Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

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

Priority Action Report

Pangea Healthcare Ltd

in respect of

Plas Newydd Care Home

Pwllheli Road
Criccieth
LL52 0RR

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

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

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

Further advice and information is available on our website
www.careinspectorate.wales

Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 11 April 2023
Our Ref: NONCO-00015363-XYGK

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

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

Regulatory Failings

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

Evidence

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

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

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

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

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

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

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

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

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

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

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

New boiler – the wall cover at the right side of the cooker has been removed to fit/repair the boiler but has not been put back, leaving torn insulation covers exposed over the cooker. The insulation covers appear to have a fibre filling which could result in fibres dropping into food prepared on the cooker top.
The tiled walls are stained with grease particles. The cooker was left uncleaned following the lunch period. The coving rail around the kitchen is dirty. We saw no evidence of cleaning schedule in place. This poses a food hygiene risk for people.

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

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

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

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

Outcomes for People
People cannot always be assured of certain areas in the home being clean and hygienic.

Timescale for completion	18 August 2023

Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 11 April 2023
Our Ref: NONCO-00015362-TFMB

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

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

Regulatory Failings

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

Evidence

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

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

At the last inspection in December 2022 we found a store room on the first floor was full of equipment which was piled on top of each other in a haphazard manner. This poses a risk of injury should equipment fall on a person or staff member, especially when accessing that equipment.
At the inspection on 11 April and 9 May 2023 we continued to find vinyl gloves stored within reach of people living in the home. This poses a choking risk should people without capacity, ingest them.

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

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

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

Impact on and / or risk to the health and well-being of people: We have assessed the potential risk and / or impact on people's health and well-being as a result of this non-compliance as Moderate .	
Outcomes for People	
People cannot be assured that obvious environmental risks are assessed and action taken to mitigate the risks.	
Timescale for completion	06 February 2023

Priority Action Notice
Identified at previous inspection (action not taken to address area of non-compliance)
dated: 11 April 2023
Our Ref: NONCO-00013659-SMKH-2

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

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

Regulatory Failings

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

Evidence

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

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

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

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

[redacted] The RI told us he provides business, development and management training for manager. The manager is scheduled to attend mandatory training in April 2023.
There is a lack of a robust managerial structure in the home and the manager / RI gave us conflicting information as to who is responsible for which aspects of the service.

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

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

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

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

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

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

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

Outcomes for People	
People cannot be assured the provider has proper oversight of the management, quality, safety and effectiveness of the service.	
Timescale for completion	06 February 2023