Inspection Report on

The Headlands Nursing Home

The Headlands Nursing Home
Tower Road
Llangollen
LL20 8TE

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

23 January 2023

23/01/2023

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About The Headlands Nursing Home

Type of care provided	Care Home Service Adults With Nursing
Registered Provider	Deevale Healthcare Limited
Registered places	28
Language of the service	Both
Previous Care Inspectorate Wales inspection	17 August 2022
Does this service provide the Welsh Language active offer?	This service does not offer an active offer of the Welsh language.

Summary

The Headlands Nursing Home cares for people who have complex care needs. People benefit from being cared for by core staff who are familiar with their needs. There are several new members of staff who are working towards familiarity with the service.

We inspected the home and identified eleven areas where urgent priority action is required to make necessary improvements within the service and one area for improvement. These are in relation to the provision of the service, standards of care and support, safeguarding, fitness of staff, supporting and developing staff, the premises, hygiene and infection control, health and safety, reporting of notifiable incidents, supervision of the management of the service, quality reviews of care and medicines management. The Local Authority have commenced their own process to identify issues and support the service to make required improvements.

The Responsible Individual/provider (RI) and the home's management team are working with Care Inspectorate Wales (CIW), the Local Authority and Local Health Board to make improvements to the service. The RI has expressed a commitment to improving the service to ensure people have appropriate levels of care and facilities. The RI has provided CIW with assurances that improvement work is currently underway at the service.

Well-being

People have limited choice and control over daily life. We saw people were not always given meal choices and alternatives to meals they disliked. A person told us they had sandwiches daily which they disliked; we saw they were not given an alternative as requested by them. A person told us they had little choice of when to get up and go to bed as they felt there was a language barrier, and staff did not always comprehend them, although they were consistently polite in their requests. We saw people's personal plans did not always document people's first language, cultural, and religious preferences. A person told us they would like opportunity to speak Welsh and be involved in Welsh culture and chapel practices which were not provided in the home. We saw there were no Welsh reading materials, and few bi-lingual signs in the home. This contravenes the regulations and is not concordant with the service's own Statement of Purpose which details the services offered to people in the home.

People are not consistently provided with activities and stimulation. There were no planned activities written on the activities board in the home during both our inspection visits. We observed the care given in one lounge in the home, no activities were offered to people or diversion techniques to provide reassurance when people displayed anxiety. A family told CIW of their concerns that their relative was mostly cared for in their room and were not offered activities, diversion, or stimulation. The family commented, "*there has to be more to life than merely existing.*" This practice does not conform to the Regulations, and we have issued a priority action notice. The provider must take immediate action to address this issue.

People's rooms are somewhat personalised. People can choose to have some of their own furniture and belongings in their room for their comfort. We saw people's rooms are not always maintained to a good standard, we saw examples of broken furniture in some people's rooms and paintwork which needs attention. People's rooms were found to be warm on both inspection visits. The décor of people's rooms, and other areas of the home, are not dementia friendly. The opportunity to use colour and texture to aid people's recognition of their room and other areas in the home, is not explored.

Staff spoken with during inspection visits could not fully explain safeguarding procedures. Staff did not know about the safeguarding app or how to contact safeguarding authorities. We saw not all staff were updated with safeguarding training. This is placing people's health and well-being at risk, and, therefore, we have issued a priority action notice. The provider must take immediate action to address this issue.

Care and Support

People are not always cared for in a proactive, person-centred manner. We observed care given in a lounge in the home, there were several staff on duty. We saw there was no

interaction between staff and people other than when a task was to be completed with them. People displayed signs of anxiety and distress, but staff were not proactive in offering reassurance and diversion. People's hygiene and continence needs were not identified in a timely manner to provide them with dignified care. No intervention was attempted for a person who was unsteady on their feet to mitigate their falls risk. An unsafe moving and handling procedure was witnessed which had potential to cause injury for the person and staff. Staff deployment is not always even to ensure people's needs are addressed in a timely way. CIW, on separate occasions, found no staff were available on upper floors of the home to monitor, and respond to people's needs. This is especially concerning as we were told that only three people have capacity to use a call bell. We saw people's personal plans, although containing detail of people's medical diagnosis and how it affects their behaviour, they contain little detail of day- to -day practicalities regarding people's needs and preferences. We saw a plan contained conflicting instructions regarding a person's moving and handling needs. This does not ensure new and agency staff have adequate direction regarding people's care needs. A priority action notice has been issued as this places people's health and well-being at risk. The provider must take immediate action to address these issues.

Whilst largely compliant, we found some issues to be addressed regarding medication administration and storage. We found medicine trolleys are not tethered to the wall when stored. We saw medicines which are to be kept in the fridge were left out on the medicines trolley. We saw laxatives prescribed for named people were left out for general "as required" use. The medicine fridge was not clean, and temperature tested as per pharmacy guidelines. We were told the risk assessed method for medicines administration during lift break downs, differed from actual practice by agency staff. Whilst no immediate impact was noted, CIW expect the provider to take action to improve these practices.

We found practices relating to infection control were poor. Good hand hygiene practices are not always evidenced as communal and staff toilets lack soap and paper hand towels. A member of staff was seen wearing a face mask incorrectly during the Covid-19 outbreak. This was reported to the manager who dismissed the risk and assumed the staff wears it correctly when giving hands on care. Visitor's temperature is not routinely tested on entry to the home during a Covid-19 outbreak. CIW were informed that monitoring teams from the Health Authority also observed instances of staff wearing Personal Protective Equipment (PPE), incorrectly and Covid-19 isolation measures are not adequately organised as per infection control and Public Health Wales guidelines. This is placing people's health and well-being at risk, and we have issued a priority action notice. The provider must take immediate action to address this issue.

The safeguarding policy in use during the inspection was not in line with current Wales Safeguarding Procedures guidance. This had not been identified by the manager or RI. An updated policy was sent to us after the inspection. The manager is unaware of practice guidelines in relation to safeguarding, does not keep relevant records and does not follow the organisation's own policy and procedure. Records kept of safeguarding incidents are

incomplete and we found incidents occurring within the home are not reported to the local authority safeguarding team or CIW. Staff involved in safeguarding incidents continue to work at the home contrary to the organisations policy and procedure. Staff spoken with are not aware of the Wales Safeguarding Procedures App which provides guidance to staff about how to identify and report safeguarding issues. Quality assurance processes do not include safeguarding and there is no evaluation of such incidents or consideration of lesson that may need to be learnt to reduce the risk of reoccurrence. The training records show that four staff are out of date regarding safeguarding training, four staff's training is unaccounted for. This has not been identified through quality assurance processes by the RI. 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

Health and safety checks in the home are not robust. We saw fire safety checks are performed regularly. A fire evacuation drill highlighted issues which require action, but these are not identified as concerning by the manager. The fire alarm could not be switched off as a member of staff had left the premises with the key, the spare key could not be located at the time of the incident. We could not evidence that staff test bathing and shower water for people to prevent scalds. We were not provided with legionella testing evidence. We saw trip hazards due to clutter on the floor in the laundry and boiler rooms. The laundry room does not have a separate hand washing sink, as per the regulations, to ensure good hand hygiene and prevent cross-contamination. We saw a prescribed cream was in general use in a communal bathroom which is a cross-contamination risk and not used as prescribed by a doctor. We saw items and equipment were placed close to the toilet in some areas which is a splash contamination and infection control risk. 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.

We saw the environment is not as clean as expected in certain areas. The kitchen has an environmental hygiene rating of 5, which is the highest available. The carpet on the stairs to both floors and on each landing are dirty and stained and faded in places. Chairs in the lounge are ripped, people had been incontinent with ingress into the cushions. Curtains in the lounges and some bedrooms are stained and hanging off the rails. The floor of the medicine room and counter tops need cleaning as does the medicine fridge. The sink in the laundry is stained with paint and detergent. We saw furniture in the lounge is scratched. Furniture in some people's rooms is broken. Paintwork in high traffic areas is dirty and peeling. Cleaning staff were on leave with no staff appointed to replace them. We asked to see cleaning checks and schedules but were not provided with them. 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.

Leadership and Management

Services are not provided in line with assurances given in the statement of purpose (SOP), including but not limited to, the quality of care, activities, safeguarding, recruitment, the environment, health and safety staff training and support. The responsible individual and manager do not have oversight or manage the service in line with legal requirements. Quality assurance processes are not effective in monitoring, reviewing, or improving the quality of the service. The views of people who use the service, their relatives, staff, and professionals are not sought. The manager told us they had not undertaken any work to find out views of people who use the service or their families since 2021. Regulation 73 reports do not evidence a cross section of stakeholders have been given an opportunity to express their views regarding the service provided. Regulation 73 reports do not evidence the records and audits reviewed to ensure a quality service. 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.

The manager told us they are unaware of what needs to be reported to CIW in relation to safeguarding incidents. We found incidents had occurred which have not been reported to CIW as required. This includes safeguarding incidents and occasions when the lift has broken. This has not been identified through quality assurance processes by the RI. 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.

We could not evidence in staff records or the training record provided that new staff complete a structured induction in line with Social Care Wales framework. Records show staff, including the manager, have not completed necessary or specialist training. Nurses, including the manager, are not provided with clinical training to ensure their skills and knowledge are up to date. Checks of supervision records and information provided show staff including the manager, are not provided with regular formal supervision and the manager confirmed none of the staff have been provided with an annual appraisal. However, on the second day of inspection CIW were provided with a copy of one supervision record in respect of the manager. This has not been identified through quality assurance processes by the RI or during Regulation 73 visits. 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.

Staff are not recruited in line with the regulatory requirements. Staff files checked do not always include references from previous employers and references on record have not been verified. Records do not include a job description, or any evidence staff are provided with the Social Care Wales code of conduct. Gaps in employment have not been identified

and one member of staff has returned to work at the home without the correct recruitment process being followed. This has not been identified through quality assurance processes by the RI. 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.

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
6	The provider has not demonstrated over-sight of the management of the service.	New
21	There is little over-sight and supervision of standards of care in the service.	New
26	We could not evidence during inspection that staff and the manager had sufficient knowledge to safeguard people in a robust manner.	New
35	Comprehensive pre-employment checks are not fully completed prior to new staff being employed to work at the service.	New
36	The provider has not ensured staff are updated regarding the knowledge and supervision required for their role. The provider has not ensured that new staff receive a robust induction in line with the	New

	requirements of Social Care Wales.	
44	The provider has not ensured the environment enables safe, dignified and respectful care for people.	New
56	The provider has not ensured the hygiene and infection control in the home is sufficient to meet the requirements of the regulations.	New
57	We identified health and safety issues during our inspection which were not identified by the provider.	New
60	The provider has not ensured notifiable events are reported to CIW.	New
66	The provider has not supervised the management of the service to ensure quality care.	New
80	The provider has not ensured there is an effective process in place to measure the quality of care.	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
58	We found issues concerning the administration and storage of medicines during inspection.	New

Date Published 23/06/2023