Inspection Report on

Ty Mawr Care Home

Station Road
Cae Hopkin
Abercrave
SA9 1TP

Mae’r adroddiad hwn hefyd ar gael yn Gymraeg
This report is also available in Welsh

Date(s) Inspection Completed
19/03/2019, 26/03/2019, 27/03/2019 & 09/04/2019
Description of the service
Ty Mawr Care Home is located in the small village of Abercrave near Ystradgynlais, Powys. It is set within grounds that are shared with other small, privately owned properties. There is a parking area to the front of the home.

The home is owned by Ty Mawr Ltd and has a manager who is registered with Social Care Wales. It provides nursing and personal care for up to 54 people, the majority of whom are aged 65 and over. There are two places for people aged between 18 and 64 years, including a person with a learning disability.

Summary of our findings

1. Overall assessment

People enjoy life at Ty Mawr. They are able to socialise and develop meaningful relationships with others. People can enjoy a range of indoor activities, although would benefit from stronger links with the community. People feel well cared for, with staff recognising and understanding their individual care and support needs. People have enjoyable meals at the home and are supported to maintain an appropriate diet. The home is set within attractive, private grounds and is generally well maintained. However, outdoor areas could be developed into more interesting spaces for people to enjoy.

The overall leadership and management of the home needs to improve to ensure staff are given clear direction and people experience the best possible service. Action is needed to improve the condition and cleanliness of some equipment, which is compromising people’s health and well-being. Staff recruitment procedures also require urgent improvement to safeguard the people living in the home. People are not being cared for by staff who are being appropriately supervised, which may impact on the quality of their care. The provider needs to take immediate action to address these serious matters, which have resulted in the issuing of non-compliance notices.

2. Improvements

There was some evidence of improvement since the last inspection. Environmental upgrades are ongoing. We also found that the quality of information within care plans had improved and that increased staffing levels had reduced time and workload pressures on staff.

3. Requirements and recommendations

Section five of this report sets out our recommendations to improve the service and the areas where legal requirements are not being met. These relate to the following:
• Staff recruitment: Appropriate recruitment procedures have not been followed to ensure that, as far as possible, people are protected by a safe workforce.

This serious matter was raised at the last full inspection but had not been satisfactorily addressed. Therefore, an urgent non-compliance notice was issued to the provider in view of the potential risks for people using the service. By our final inspection visit, we were not satisfied that compliance with regulation had been fully achieved.

Further non-compliance notices have been issued regarding the following:

• Infection control: Some of the equipment and furniture in use is in poor condition and is not being cleaned to a satisfactory standard. This is increasing the risk of cross infection.

• Staff supervision: Staff are not receiving two monthly supervision or annual appraisals of their performance.

• Leadership and management: The service is not being managed with due care and attention to regulation and minimum standards. The lines of accountability within the home are not clear and communication amongst team leaders, the manager and responsible individual is disjointed.
1. Well-being

Summary

People are happy at Ty Mawr, where they can socialise with others and take part in a range of indoor activities. However, they would benefit from better links with the community and more regular outdoor activity.

Our findings

People living at Ty Mawr have things to look forward to. We saw people enjoying a game of snakes and ladders and a physical activity, which involved throwing beanbags into a large bowl. A college student assisted an activities coordinator in facilitating these activities. There was a fun, light-hearted atmosphere as people also sang along to music that was playing. We saw a range of craft items people had created, including sheep made out of card and wool to represent the Spring season. A relative told us their loved one had recently enjoyed a concert at the home. One person told us they chose not to join in some activities as they considered them too childlike. We saw other people knitting, reading magazines and watching television. A health professional told us they always found people to be occupied and involved in home life. We saw a thank you card that stated an individual had been, “So happy and content at Ty Mawr”. People are happy in a home where they can take part in a variety of in-house activities.

However, we recommend that the home develops better links with the community and organises more regular outings. Four people told us they had not been on any trips outside the home. One person commented they were often bored indoors and would enjoy going out for a meal. People told us they spent time outside the home only if friends or relatives could take them. An activities coordinator told us they did not have suitable, accessible transport for supporting people with mobility needs in the community, although three people had been out for lunch that week in a staff member’s car. The manager told us plans for schoolchildren to take part in a media based activity with residents had not gone ahead due to the lack of WiFi in the home. Arrangements had been made for this to be provided in the future. The evidence shows that people would benefit from being more involved in community life.

People are able to develop meaningful relationships with others. We found that people valued the friendships they had formed. We saw people eating and socialising with one another in various parts of the home. People referred to others by name and spoke knowledgeably about their particular preferences and routines. Relatives also appeared at ease as they provided support during a group activity. We saw that people interacted well with staff, who were very familiar with their personal circumstances. One person confirmed they knew most of the staff working at the home. A relative reported that staff went the extra mile to help and always had fun and laughter with their loved one. We saw that the home
had also been praised in a recent online review: ‘…surrounded by wonderful staff and many friends...You all do a superb job’. We can conclude that people benefit from socialising with others.
2. Care and Support

Summary

People receive personalised and appropriate care and support. People feel well looked after by caring and attentive staff. They enjoy the food provided at the home.

Our findings

People are satisfied with the quality of their care and support. We were told that staff looked after people well. One person commented, “We wouldn’t be here without them” and another said, “There’s no fear of them doing a bad job here”. We saw that many relatives had complimented the home; one stated they had experienced “love and kindness” and “tender care”. Other compliments included:

- “Ty Mawr has been a big part of my life”
- “I had a very warm welcome”
- “The care he received was exemplary”

A health professional told us they attended the home weekly and had no concerns about the support provided by staff. We saw that staff responded promptly to call bells and provided the guidance and emotional support people needed. A relative told us they were informed quickly about any changes to their loved one’s care. A nurse working at the home commented that care workers were very responsive to people’s particular requests, which we also observed. People therefore experience kindness and compassion in their day-to-day lives.

People’s individual needs are recognised and understood. We found that care records contained details about people’s life histories. Their particular care needs, and how these were to be met, were outlined within a range of risk assessments and care plans. We found that the overall quality of information within care plans had improved. These improvements need to continue to ensure future compliance with regulation. We saw in one file that not all the relevant care plans had been updated following a change in an individual’s needs. There was also inconsistency regarding the completion of documents relating to people’s oral care needs. We encourage regular audits of monitoring charts to ensure care delivery is well evidenced and appropriate. Otherwise, we found that care was being provided in line with people’s care plans. The manager told us a specialist nurse would be training staff in assessing and planning for people's oral care needs. We viewed the staff training matrix and found many gaps in staff training that had not been accounted for in the home’s training schedule. The manager agreed to address this, and provide details of the anticipated timeframes and training providers. Overall, people receive individualised and effective care and support.

People enjoy their meals at the home. People told us there was plenty of choice available and described the food as, “Excellent”, “Delicious” and “Very good”. There was a sociable atmosphere at lunchtime as people dined together in the home’s thoughtfully laid out dining
room. We saw staff serving some people their meals in their own bedrooms, assisting them immediately if required. Staff provided this assistance at a relaxed pace and in a dignified way, ensuring that clothing protectors were worn if needed. People were given cakes and hot drinks between main meals, which they appeared to enjoy. We saw one person drinking their prescribed supplement drink; medication records indicated that these had been given as frequently as prescribed. Food and fluid monitoring charts had been kept up to date and we saw that these had been audited by the clinical lead during times when people were particularly unwell. This shows that people are supported to maintain a healthy diet.
3. Environment

Summary

People live in a generally well maintained home that is set within attractive, private grounds. However, outdoor areas could be developed into more interesting spaces for people to enjoy. The condition and cleanliness of some equipment is compromising people’s health and well-being and must be addressed.

Our findings

People are at risk of cross contamination and infection. This is because some of the equipment in use was in poor condition and had not been cleaned to a satisfactory standard. We saw that many of the chairs in the ground floor lounges were either stained, soiled, heavily worn or damaged. They varied in style and were generally shabby. The wallpaper in these rooms was ripped in places. Three cantilever tables were also damaged; the surface material had worn away, revealing the inner chipboard. We visited many people being cared for in their rooms and found that their bedrail bumper pads were stained with pen and/or splashed with food and drink or bodily fluids. Residents used these items daily. The staff training matrix showed that thirteen out of fifty three staff had completed infection control training within the last two years, despite previous inspections identifying concerns regarding overall standards of hygiene at the home. As such, a non-compliance notice has been issued to the provider regarding this matter. We also recommend that a programme be introduced to replace the worn, mismatched furniture in the two lounges to make these rooms more inviting. The evidence shows that people are using everyday items that are not clean or hygienic, and this may adversely affect their health and well-being.

People would benefit from outdoor areas that are well maintained. We saw that the home was set within pleasant grounds with scenic countryside views. A patio area was available where people could sit and enjoy the outdoors. However, there were limited points of interest and the patio furniture was heavily worn and in need of a clean. A number of building materials had been discarded to one side of the home, providing an unsightly view from some windows. These included a shattered glass pane, a toilet and cistern, a mattress, broken window frames and pipework. These items had been left there for over a week, which we brought to the manager’s attention. The manager agreed to arrange for this area to be cleared. We can conclude that better use could be made of the outdoor space available.

There are suitable maintenance systems in place to promote people’s safety. The manager told us that in-house checks of moving and handling equipment were carried out monthly and that all hoists and slings had recently been serviced. We saw records confirming this. Weekly checks of water temperatures had been carried out and records showed that these were within a safe range. We saw that the home had achieved a food hygiene rating of 5
(very good) following a recent inspection by the Food Standards Agency in February 2019. On our first two inspection visits, the passenger lift was out of use. A lift company had inspected the lift and a replacement part had been ordered. Some people residing on the home’s top floor could not access communal rooms on the ground floor whilst the lift was out of use. To promote their safety and well-being, additional staff worked on the top floor, serving people meals in their rooms and checking on them more frequently. The evidence shows that people live in a home that is generally well maintained.
4. Leadership and Management

Summary

The overall leadership and management of the home needs to improve to ensure that people’s health and well-being is not compromised. Urgent action is needed to improve staff recruitment procedures and safeguard the people living in the home. People are not being cared for by staff who are being appropriately supervised, which may impact on the quality of their care. The provider needs to take immediate action to address these serious matters, which have resulted in the issuing of non-compliance notices.

Our findings

People are not being cared for by staff who have been robustly recruited. CIW and commissioners had been made aware that one staff member had been employed whist subject to an investigation into their practise at another care setting. The responsible individual had told us this staff member would not be left in sole charge of the home. However, rotas showed that this safeguard had not been implemented. There was also very limited information about the investigation within this staff member’s records, or confirmation as to how the staff member’s suitability for employment had been determined in light of this. We also found that full and satisfactory information had not been obtained for other persons working at the home. For example, there were missing references and unexplained gaps in some staff members’ employment histories. We considered that these matters placed people at increased risk of harm and issued an urgent non-compliance notice to the provider. We were not satisfied that regulation had been complied with by our final inspection visit to the home. People’s safety and well-being is being compromised by unsafe recruitment procedures.

Staff are not being appropriately supervised, which may impact on the quality and consistency of care people receive. We found that staff had not received two monthly formal, individual supervision and annual appraisals of their performance. Some staff told us they had received supervision once or twice in the last year, and supervision records confirmed this. We also saw that the clinical lead had not received supervision from an appropriate person with relevant clinical experience. The manager was unable to recall when he had last had supervision and the responsible individual failed to provide these records upon request. The manager confirmed that staff had not received an annual appraisal since he had been appointed in January 2018; this was due to the volume of his workload and the expectation that a nurse consultant would be contracted to support the home with this. Therefore, staff performance had not been adequately monitored to support in their professional development. This may impact on staff retention and standards of practise. As such, people may not always experience the best possible care from motivated staff who are valued in their roles.
The overall leadership and management of the home needs to improve to ensure people experience a consistent, reliable service that meets legal requirements. We found that the service was not being conducted with due care and attention to regulation and minimum standards. As set out within this report, the home has failed to meet legal requirements in relation to its standards of infection control, staff supervision and staff recruitment. These matters had been raised during previous inspections. The continued non-compliance demonstrates a lack of appropriate, responsive action by the registered persons.

Staff told us the manager and responsible individual were approachable and that the manager had made some positive changes in the home. They described him as “Fab” and “The best manager we’ve had”. We saw that the manager was visible and accessible to people within the home. However, staff were not always given clear direction because lines of accountability were not clear and communication was disjointed. For example, some staff told us they could not raise any issues with their rota to the manager because he was unable to act upon them. The manager confirmed that he had been advised by the responsible individual that any changes to care staff’s rotas must be made by the team leader for the kitchen. This arrangement prevented the manager from changing rotas as necessary to ensure the safe, smooth running of the home. It also undermined his position and authority. Likewise, the responsible individual had arranged for a CCTV camera to be installed in the laundry room without consultation with the manager and laundry staff.

The system for monitoring and improving standards of practice also required improvement. We found that the responsible individual had not evidenced three monthly formal visits to the home, which included an assessment of the standard of people’s care and support. There was also no evidence that complaints, if any, had been considered during these visits, as is required. We saw that the complaints policy and procedure had not been reviewed since 2014 and contained inconsistent information. The manager told us a quality of care review had been carried out, but the report was not available at the home.

In light of these issues, we advised the registered persons that the service was not meeting legal requirements in relation to its leadership and management, and have issued a further non-compliance notice to the provider. The evidence shows that people are not experiencing an improving and compliant service on which they can rely.
5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

At the previous inspection, we advised the provider that improvements were in needed in relation to the following, in order to meet legal requirements:

- **Health and welfare (Regulation 12(1)(a))**: At this inspection, we were satisfied that compliance with regulation had been achieved. We found that the overall quality of information within care plans had improved. Food and fluid monitoring charts had also been kept up to date, with people’s daily intake being reviewed. These improvements need to continue to ensure future compliance with regulation.

- **Record storage (Regulation 17(1)(b))**: At this inspection, we were satisfied that compliance with regulation had been achieved. We saw that care records were either stored on a password-protected database, or within an office that was fitted with a keypad and locked when unmanned. Likewise, staff records were stored in a lockable filing cabinet within an administrative office that was locked when unmanned.

- **Infection control (Regulation 13(3))**: At this inspection, we were not satisfied that compliance with regulation had been achieved and have issued a non-compliance notice to the provider due to the potential risks for people using the service.

- **Leadership and management (Regulation 10(1))**: At this inspection, we were not satisfied that compliance with regulation had been achieved and have issued a non-compliance notice to the provider due to the potential risks for people using the service.

5.2 Recommendations for improvement

During this inspection, we identified areas where the registered persons are not meeting legal requirements and this is resulting in potential risk and/or poor outcomes for people using the service. Therefore, we have issued non-compliance notices in relation to the following:

- **Staff recruitment (Regulation 19(2)(d))**: Appropriate recruitment procedures have not been followed to ensure that, as far as possible, people are protected by a safe workforce.

- **Infection control (Regulation 13(3))**: Some of the equipment and furniture in use is in poor condition and is not being cleaned to a satisfactory standard. This is increasing the risk of cross infection.
• **Staff supervision** (Regulation 18(2)): Staff are not receiving two monthly supervision or annual appraisals of their performance.

• **Leadership and management** (Regulation 10(1)): The service is not being managed with due care and attention to regulation and minimum standards. The lines of accountability within the home are not clear and communication amongst team leaders, the manager and responsible individual is disjointed.

Detail of the action required is set out in the non-compliance notices attached to this report.

We recommend the following:

• Regular outings should be organised to provide people with more opportunities to spend time outdoors and in the community.

• Outdoor areas should be kept clear of building rubble and a programme to upgrade the furniture within the two lounges should be introduced.

• The quality of care documentation needs to continue to improve, ensuring all required documents are completed and all relevant care plans are updated following any changes in people’s needs.

The following recommendations made at the last inspection remain outstanding:

• The service should review and update its service user guide, ensuring that it accurately reflects the service being provided.

• Consideration should be given to displaying bilingual signage and introducing key documents in Welsh.
6. How we undertook this inspection

This full inspection was prompted by concerns from commissioners that the home was not providing evidence of improvement or responding to their requests in a timely manner.

There were four unannounced visits.
Two inspectors made two unannounced visits to the home on:
- 19 March 2019 between 10:15 am and 4:10 pm.
- 26 March 2019 between 10:25 am and 4:15 pm.
One inspector made two unannounced visits to the home on:
- 27 March 2019 between 11:15 am and 2:20 pm.
- 9 April 2019 between 10:40 am and 1:55 pm.

The following methods were used:

- We spoke with seven of the people living in the home and visited three people who were receiving care in bed.
- We spoke with a visiting relative and a visiting health professional.
- We spoke with six care workers and other members of staff. This included nursing staff, domestic staff, the administrator, an activities coordinator and the manager.
- We observed how all staff interacted with people.
- We provided inspection feedback to the responsible individual via email.
- We viewed five people’s care records and a sample of monitoring charts.
- We viewed the personnel records of eleven members of staff.
- We considered other relevant documentation, such as:
  - The home’s statement of purpose
  - Incident records
  - Minutes from recent staff meetings
  - Compliments file
  - A sample of maintenance records
  - Staffing rotas
  - The staff training schedule and matrix
  - Reports produced by the responsible individual following formal visits to the home.

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

<table>
<thead>
<tr>
<th>Type of care provided</th>
<th>Adult Care Home - Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Person</td>
<td>Ty Mawr Ltd</td>
</tr>
<tr>
<td>Manager</td>
<td>There is a manager in post who is registered with Social Care Wales</td>
</tr>
<tr>
<td>Registered maximum number of places</td>
<td>54</td>
</tr>
<tr>
<td>Date of previous Care Inspectorate Wales inspection</td>
<td>12 September 2018</td>
</tr>
<tr>
<td>Dates of this Inspection visit(s)</td>
<td>19 March 2019, 26 March 2019, 27 March 2019 &amp; 9 April 2019</td>
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<tr>
<td>Operating Language of the service</td>
<td>Both</td>
</tr>
<tr>
<td>Does this service provide the Welsh Language active offer?</td>
<td>Working towards</td>
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</table>

**Additional Information:**

This is a service that is working towards providing an ‘Active Offer’ of the Welsh language and intends to become a bilingual service or demonstrates a significant effort to promoting the use of the Welsh language and culture.

Date Published – Wednesday, 15 May 2019
Care Inspectorate Wales

Care Standards Act 2000

Non Compliance Notice

Adult Care Home - Older

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.

Further advice and information is available on CSSIW’s website www.careinspectorate.wales

Ty Mawr Care Home

Station Road
Cae Hopkin
Abercrave
SA9 1TP

Date of publication: Wednesday, 15 May 2019
**Non-compliance identified at this inspection**

<table>
<thead>
<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
</tr>
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<tbody>
<tr>
<td>Some of the equipment in use is in poor condition and is not being cleaned to a satisfactory standard. This is increasing the risk of cross infection. The registered persons must make suitable arrangements to prevent the spread of infection at the home.</td>
<td>13 (3)</td>
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</tbody>
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**Evidence**

The service is non-compliant with Regulation 13(3) of The Care Homes (Wales) Regulations 2002.

This is because there are inadequate infection control measures in place, which is increasing the risk of cross contamination and infection.

The evidence observed during inspection visits carried out on 19 March 2019, 26 March 2019 and 27 March 2019 is as follows:

1. The bedrail bumper pads in eight people’s bedrooms were not clean. Many had pen stains on them and six had food/drink and/or bodily fluid stains on them. We saw people being cared for in bed whilst these bedrail bumper pads were in place. Of the eight affected, two had been replaced by our inspection visit on 27 March 2019.

2. The majority of chairs in the two ground floor lounges were in poor condition:
   - Two fabric chairs were heavily worn, discoloured and stained in places, including the armrests, chair backs and seat cushions.
   - One chair had paint marks on the seat cushion and the wooden armrests were heavily worn.
   - One chair had a few small holes in it where the outer material was damaged or breaking down. The chair needed to be cleaned.
   - The seams of one chair were broken and it needed to be cleaned.
   - Two matching chairs were heavily worn, particularly at the seams where the material had thinned and worn away. The chairs were splashed with food/drink and there was some debris within the seat cushions. A person’s pillow was resting on one of the seats.
   - The back of a lounge chair in the main dining room was soiled with food/drink.

We observed all of these lounge chairs being used at various times by different residents.

3. Three of the cantilever tables being used in the two lounges were in poor condition. The surface of the tables had worn away along some of the edges, exposing the material
underneath. One was particularly worn in one corner, having crumbled away from the table’s outer plastic rim. People were using these tables to hold their food, drink and other items. The manager told us they had audited the cantilever tables in January 2019 and had requested that seven be replaced. This had not been actioned.

4. The staff training matrix showed that, out of 53 staff, only two had completed training in infection control in the past year and eleven within the past two years.

The evidence shows that some of the equipment in use is in poor condition and is not being cleaned to a satisfactory standard.

The impact for people using the service is as follows:
• Using everyday equipment that is dirty and unhygienic may adversely affect people’s general health and well-being and increase the risk of cross infection.
• People may not feel valued or respected having to use equipment that is unhygienic and in poor condition.
**Leadership and Management**

**Our Ref: NONCO-00007525-WQYT**

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<table>
<thead>
<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
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<tr>
<td>The lines of accountability within the home are blurred and communication amongst leaders and managers is disjointed. The manager has not been involved in making decisions that affect the everyday running of the home and is unclear about the rationale for some of the decisions made. The service is not being delivered with due care and attention to regulation and minimum standards. The registered persons must ensure that the home is managed with sufficient care, competence and skill.</td>
<td>10 (1)</td>
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**Evidence**

The service is non-compliant with Regulation 10(1) of The Care Homes (Wales) Regulations 2002.

This is because the service is not being managed effectively and has failed to meet regulatory requirements.

The evidence observed during inspection visits carried out on 19 March 2019, 26 March 2019 and 27 March 2019 is as follows:

1. The service was found to be non-compliant in relation to its recruitment procedures, staff supervision and standards of infection control. Separate non-compliance notices have been issued to the provider regarding these matters. The service had previously been notified that they were not meeting legal requirements regarding standards of infection control at a focused inspection carried out in September 2018. Likewise, the service had previously been notified that they were not meeting legal requirements regarding staff supervision at the last full inspection carried out in April and May 2018. At this inspection, we had also advised the registered persons that recruitment procedures needed to be more robust. We found that the manager had carried out an audit of staff files in December 2018, which had identified that several recruitment documents were missing. This had not been addressed. The service’s continued non-compliance identifies a lack of appropriate, responsive action by the registered persons.

2. The responsible individual and manager told CIW and commissioners that one staff member would not be left in sole charge as the Registered Nurse (RN) on duty at the home. This RN would also only work with the manager or a more senior RN due to an ongoing investigation into their practice. However, the rota covering the period 3 March
2019 - 16 March 2019 indicated four occasions when this RN had worked in a senior position, without oversight from the manager or a more senior RN. The manager was unable to provide an explanation for this. This shows that the registered persons have failed to implement the agreed measures to safeguard both the people living in the home and the staff member who is subject to the ongoing investigation.

3. A staff member told us they had reported concerns about proposed changes to their staffing rota, which the manager had acknowledged but not been able to act upon. The manager confirmed they were unable to make changes to the staffing rota as the responsible individual had advised that this was only to be done by one of the home’s team leaders. This team leader had been given confidential information about another member of staff, which the manager agreed was not appropriate. They had also been involved in the recruitment of a staff member who was to work in the housekeeping team, yet the housekeeping team leader had not been involved. This arrangement prevents the manager from revising rotas as they see fit to ensure the smooth and safe running of the home. It also provides staff with a lack of clarity regarding the lines of accountability within the home.

4. We saw that a CCTV camera had been installed in the laundry room. The manager and laundry worker were unclear about its purpose and believed it may have been installed by the responsible individual as a fire safety precaution. The manager was not aware whether a CCTV policy was in place. Shortly after the inspection, CIW requested that the responsible individual provide a rationale for the use of the camera and a copy of the home’s CCTV policy; these are yet to be provided. This event highlights the manager’s lack of involvement in decision making about matters relating to the running of the home. It also indicates a breakdown in communication between the manager, responsible individual and wider staff team.

5. The home’s system for monitoring, reviewing and improving the quality of care being given is not robust.

We found that the responsible individual had not completed reports every three months following formal visits to the home, during which service standards must be assessed (Regulation 27). Since February 2018, three reports had been produced. It was not clear from two of these reports what feedback had been gathered from residents regarding their care and support, as is required by regulation. The only reference made within these two reports related to residents’ views about environmental upgrades.

We requested a copy of the report from the home’s annual quality of care review (Regulation 25), although the manager was unable to provide this. We were told the report had been completed by the responsible individual and there was not a copy available at the home.

There was no system in place for routinely auditing the completion of people’s monitoring charts. This had been previously recommended by CIW and commissioners. The manager told us he had reviewed monitoring charts during a recent shift at the home, but had not recorded his findings. Records showed that the clinical lead had audited food and fluid monitoring charts for people during September and October 2018, although there was no evidence that all monitoring charts were being routinely audited.

There was no evidence that the responsible individual had considered any complaints received during his formal visits to the home. The manager did not believe any formal
complaints had been made whilst he had been in post, although was unable to locate the designated complaints file. We were provided with a complaints procedure that had last been reviewed in February 2014 and a complaints management policy that was dated 17 December 2014. We saw inconsistent information within these documents regarding who complaints should be reported to and what the timescale was for resolving them (Regulation 23B(1)). CIW details were also inaccurate. We saw evidence that the manager was in the process of reviewing and updating all of the home’s policies and procedures.

We noted that there was limited progress in implementing an electronic care planning system. The responsible individual’s report from February 2018 anticipated that the system would be operational by June 2018. However, subsequent reports showed that the work to set up the system had been more time consuming than expected and that additional resources were needed to ensure it was implemented by the end of 2018. At the time of the inspection, the electronic care planning system was not in use for those people requiring nursing care; it was only in use for people requiring personal care.

The failure to effectively review standards of practice has meant that progress has been very slow. There is little evidence that people have been involved in defining and measuring the quality of care and support they receive. Those using the service may lack confidence that action will be taken to drive improvement where necessary.

6. Administration systems are disorganised. We found that many key documents could not be provided upon request. The home’s statement of purpose had recently been updated by the manager and responsible individual. However, a copy was only held by the responsible individual and not available at the service. This was forwarded to CIW shortly following the inspection.

There was no evidence that the resident guide had been updated since 2011.

We saw that the manager’s hours were not being recorded on staffing rotas. This provided an inaccurate picture of those working at the home and prevented staff from seeing when the manager was available. Although staff knew who to contact if they needed support out of hours, there was no formal process in place for new or agency workers to refer to if needed.

The filing of documents within staff personnel files was poor. They did not appear to have been filed in date or type order, making it difficult to identify where particular records were kept. One staff member’s application form and references could not be located.

The lack of effective administration means that people using and visiting the service may not have access to the written information about the home they need. The service is unable to evidence compliance with regulation if records are unavailable and cannot be provided upon request.

7. This inspection was prompted by concerns from commissioners about the home’s failure to respond to requests in a timely manner. This included providing information as part of the provider performance review process. Failure to do so indicates an inability to work effectively with commissioners in delivering a safe, reliable service.

The evidence indicates the following:
The overall leadership and management of the service is not effective. 
- The lines of accountability are not clear and this has led to breakdowns in communication. 
- Staff are not receiving clear direction. 
- The quality assurance systems in place are not driving improvements within the service and ensuring compliance with regulation and minimum standards.

The impact for people using the service is as follows:
- People are not experiencing a consistent, reliable service; they may be unclear who to go to if they have any concerns.
- People may lack confidence in the service they receive; if things are not right they may not be dealt with quickly and appropriately.
- People’s health and well-being may be adversely affected by the home’s failure to meet legal requirements and implement any necessary safeguards.
- Staff are not being given clear direction and this may affect the quality and consistency of their practise.
Leadership and Management

Non-compliance identified at this inspection

<table>
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<tr>
<th>Timescale for completion</th>
<th>05/04/19</th>
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<table>
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<tr>
<th>Description of non-compliance/Action to be taken</th>
<th>Regulation number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The registered persons have failed to ensure that staff are recruited in a manner that promotes people’s safety and well-being. The registered persons must ensure that full and satisfactory information is available in respect of all persons working in the home, in order to determine their suitability for employment.</td>
<td>19 (2) (d) [i]</td>
</tr>
</tbody>
</table>

Evidence

The service is non-compliant with Regulation 19(2)(d)(i) of The Care Homes (Wales) Regulations 2002.

This is because staff have not been recruited in a manner that promotes the safety and well-being of the people living in the home.

Two inspectors carried out an initial inspection visit to the home on 19 March 2019, during which the personnel files of five members of staff were examined. We found that full and satisfactory recruitment information and documentation, as set out within Schedule 2 of The Care Homes (Wales) Regulations 2002, had not been obtained.

The evidence observed is as follows:

1. CIW and commissioners of the service had been made aware of an ongoing investigation relating to the practice of one of the nurses working at the home; this had started whilst the nurse was working in another care setting. The home had requested a written reference from the nurse’s last employer on 22 October 2018. This was not received until 21 February 2019, yet the nurse had accepted an offer of employment at the home on 30 October 2018. The responsible individual had interviewed the nurse on 21 October 2018, prior to them submitting an employment application form on 22 October 2018. The brief handwritten interview notes did not include details of the issues relating to the nurse’s practise, or a clear assessment of their suitability for employment in light of the ongoing investigation. There was a 15 year unexplained gap in the nurse’s employment history. The file did not contain a recent photograph. The manager told us the nurse was not left in sole charge of the home, yet there was no evidence of this decision making within their records. There was a Disclosure and Barring Service (DBS) certificate on file that had been requested by an employer that was not listed in the nurse’s employment history; this did not appear to have been identified or followed up.
There was no evidence that this nurse had received formal, individual supervision since they started employment.

2. There was no application form in one staff member’s personnel file. As such, no education or employment history was available for this staff member at all. Neither were there two written references or a recent photograph.

3. There was only one written reference for another nurse. Although we were told by the manager that a recent DBS check had been carried out, this had not been evidenced within their records. Similarly, the current Nursing and Midwifery Council (NMC) registration status of the nurse had not been evidenced within their records.

4. There were inadequate written references in another staff member’s file. The designation of one of the referees was not stated and the second reference had not been signed or completed in full. There was no evidence that these references had been verified.

The evidence indicates that robust recruitment procedures have not been followed.

The impact for people using the service is:

- They are being cared for by workers whose suitability for employment has not been carefully considered.
- As such, the provider is not ensuring that, as far as possible, people are cared for by a safe workforce.
- This increases the risk of people being harmed or neglected.
**Leadership and Management**

<table>
<thead>
<tr>
<th>leader of the organization</th>
<th>Our Ref: NONCO-00007548-HQJY</th>
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<tbody>
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<td>Non-compliance identified at this inspection</td>
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<td>Timescale for completion</td>
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<tbody>
<tr>
<td>Staff working at the home are not receiving two monthly supervision or annual appraisals of their performance. The registered persons must ensure that all persons working at the home are appropriately supervised.</td>
<td>18 (2)</td>
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</table>

**Evidence**

The service is non-compliant with Regulation 18(2) of The Care Homes (Wales) Regulations 2002.

This is because staff are not receiving two monthly supervision or annual appraisals of their performance, in line with National Minimum Standards 24.3 and 24.6 of the National Minimum Standards for Care Homes for Older People.

The evidence observed during inspection visits carried out on 19 March 2019, 26 March 2019 and 27 March 2019 is as follows:

We reviewed five staff files and found the following:

- One staff member had not received formal, individual supervision since their employment in October 2018.
- One staff member had received formal, individual supervision in December 2018. This was their only supervision since July 2017. There was no evidence they had received an annual appraisal of their performance.
- One staff member had received two formal, individual supervisions during 2018. These had been carried out in September 2018 and December 2018. There was no evidence they had received an annual appraisal of their performance.
- One staff member had received formal, individual supervision in July 2018 and December 2018. There was no evidence they had received an annual appraisal of their performance.
- One staff member had received formal, individual supervision in July 2018 and December 2018. There was no evidence they had received an annual appraisal of their performance.

The manager confirmed that staff had not received an annual appraisal since his appointment in January 2018. A template had been devised by a nurse consultant who had worked at the home, although appointments had not been made for staff to have their appraisals as expected.

The manager’s electronic supervision planner showed that the majority of staff had received formal, individual supervision during the summer of 2018. However, the manager confirmed that these had been carried out ad hoc since then due to the volume of his workload. Two staff members told us they had received supervision twice in the last year and two staff members told us they had received supervision once in the last year. The manager told us the responsible individual had agreed for a nurse consultant to support the home in carrying out
regular staff supervision sessions, although this consultant had not worked at the home since November 2018. The manager did not know if or when the nurse consultant would be carrying out further work at the home.

We noted that the manager, who did not have relevant clinical experience, had carried out the clinical lead’s latest supervision. CIW and commissioners had been told that the clinical lead would receive supervision from a nurse consultant. The manager told us this had not taken place. The clinical lead confirmed they had not received formal clinical supervision at the home and generally received support with clinical issues from the local health board.

The manager was unable to recall when they had last received formal, individual supervision from the responsible individual. We requested that the responsible individual provide copies of the manager’s last three supervision records, as these were not available for inspection at the home as required. CIW is yet to receive these records.

The evidence indicates that staff have not been appropriately supervised.

The impact for people using the service is as follows:

- Staff are not being adequately supported to continually develop personally and professionally. This may prevent them from maximising their potential and improving their practise.
- Staff may feel demotivated and undervalued, which could affect staff retention and continuity of care for people.
- Any staff performance issues may not be identified and acted on appropriately; this may adversely affect the quality of care and support people receive.