



Inspection Report on

Eithinog

**Eithiniog Leonard Cheshire Home
Old Highway
Colwyn Bay
LL28 5YA**

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

07/07/2023

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About Eithinog

Type of care provided	Care Home Service Adults With Nursing
Registered Provider	Leonard Cheshire Disability
Registered places	42
Language of the service	Both
Previous Care Inspectorate Wales inspection	11 May 2022
Does this service provide the Welsh Language active offer?	The service provides an 'Active Offer' of the Welsh language. It anticipates, identifies and meets the Welsh language and cultural needs of people who use, or may use, the service.

Summary

The systems in place to monitor, review and improve the service are not robust and therefore we found significant, systemic failings in terms of the supervision of leadership and management of the home. Staff training and supervision requires improvement. Staff recruitment is safe. Internal audits and environment safety checks are carried out on a monthly basis; however, they have failed to identify the failures seen at this inspection. Some aspects of the environment need improvement, such as bedrooms and corridors and the storage of lifting equipment.

Personal plans and associated care documentation are person centred and are very detailed, however staff do not always follow the prescribed treatment. People are referred to professionals when needed. Staff deployment and the clinical supervision of people is inadequate to safely meet the needs of people in the home in a timely manner. The service is using a high number of agency staff who do not always know the residents. Improvements are required in ensuring the environment is homely, calm and people's wishes are respected. The reporting of safeguarding incidents also requires improvement. Improvements are required in storing confidential information.

Well-being

People do not always have control over their day-to-day life. People are able to voice their opinions at resident meetings, however these meetings are not consistent. There is an array of opportunities for people to engage in a variety of activities, however we saw occasions where items such as puzzles were placed beyond the person's reach. There is a good menu choice and people stated they enjoyed the food offered. People can choose where to spend their time, in communal areas or their own bedrooms. We saw nearly all bedroom doors are left open which does not afford people's privacy, safety, dignity and is not respectful. We heard many instances where staff referred to people by their room numbers and congregated in the corridors outside people's rooms to have loud discussions. We heard one staff member discuss a person's health condition in corridor so everyone could hear.

People's physical, mental health and emotional well-being needs are not always being met. One person displayed signs of distress, but staff were not proactive in offering reassurance and diversion therapy. We observed care given in the activities room and no staff were in this area for fifteen minutes despite there being a number of people who are at risk of choking. When staff were in this area, there was limited interaction between staff and people other than when a task was to be completed with them.

People are not always protected from harm. Staff are recruited safely with necessary checks in place. Many staff have left over recent months and there is a high use of agency staff who do not always know people's needs. Staff training and supervision requires improvement. Not all staff have received training in safeguarding, infection prevention and control or health and safety.

People live in a home which is not being well maintained or safe. The home has received a food hygiene rating of 5 (indicative of 'good' kitchen hygiene practices). The home has dedicated housekeeping staff to ensure the home's cleanliness is maintained, however we saw many areas which required a deep clean such as the dining room and behind doors. People's confidential information is not secure as we saw many care files in the corridors. Wheelchairs and lifting equipment are stored in corridors and bathrooms. Doors are left unlocked in cleaning cupboards and clinical storage areas. One bedroom requires urgent attention as it poses a safety hazard, and some bedrooms had an unpleasant odour.

Care and Support

People cannot be assured they will get the right care at the right time. We saw personal plans contained lots of detail regarding people's preferred routines, likes and dislikes. The Responsible Individual (RI) confirmed staff have protected time so that they can read personal plans and risk assessment. However, staff had not implemented the care prescribed into practice. There was one instance where one person required assistance with their position to prevent them from choking but staff did not respond and another other instance where staff had failed to supervise people in the activities room.

People do not always receive appropriate person-centred care. Staff did not always interact with people when supporting them to eat. There were instances when staff did not always speak with them while sitting with them and a staff member did not sit with the person, they were supporting but stood over them. We saw on many occasions the environment in the main building was chaotic, noisy and many instances' staff referred to people by their room numbers. Three people have previously complained about staff congregating in corridors and the noise level. Their complaints have been ignored as we heard many instances when staff gathered outside people's rooms. 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.

People are not always safe from the risk of abuse or neglect. The safeguarding policy was last reviewed in June 2021 and staff we spoke with did not know about the safeguarding App or how to contact safeguarding authorities. We also noted on two occasions, instances of abuse had not been reported to the safeguarding team. We saw not all staff were updated with safeguarding training. 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.

People did not have their communication needs met. Communication needs are assessed and planned for; however, staff are not aware of people's specific communication needs when supporting people. This meant the person may not have been able to communicate effectively. Two people required adaptations to support them with communication. We did not observe this being used. We spoke with another resident who was able to fully understand what is being said to but no way of communicating with others as they have limited words such as "yes and no". We asked whether the service have tried to create a communication tool with them so they can communicate, they replied "No" and gestured a feeling of frustration. 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

People cannot be confident they are cared for in safe, secure, and maintained surroundings. Our identification was not checked before entering the service. Not all COSHH (Control of Substances Hazardous to Health) materials are stored correctly, in line with the COSHH Regulations 2002. Oxygen cylinders are not stored safely and no signage to advise these were stored in the cupboard. There are a number of specialist wheelchairs throughout the corridors which made it difficult for those who are mobile using a wheelchair to get by safely. This is placing people's health and safety at risk and a priority action notice has been issued. The provider must take immediate action to address this issue.

People do not live in an environment which is always uplifting, clean and homely. Some areas of the environment in the main building is clinical such as the corridors and dining room and does not contribute to people's wellbeing. High traffic areas are cleaned however, behind doors and the worktops and tiles, grouting and the worktops were chipped in the dining room. Some bedrooms are in need renovation as the furniture is old, damaged, and unsightly. We saw multiple areas in urgent need of repair and redecoration. Four bedrooms had an unpleasant odour. We requested a refurbishment plan and to date this has not been received. 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.

People cannot be confident that their records will be treated confidentially. We saw people's care records stored in communal areas which pose a data protection risk. There was a number of care files in the corridors in the main building and on the back of people's chairs. Staff had recorded on a napkin in the dining room who had been washed and who had breakfast. We saw the resident's bowel tracker list was left on the trolley in the main corridor and list of Hydrotherapy treatment which included different residents' initials and room numbers displayed on a resident's bedroom wall. We discussed with the RI the issue of staff leaving confidential information around communal areas within the home and not respecting people's privacy and dignity and immediate was taken on the day but this is clearly usual practice. 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.

People can be confident appropriate certification is in place regarding facilities and testing of equipment. Gas and portable appliance testing (PAT) and fire-related safety checks are carried out and people have an up-to-date personal emergency evacuation plan (PEEPs). The fire safety risk assessment has recently been reviewed. The five-year Electric Safety Certificate is in date. Lifting Operations and Lifting Equipment Regulation (LOLER) are tested.

Leadership and Management

People living at the service cannot be confident that the home is well managed to safeguard and promote their welfare. The manager and clinical lead nurse are absent from the service. This void is covered by operations manager and clinical operations manager. The RI is also at the service regularly. During the inspection all management based themselves in the office with the door closed. We found the arrangements in place to assess, monitor and improve the quality and safety of the service are not robust. The six-monthly quality care review and the RI report has failed to identify these issues found at this inspection. 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.

There is a high dependency of care needs and staff deployment does not ensure the care is delivered in accordance with personal plans. We saw many instances where staff lacked guidance and therefore, people were not always properly supported and supervised. Staff adopt a task-based approach to care. They were rushed and very busy attending to different people; consequently, care was hurried and institutionalised and did not maintain people's dignity. There is high staff turnover and whilst recruitment is ongoing the service regularly use a high percentage of agency staff to cover the rota. The RI told us they try and provide regular agency staff so that they are known to people and familiar with their needs. Call bell response times show a significant number of calls bells were not answered in a timely manner. 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.

People cannot be confident that staff have completed the appropriate training that will equip them with the necessary skills and knowledge to effectively carry out their care roles. The home's own statement of purpose states that '*Staff are part of a comprehensive training programme which includes induction, mandatory and specialist training are required*'. Records showed staff training was not up to date and several staff had not received training related to the needs of people living in the home. The agency file showed each staff member had attended up to eleven training modules in one day. There was no evidence that the provider had questioned the agency as to the competency of the staff being used in the service; therefore, they could not be assured the people in the home are being cared for by competent and skilled staff. 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.

Recruitment practices keep people safe. We checked the recruitment records of four staff personnel files. They all contained the required information and all necessary checks had been completed before staff had started work. All new staff complete an induction and undergo a probation period. Existing staff are registered with Social Care Wales.

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
44	The provider has not ensured the premises is maintained to an appropriate standard to meet the needs of people cared for. Some areas of the environment are not clean, and risks regarding health and safety are not always mitigated.	New
47	People's personal information are not always stored securely.	New
36	Staff have not completed mandatory or specialist training appropriate to the work to be performed by them.	New
24	The provider has not ensured staff can communicate with people effectively.	New
66	Failures in the service have not been identified through the service's own audits or through their own	New

	quality of care review report and this is placing people at risk of harm.	
57	The provider is not proactive in their approach towards the safety of the people using the service and has failed to ensure that unnecessary risks to the health and safety of people are identified and eliminated.	New
25	People are not always listened to and communicated with in a courteous and respectful manner with their care and support needs.	New
34	There are not enough staff employed at the home to ensure the safety of the residents.	New
26	Staff and the Responsible Individual do not have sufficient knowledge and oversight to safeguard people in a robust manner.	New

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
N/A	No non-compliance of this type was identified at this inspection	N/A
34	People cannot always achieve their personal outcomes because there are not enough staff on duty to meet their needs.	Achieved

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