsupported at times and felt exhausted due to the staffing situation. We saw the provider offered infrequent one to one supervision with staff to ensure staff felt supported in their role. Staff said management held infrequent staff meetings and management were not always empathetic regarding the staffing situation. Having insufficient staff numbers to provide the care required is a serious matter and does not meet with legal requirements. This situation needs to be rectified to ensure people's safe care.

Recruitment practices are safe. We looked at a selection of staff records including new staff to the service. We found the recruitment process was compliant with legislation with sufficient safety checks to ensure staff were appropriate to work with vulnerable adults. New staff were subject to a probationary period to ensure they were suitable for care work. Staff have been safely recruited for their role.

5. Improvements required and recommended following this inspection

5.1 Areas of non-compliance from previous inspections

• **The service provider is not compliant with 'The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017, 15 (1), (2) and (7).** This is because the service provider has failed to prepare an accurate personal plan for all individuals as to how their needs are to be met. Personal plans and associated documents are not always available, reflective of people's needs and risks, and they contain conflicting information.	The non-compliance has been met. We found during this inspection, personal plans had improved. Plans contained more detail regarding people's care and contained more instruction for staff regarding people's needs. Personal plans were written according to people's individual preferences, likes, and dislikes.

5.2 Areas of non compliance identified at this inspection

During this inspection we identified areas where Meddyg Care (Porthmadog) Ltd is not meeting legal requirements and this is resulting in potential risks and poor outcomes for people using the service. Therefore, we have issued non-compliance notices in relation to the following:

- Regulation 34 – Staffing. The service provider has not ensured that at all times a sufficient number of suitably qualified, trained, skilled, competent and experienced staff are deployed to work at the service.
- Regulation 60 – Notifications. The service provider has not notified CIW of notifiable events relating to people's well-being, health and safety.
- Regulation 66- Over-sight. The service provider has not provided sufficient over-sight of the service and the standards of care provided for people.

5.3 Recommendations for improvement

We recommend the following to improve the service:

- The provider should consider an improved active offer of the Welsh language to further meet people's first language choices and culture.
- The provider should provide consistent, meaningful activities for people with dementia.
- The provider should consider a more varied menu choice for people to meet their health and nutrition needs.

6. How we undertook this inspection

This was a focused, unannounced, inspection undertaken to assess the service's progress regarding a non-compliance notice issued at a previous inspection. The service was inspected under The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017. The home was inspected by two inspectors due to the complex needs of people using the service. We visited the service on 30 January 2020 between the hours of 10:10am and 6:15pm, and 6 February 2020 between the hours of 10:45am and 6:15pm.

We used the following methods during the inspection:

- We spoke with the RI, provisional manager, deputy manager, several staff members, two people's relatives and several residents.
- We used the Short Observational Framework for Inspection (SOFI version 2). The SOFI tool enables inspectors to observe and record care to help us understand the experience of people who cannot communicate with us.
- We visited several people's rooms, the communal facilities, kitchen, and the medications room.
- We looked at a broad selection of records kept by the registered service and concentrated upon: people's personal plans and health monitoring documents, the Statement of Purpose to measure if the service given to people matched that which was outlined in the document, staff training and supervision records, several people's personal plans and associated documents, skin bundles and wound management files, health and safety records, RI report and unannounced visits notes, family and staff meeting minutes, several staff records, medication records.
- We provided staff and families with questionnaires to ask their opinion regarding the service. We had not received any returned questionnaires by the time of writing this report.

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

About the service

Type of care provided	**Care Home Service**
Service Provider	**Meddyg Care (Porthmadog) Ltd**
Responsible Individual	**Kevin Edwards.**
Registered maximum number of places	**44**
Date of previous Care Inspectorate Wales inspection	**14 October 2019.**
Dates of this Inspection visit(s)	**30 January 2020 & 06 February 2020**
Operating Language of the service	**Both**
Does this service provide the Welsh Language active offer?	**The service does not fully offer an active offer of the Welsh language. We recommend the provider consider Welsh Government's "More Than Just Words a Follow on Strategic Guidance for Welsh Language in Social Care."**
Additional Information:	

Date Published 06/08/2020

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Care Home Service

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.

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Meddyg Care Nursing Home (Porthmadog)

Garth Road,
Porthmadog
LL49 9BN

Date of publication: 08/04/2020

Leadership and Management	Our Ref: NONCO-00009291-VYCM
Non-compliance identified at this inspection	
Timescale for completion	**01/06/20**
Description of non-compliance/Action to be taken	**Regulation number**
Regulation 34- This concerns the lack of staff numbers in the home. The insufficient numbers of staff has impacted on people's well-being and safety. This also concerns the lack of consistent leadership and management in the home to provide sufficient over-sight of the service.	Regulation 34 (1)

Evidence

- The registered person is not compliant with regulation 34(1) of The Regulated Services (Service providers and Responsible Individuals) (Wales) Regulations 2017.
- This is because we saw evidence the service was under-staffed which impacted upon people's well-being and safe care. We found the service lacked consistent management and leadership to ensure sufficient over-sight of the care given to people and to ensure the smooth running of the home.
- The evidence:

• There were only two nurses specifically contracted to Meddyg Care Porthmadog and one long term agency nurse. Two pre-registration nurses had been recruited but needed to complete the examination to gain their PIN (they were qualified and experienced in their countries of origin but needed to complete examinations in order to obtain their PIN in the UK).

• Only one of three current nurses had completed their catheterisation competencies and there were at least three residents with long-term indwelling catheters.

• Several staff supervision sheets were seen in which apologies were made for being short of staff with 7 staff on each day shift rather than the 8 claimed by the provider and manager and as detailed on rotas given to CIW, (we saw six supervision sheets stating this). CIW had received anonymous screen shots from staff's personal phones, staff were desperately looking for staff to work shifts throughout February. There were crying emoji's on some of the screen shots and staff stating there were only two or three of them on shift, staff commented on feeling exhausted and stressed.

• Three staff supervision documents recorded staff were concerned about the shortage of staff and the impact on quality of care. Anonymous concerns sent to CIW from staff state that people were at risk as there were insufficient staff on duty to give appropriate care.

• Staff told CIW they felt anxious and unsupported as the manager had left and they were not aware of future leadership plans. Emergency out of hours contacts and future leadership structure plans were not clear to staff.

• CIW found the lack of staff impacted on the continuity of care, for instance, a person waited 4 days for a morphine prescription, and a lower dose than the prescribed amount was also given as the morphine was running out. Personal plan entries commented on the

person's pain during this time period.

- Low hydration provision was noted for some residents requiring aid with food and fluids. A person's personal plan stated they "required 1000mls to 1500mls to maintain skin hydration". Yet the recorded amount for 2/2/20 was 300mls; 3/2/20 was 550mls; 4/2/20 was 500mls and 5/2/20 was 150mls. Another person had received a drink at 11pm, there were no other drinks then noted until 1pm the following day, and the person required assistance and was diabetic.
- A resident told us, "I don't feel management are being honest with us regarding staffing". Another resident said, "There are a lot of temporary staff here." One said, "I've seen a difference in the last six months, lots of people need more assistance, there's not enough staff. Care is different now, I used to have two carers helping me at bedtime but the nurse is always asking them for help now making the whole process longer." A person said, "I have to wait a long time for assistance. I had to wait an hour for the toilet and wet myself. They are short staffed, staff do not have time to chat. They are rushed in the evening getting everyone to bed." A resident told us, "I asked for a shower prior to a hospital appointment, I was told by the night staff they did not have the time and I would have to ask the day staff." Another resident told us a resident had been incontinent in the corridor, they were told by night staff they would have to wait until the cleaner arrived in the morning for the corridor to be cleaned. All the residents quoted were assessed as having mental capacity in their personal plans and were not subject to DoLS processes.
- The service was heavily reliant on agency staff –the work rota was not able to be done a month in hand with names of nurses-it simply stated the name of the nursing agency to be used.
- Staff stated that some agency staff had more commitment to the role than others i.e. some would only do the basic requirements asked of them whilst others would take responsibility for things such as checking prescriptions and ordering stock.
- The agency nurse in charge of the shift was unable to locate the medicine policies during inspection. We saw an agency nurse give a person tablets without checking against the MAR sheet to ensure they were the correct person.
- We saw diary entries to ask the district nurse to do basic nursing tasks such as taking blood samples from people and checking a person's weeping legs.
- We saw there was poor oversight of bowel management- the care files demonstrated one person had not had their bowels opened for 14 days and another for 20 days. This signified a lack of consistent monitoring and poor communication from shift to shift regarding the health of people's bowels. We also saw a supervision document where it had been stated a bowel audit had demonstrated bowel monitoring was not of a sufficient standard.
- There was a lack of staff experienced with the service- many of the staff spoken with had only worked in the service a number of weeks or months. We were told that regular agency staff were used for continuity of care yet the agency staff spoken with had only worked two shifts in the home and was unable to locate key protocols and policies. The agency name rather than staff's names were used on the rota which did not support the consistent use of agency staff members.
- CIW found a lack of consistency and choice regarding baths and showers for people. The temperature checking charts in the shower room stated, "the water temperature should be checked and recorded prior to every shower or bath." We saw two entries for the 15/12/19, nothing was then recorded until 21/12/19 followed by entries on 7/1/2020 and 20/1/2020. We saw a note in capitals on the daily hand overs saying, "Don't forget baths and showers". We saw very few entries in people's personal plans regarding baths and showers even though some personal plans stated people preferred daily showers.
- A person's relative told us they had seen another resident repeatedly falling in the lounge

due to a lack of staff available to help them to the toilet.

- CIW had received concerns regarding the lack of staff on night shifts which given the evidence, have been be upheld.

- The impact on people using the service is they cannot be confident of receiving safe and appropriate care from sufficient staff numbers. People cannot be assured of sufficient managerial over-sight of the service to ensure the quality of the care received and to ensure the smooth running of the service.

Leadership and Management	Our Ref: NONCO-00009292-QDPJ
Non-compliance identified at this inspection	
Timescale for completion	**01/06/20**
Description of non-compliance/Action to be taken	**Regulation number**
Regulation 60- The service provider must notify the service regulator of the events specified in Parts 1 and 2 and Schedule 3.	Regulation 60

Evidence

- The registered person is not compliant with regulation 60 of The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017.
- This is because we found notifiable incidents had not been reported to CIW as per the regulation stipulations.
- The evidence:

. CIW found evidence of eight residents and six staff suffering with diarrhoea during December 2019 to January 2020. We saw an entry in the staff communication diary saying that as it was not Noro Virus, it was not to be reported to the authorities. It was not clear if the Public Health Department had been notified. CIW had not been notified.

- CIW had received no notifications regarding staff shortages.
- We found a resident had experienced an unwitnessed fall with possible head injury and a laceration to their fore-head, resulting in bruising and pain. We saw the person had severe bruising to their face and arm, they told us they were still in pain. We saw entries in their personal plans regarding associated pain following the fall for up to a month following the event. CIW were not notified of this fall which impacted upon the well-being of the person for over 28 days.
- We saw daily care entries on file regarding a person who expressed anxiety and distress by hitting out at staff members and other residents. These incidents had not been reported to CIW or the safeguarding authorities.
- We saw it was documented on another person's care file that they had been expressing anxiety by hitting and pinching staff, slapping their heads, and attempting to kick another resident whilst being aided to the toilet. This incident had not been reported to CIW or to teh safeguarding authorities.
- We saw entries on a person's personal plan that they often switched off other resident's oxygen and C-PAP machines thinking that they were saving electricity. These incidents had not been reported to CIW or to the safeguarding authorities.
- We found documented evidence of a person having five sores, one was a deep tissue injury which could not be graded. This had not been reported to CIW.

- The impact on people using the service is people cannot be assured of proper measures being taken to reduce risk of harm and promote well-being. If CIW and safeguarding authorities are not informed, an independent investigation cannot be carried out.

Leadership and Management	Our Ref: NONCO-00009412-RNXM
Non-compliance identified at this inspection	
Timescale for completion	**01/06/20**
Description of non-compliance/Action to be taken	**Regulation number**
Regulation 66- The responsible individual did not effectively supervise the running of the service.	Regulation 66

Evidence

- The registered person is not compliant with Regulation 66 of The Regulated Services (Service Providers and Responsible Individuals (Wales)) Regulations 2017.
- This is because the responsible individual failed to have proper oversight of the management of the service.
- The evidence:
- We saw little evidence of focus and audit of people's well-being and personal outcomes. The monitoring of people's health required further work. People's reasonable requests regarding daily care and routines were not met.
- People living in the home told us their opinions were not listened to.
- People told us their concerns regarding lack of staff in the home was not responded to in a positive manner.
- People were placed at unnecessary risk due to lack of staff numbers and a lack of staff who were familiar with their needs.
- The service and staffing levels outlined in the Statement of Purpose were not always fulfilled.
- There were not always sufficient numbers of staff who were trained, competent and skilled to undertake their role on duty.
- There was insufficient evidence to demonstrate systems were in place to review and assess actions taken by the manager in running the service and of quality assurance systems and reported actions taken within required time-scales.
- The lines of accountability for the service were not clear. Staff told us they were unaware of future plans for the management of the service and who to contact in emergencies.
- On-call arrangements between the manager, deputy manager and responsible individual were not clear.

- The impact on people using the service is there was no proper oversight of the management, quality, safety, and effectiveness of the service offered to them to ensure their safety and well-being.

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Date of publication: **(manually entered)**

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- We found a resident had experienced an unwitnessed fall with possible head injury and a laceration to their fore-head, resulting in bruising and pain. We saw the person had severe bruising to their face and arm, they told us they were still in pain. We saw entries in their personal plans regarding associated pain following the fall for up to a month following the event. CIW were not notified of this fall which impacted upon the well-being of the person for over 28 days.
- We saw daily care entries on file regarding a person who expressed anxiety and distress by hitting out at staff members and other residents. These incidents had not been reported to CIW.
- We saw it was documented on another person's care file that they had been expressing anxiety by hitting and pinching staff, slapping their heads, and attempting to kick another resident whilst being aided to the toilet. This incident had not been reported to CIW.
- We saw entries on a person's personal plan that they often switched off other resident's oxygen and C-PAP machines thinking that they were saving electricity. These incidents had not been reported to CIW.
- We found documented evidence of a person having five sores, one was a deep tissue injury which could not be graded. This had not been reported to CIW.

- The impact on people using the service is people cannot be assured of CIW being notified of incidents which affect their well-being.

Leadership and Management	Our Ref: NONCO-00009412-RNXM
Non-compliance identified at this inspection	
Timescale for completion	**01/06/20**
Description of non-compliance/Action to be taken	**Regulation number**
Regulation 66- The responsible individual did not effectively supervise the running of the service.	

Evidence

- The registered person is not compliant with regulation 66 of The Regulated Services (Service Providers and Responsible Individuals (Wales)) Regulations 2017.
- This is because the responsible individual failed to supervise the management of the service.
- The evidence:
- We saw little evidence of focus and audit of people's well-being and personal outcomes. The monitoring of people's health required further work. People's reasonable requests regarding daily care and routines were not met.
- People living in the home told us their opinions were not listened to.
- People told us their concerns regarding lack of staff in the home was not responded to in a positive manner.
- People were placed at unnecessary risk due to lack of staff numbers and a lack of staff who were familiar with their needs.
- The service and staffing levels outlined in the Statement of Purpose were not always fulfilled.
- There were not always sufficient numbers of staff who were trained, competent and skilled to undertake their role on duty.
- There was insufficient evidence to demonstrate systems were in place to review and assess actions taken by the manager in running the service and of quality assurance systems and reported actions taken within required time-scales.
- The lines of accountability for the service were not clear. Staff told us they were unaware of future plans for the management of the service and who to contact in emergencies.
- On-call arrangements between the manager, deputy manager and responsible individual were not clear.

- The impact on people using the service is there was no proper oversight of the management, quality, safety, and effectiveness of the service offered to them to ensure their safety and well-being.