Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Springholme Care Anglesey Ltd

Springholme
Red Wharf Bay
Pentraeth
LL75 8EX

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

22/11/2023

About Springholme Care Anglesey Ltd

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	SPRINGHOLME CARE ANGLESEY LTD
Registered places	45
Language of the service	English
Previous Care Inspectorate Wales inspection	17 August 2023
Does this service promote Welsh language and culture?	This service is working towards providing an 'Active Offer' of the Welsh language and demonstrates a significant effort to promoting the use of the Welsh language and culture.

Summary

The service is not effectively overseen or managed by the responsible individual (RI). Quality assurance measures continue to require improvement as we continue to find the same failures found at the previous two inspections which demonstrates a lack of oversight of the service and awareness of the requirements of the regulations and safeguarding processes. A new manager is in post who is qualified but lacks the experience and knowledge to manage the home. There is an additional experienced manager supporting the management on a part time basis. Improvements are required in ensuring there is enough staff on duty to supervise people and ensure they are safe.

Safeguarding within the home requires improvement. There is a continued failure by the provider to ensure people are safeguarded from harm and not ensure people have care and risk assessments in place which are reviewed after an incident. Staff have not completed all the required training in Safeguarding, Mental Capacity Act and Deprivation of Liberty safeguards to provide them with the skills and knowledge to support people effectively and safely.

Improvements are underway to improve personal plans and care documentation to ensure they are person-centred, but this is in the very early stages. We continue to see information is inconsistent and information is not always reflective of people's current needs. Key members of staff are not provided supernumerary time complete these tasks. Actions from professionals are not always acted upon and we continue to see unwitnessed falls and incidents and the correct safeguarding processes not being followed.

Well-being

People do not always have control over their day-to-day lives to keep them safe from harm**.** We saw people are settled and comfortable with the care staff supporting them; people are treated with courtesy and kindness. We observed positive relationships and warmth between care staff and people living at the home. Care staff work hard but there is not always enough staff, particularly during the night and at weekends, to meet people's needs effectively. The home employs a full-time activities person who provides a range of exciting activities and also helps with care duties when there are staff shortages.

People's physical, mental health and emotional well-being needs are not always being met. Care records are incomplete and not reflective of people's care needs, but improvements are underway. Advice from professionals is not always completed in a timely manner. We did see instances when this did not happen and information from external professionals have not been effectively communicated to staff by the management which has placed people at risk of harm. Care staff provide physical and emotional support in a dignified, respectful way.

People are not always protected from abuse and harm. The safeguarding policy does contain the relevant information in line with the All-Wales Safeguarding procedures and staff lack the knowledge in what is reportable to safeguarding. Safeguarding referrals are not always made when people are put at potential risk of harm. Outcomes of safeguarding enquiries and concerns are not recorded or reflected on. Not all staff have had training to recognise signs of abuse.

People cannot be confident risks to their health and safety are promptly identified and prioritised. The service does not always have enough staff on duty to supervise people who require increased monitoring with behaviours that may challenge or people who are at high risk of falling and injuring themselves. Improvements are still required in ensuring falls risk assessments are in place and reviewed after a fall and action taken to mitigate any further falls and accidents to protect people from harm. Floor sensor mats or other equipment is not put in place in a timely manner.

Care and Support

At the last two inspections we informed the provider personal plans and care documentation require improvements to reflect people's current needs. At this inspection we saw very little improvements. Plans are in place to review peoples care files and this is in its very early stage. Personal plans seen are generic and not always reflective of people's current needs. Two of the three personal plans we checked did not always include information about people's support needs and how they should be met. We found information within care records is inconsistent and not always reflective of people's current needs or the care and support they are receiving. Positive behaviour support plans are still not in place for staff to support people regulate their emotions and behaviours. This is still having an impact on people's health and well-being and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

People are mainly seen by the medical team in a timely manner however we did see several instances where people were not. Advice from professionals regarding referring to the Speech and Language Therapist was not cascaded to staff therefore actions have not been taken placing them at risk of aspirating. Contact with the district nurse regarding pressure damage has not been made in a timely manner. One person's weight has not been managed effectively as recorded in their personal plan. This is still having an impact on people's health and well-being and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

Processes in place to safeguard the people they support, and care for continues to require improvement. We identified improvements are required in the last two inspections for people to be kept safe and we continue to see little improvements. Not all staff including the responsible individual have completed training in Safeguarding, Deprivation of Liberty Safeguards and Mental Capacity Act. Training had been arranged by the Local Authority however the first session was cancelled due to the previous manager not recording the training dates in the diary and further sessions were not fully attended by staff due to staffing shortages. The safeguarding policy is not reflective of Welsh legislation and local safeguarding procedures. Improvement is still required in falls risk assessments being implemented and reviewed after a fall and staff follow the correct safeguarding procedures in reporting events. This is placing people's health and well-being at risk, and we have therefore issued a Priority Action Notice. The provider must take immediate action to address this issue.

Environment

As this was a focused inspection, we have not considered this theme in full.

Systems and processes to ensure risks to people health and safety require strengthening. A new call bell system has now been installed which supports additional equipment such as floor sensor mats which will alert staff of people who are at high risk falling. We saw instances when sensor equipment was not put in place in a timely manner and people continue to have unwitnessed falls. Appropriate systems and oversight need to be put in place to ensure risks are appropriately identified and prompt actions is taken to mitigate falls risks and ensure people are staff. On our arrival we were greeted by external workmen who offered us the keycode to let us in and then offered to open the front door. We spoke with the manager who addressed this during the inspection. This is still having an impact on people’s health and well-being and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

Leadership and Management

The RI has been unable to evidence proper oversight of the management, quality, safety, and effectiveness of the service. The RI has failed to act on the serious issues identified by CIW and other professionals in relation to following safeguarding procedures and falls and measures are not put in place to review, evaluate, and apply any lessons learnt as part of the quality assurance processes. Record keeping and the lack of involvement of people and relatives in care planning are areas of concern which the RI has failed to address. New areas of concern have been identified at this inspection relating to DBS checks, staff training and staffing levels. The RI has failed to identify and rectify these issues. This is still having an impact on people's health and well-being and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

At the last two inspections we have issued a priority action notice because arrangements were not in place to monitor, review and improve the quality of the service. Although some improvements have been at this inspection, two quality-of-care review report has now been produced, but there is no evidence the views of people using the service, families, representatives, staff, and other professionals have been sought. The reports contain no evidence of analysis of safeguarding, complaints, and notifications so there are no lessons learned or actions to improve the quality of the service. This is still having an impact on people's health and well-being and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

Sufficient staffing levels are not always provided to ensure people are supervised to ensure their safety. Staff rotas show there is reduced staffing levels employed especially during the night and at weekends. There are no domestic staff employed at the weekend and the activities person helps with care duties. Some residents are at high risk of falling and others require close observations. Key staff members are not allocated supernumerary time to complete their work as they are covering the shortfall in staff numbers. We continue to find there is a high number of unwitnessed falls. The RI has not identified the need to ensure adequate staffing arrangements to protect the people in living in the home. This is placing people's health and well-being at risk, and we have therefore issued a Priority Action Notice. The provider must take immediate action to address this issue.

At the last inspection we identified improvements were required in the provider reporting events to the regulator. At this inspection we found no improvements have been made. We continue to find CIW have not always been informed about all reportable events or within the specified timescale which affect the well-being of people and the smooth running of the service. This is still having an impact on people's health and well-being and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
35	The responsible individual has failed to inform the relevant professional bodies when a person is no longer fit to work at the service. The responsible individual must inform the relevant professional body and regulator when a person is no longer fit to work at the service.	New
26	Staff and the Responsible Individual do not have sufficient knowledge and oversight of incidents in the service to safeguard people in a robust manner. Staff and Responsible individual must attend training in safeguarding to ensure staff are aware of All Wales Safeguarding procedures.	New
36	Not all staff, including the responsible individual, have completed training in Safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards. All staff must attend training in these subjects to ensure they	New

	have the knowledge and skills to care for people in a safe manner.	
34	The service provider has not ensured there are sufficient numbers of staff working in the service, having regard to the care and support needs of the individuals. The provider must ensure there is enough staff on duty at all times to supervise people to ensure they are safe from harm.	New
21	The service provider has not ensured the service is responsive and proactive in identifying, responding to and mitigating risks. Improvements in care documentation, risk assessments, its monitoring and oversight by management are required to ensure care and support is provided in a way which protects and maintains the safety and well-being of people.	Not Achieved
80	The quality-of-care review report does not evidence that the RI has obtained feedback from people about their experiences of living in the service, alongside feedback from relatives and professionals. The report does not comply with what is required with the regulation. The responsible individual must ensure there are suitable arrangements in place to establish and maintain systems for monitoring, reviewing and improving the quality of care and support provided by the service including feedback from people using the service and other stakeholders.	Not Achieved
66	Systems to ensure proper oversight of the management of falls, quality, safety and effectiveness are inadequate. The Responsible Individual must have sufficient processes in place to enable proper oversight of the service.	Not Achieved
60	The provider has failed to notify CIW of some events as required in regulations. Notifiable events must be reported to CIW within the required timeframe.	Not Achieved
57	The service provider is not proactive in their approach towards the safety of the people using the service. The provider must ensure that unnecessary risks to the health and safety of people are identified and eliminated.	Not Achieved

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
35	The provider has not ensured new DBS certificates have been issued within the three-year timeframe. The provider must ensure there are systems in place to identify when a staff member's DBS is due to expire so that appropriate action can be taken.	New

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