Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Dyserth Care

The Old Manor
Waterfall Road
Dyserth
Rhyl
LL18 6DB

Date Inspection Completed

09/09/2019

Description of the service

Dyserth Care is a care home service located in the village of Dyserth close to all local amenities. The home provides care and support for up to 26 people. The responsible individual (RI) is Mrs M. E. Goddard.

Summary of our findings

1. Overall assessment

The quality of the care and support provided at Dyserth Care is inconsistent. Pre-assessment documentation, personal plans and risk assessments were not always in place for people and some contained conflicting information, or were partially completed. Overall, people were happy with the care and support they receive from caring and familiar staff. People are positively encouraged to partake in activities and/or in daily living tasks to increase their independence.

The lack of effective systems in place by the service provider to oversee and improve the service must be strengthened. An enhanced quality assurance system will afford the service provider more prompt and effective oversight of the management, quality, safety and effectiveness of the service. At the time we visited, the service was operating without an appointed manager.

2. Improvements

This is the service's first inspection under the new legislation – Regulation and Inspection of Social Care (Wales) 2016.

3. Requirements and recommendations

Section five of this report sets out our recommendations made to improve the service and the areas, where the care home is not meeting legal requirements. These include the following:

- Care and support;
- Fire safety;
- Supporting and developing staff and
- Leadership and management

1. Well-being

Our findings

People are treated with respect and sensitivity. We observed people being supported by enthusiastic and a committed staff team who actively listened to, and communicate with, in a courteous and respectful manner. People spoken with told us they were happy living in Dyserth care and were satisfied with the standards of their care and support. Comments included "*I've come a long way since living in a stable environment*", *the staff have really helped me*" and "*staff are good fun*". People have positive relationship with staff.

People are not always supported with their physical, mental health, emotional and social well-being. We did not evidence that care and support was discussed with individuals receiving a service or their relatives/representatives. Pre-assessment documentation and personal plans were not always available, or did not provide clear action required by staff to meet the individual's well-being, care and support needs on a day-to-day basis. Policies and procedures did not always provide up-to-date and clear guidance for staff, to follow and comply with. Although staff spoken with told us they felt supported and worked well as a team, documentation did not always support this. Staff have access to core training but there is a lack of specific training to support people with their individual mental health needs and health conditions. Although the service provider visits the service most days we did not evidence they had effective arrangements in place to drive continuous improvement. The service provider must be accountable for both the service quality and compliance to ensure the well-being of people is maintained.

People's safety is inconsistent. Risk assessments did not always provide staff with sufficient information to ensure people's needs, were met in a safe and effective way. Staff did not always know what to do if they suspected people were at risk in relation to their mental health or specific health needs. We did evidence Deprivation of Liberty Safeguards (DoLS) applications were completed and requests for review made when required. However, the requests and other incidents were not reported to Care Inspectorate Wales (CIW). Staff have received training in relation to safeguarding and had good knowledge of what they would do if they had any concerns. However, the service's policy and procedure in relation to safeguarding was not up-to-date or aligned to current legislation, national guidance and local safeguarding procedures. The service did not have a complaints policy and procedure in place and at the time of inspection did not have an effective system to log complaints or concerns. Overall, improvement is needed to ensure people are safe and protected from abuse and neglect.

People live in a homely and lively atmosphere. The service is located within easy access of the town and other facilities. People told us they often access the local community independently or with staff. On the day of inspection, the home was clean, tidy and warm and we observed people take part in household chores. A part time domestic is employed

at the home to ensure standards of cleanliness are maintained. People spoken with were happy with their bedrooms and overall environment. We did see poor practices in relation to fire safety and this is an area, which requires urgent improvement. Overall, people live in accommodation, which meets their individual needs. However, improvement is needed to ensure the health and safety of the people living in the service, staff and visitors.

2. Care and Support

Our findings

People are insufficiently assessed and relevant information is not always gathered to consider, if their individual needs can be met by the service. 'The admission of residents' procedure' did not have a date, was not specific to the service and was referring to 'nursing manager'. We reviewed the statement of purpose (SOP) and noted a summary of the admission procedure is not included. We reviewed three care files, two of which had incomplete and insufficient information within their pre assessment documentation and one did not have an assessment at all. The assessments we reviewed, did not evidence the service provider had taken into account people's views, wishes and feelings or any risk to the individual's well-being, or to other individuals to whom care and support is provided. It was also noted that the service provider had not obtained copies of or gave consideration to any existing care and support plans or involved the individual and/or their relatives/representatives to determine what matters to them. It was not clear on the day of inspection who was responsible for conducting the pre-admission assessments. We were told, "*It's sometimes a senior carer or the owner".* We discussed this with the RI who confirmed it was a senior carer however; documentation did not support this as one pre-assessment was signed as being completed by a carer. We did not evidence that the senior carer or carer had received training in carrying out of assessments. This area of practice requires improvement. People cannot be assured that the service provider considers a wide range of information to confirm the service is able to meet their individual needs, and support them to achieve their personal outcomes.

People cannot be assured that staff have access to accurate personal plans and risk assessments, which give clear and constructive guidance for staff to follow, to ensure the safety and well-being of individuals. We did not evidence that personal plans had been developed, co-produced with the person receiving a service or their relatives/representatives. Therefore, important information about what matters to them was not always apparent. We reviewed three care files and found they did not have an up to date, accurate personal plan in place for how people's care is to be provided. Personal plans did not detail how people's care and support needs would be met by staff on a day-to-day basis. We did not evidence staff were checking or documenting any concerns. For example a personal plan evaluation completed by staff documented 'no concerns' from January 2019 – August 2019 despite Betsi Cadwaladr University Health Board (BCUHB) transfer of care document stated 'pressure areas checked, yes, redness beneath stomach fold dated 14 April 2019. We reviewed a care file for the most recent admission dated 31 July 2019, we did not evidence that all information in relation to their behaviour and relapse indicators had been transferred into their personal plan. Staff spoken with were not fully aware of condition or symptoms. It was also noted that a person's 'nutrition' personal plan did not mention diabetes despite this being in the persons pre-assessment and discharge

advice letter. The same care file had numerous personal plans that were uncompleted. For example, personal plan for 'psychological and emotional needs' was blank despite a person having a specific mental health diagnosis. Personal plan evaluations were being completed by staff but what they were evaluating is unclear. The review of personal plans must be reviewed in a meaningful way taking into account people's changing needs. We conclude that staff do not have sufficient or accurate information to follow and provide appropriate and safe care, and therefore people do not always experience enhanced well-being from the care and support received. As a result, we have issued a non-compliance notice in relation to standards of care and support, further details can be found in the attached notices.

People have access to activities and can generally do things that matter to them. We saw people come and go throughout our visit with some returning from being out to the local community. One person we spoke with stated "*I enjoy making things and a lady comes every fortnight to do arts and craft with us".* This person was keen to show us their flower art work which was displayed in the dining room. Other comments from people living in the home included "*I can come and go as I please*", "*I went to Emmerdale recently it was good*" and "*I love bingo*". We saw various pictures of people participating in different activities including day trips to Blackpool and Emmerdale. On the day of inspection we observed people participate in Bingo. Staff were very enthusiastic and encouraged people to take part, which they responded well to. We saw an external arts and crafts person visit the home during the afternoon, which we observed to be very popular with the people living in Dyserth Care. Our observations concluded that people were very willing and excited in participating. People were laughing and smiling and engaged well with the person holding the session. The arts and crafts person told us they visit the home regularly but people do comment they would like to see them more often. We recommend the service provider considers enrolling onto the Cartrefu, Age Cymru's arts in care homes project, which focuses on empowering care home staff to improve the range and quality of creative provision in their service. People can be involved in activities should they choose to participate.

3. Environment

Our findings

People receive care and support in a clean and homely environment. Upon arrival we saw numerous items being stored outside the home, for example an old mattress and a toilet. By the time we left the home these items had been removed and taken away. We saw the dining room and kitchen to be clean, tidy and free from hazards. We observed people complete daily living tasks within the home, which encouraged independence and gave people a sense of achievement and ownership of their surroundings. We viewed 10 bedrooms and found they were all personalised to varying degrees and contained personal items, that were of importance to people living in the home. Each person we spoke with were happy with their bedroom, with some keen to show us which bedroom were there's. It was noted that one bedroom which had an adjoining lounge had an old mattress, headboard and broken blinds being stored there. This was discussed with the RI who assured us they were in the process of removing the items. On the day of inspection professional cleaners were present and were in the process of deep cleaning a person's bedroom carpet. Communal bathrooms were clean and hot water was available in all areas of the home. On the day of inspection, the heating was on and the home was warm. People we spoke with told us that hot water was sometimes not available during the morning and that the home was sometimes cold due to the heating not working. We recommend the service provider reviews its hot water and heating system on a regular basis to ensure people have access to hot water and warmth at all times.

We reviewed a sample of health and safety records relating to fire safety and infection control. On the day of inspection we did not, evidence the service had an appropriate fire risk assessment in place specific to the home. An undated fire policy was in place but it was not specifically for Dyserth Care. We also noted that a smoking room was adjoined to the main lounge. We did not evidence a specific risk assessment in relation to this smoking area. We saw Raven Fire and Security had tested the fire alarm, fire extinguishers, and emergency lighting in May 2019. We viewed the documentation for fire safety and saw that regular testing of equipment was completed consistently. It was noted that emergency evacuation drills had not been carried out despite the fire policy stating 'evacuation drills 6 monthly'. Fire drills should be completed during the day and night to ensure all staff understand and are familiar with the emergency evacuation procedure. This will also enable the service to evaluate the effectiveness and identify any weaknesses in the evacuation plan. Each person living in the home had a personal emergency evacuation plan (PEEP) which gave staff and overview of what assistance each person may require during the event of an emergency. It was noted during our inspection that some bedroom doors were being wedged opened with ornaments, flip-flops and personal items for example a moisturiser tub. This is a serious fire safety risk. We strongly recommend the service provider invests in fire door retainers, which comply with fire safety regulations. A review of

the staff training matrix did evidence that staff had received training in relation to fire safety on the 21 November 2018. We reviewed the infection control, food safety and hazards policy and procedures dated 19 July 2019 and found this to be aligned with current legislation and guidance. Staff spoken with were aware of the policy and safe working practices. However, it did state in the food policy in relation to training ‘Intermediate level all cooks involved in the running of kitchen and supervision of other staff’. We did not evidence that the cook that was working on the day of inspection or the staff that were responsible for the kitchen in the week had receive ‘intermediate level training’. We saw cleaning programmes were in place and domestic staff spoken with confirmed they had received appropriate training and had access to appropriate equipment. All control of substance hazardous to health (COSHH) were stored safely. We reviewed personal protective equipment policy and procedure and noted it was relating to another service. We recommend that the service provider invest in paper towels as they were not always available. This will reduce the risk of cross infection.

We conclude people live in a clean and homely environment, which they are happy with. However, fire safety within the home is inconsistent. As a result, we have issued a non-compliance notice in relation to health and safety; further details can be found in the attached notices.

4. Leadership and Management

Our findings

The well-being of people using the service is not promoted through effective and sufficient leadership and management. On the day of inspection the service was operating without an appointed manager to manage the delivery of the service on a day-to-day basis. We did not evidence the RI had made suitable arrangement in place in relation to the management of the home. The service has not had a manager in post who is appropriately qualified, registered with Social Care Wales or had the relevant experience in managing care services since May 2018. We conclude the RI has not put suitable arrangement in place, to ensure the service is overseen effectively by a deputising system, which if competent to provide leadership on a day-to-day basis. As a result, we have issued a non-compliance notice in relation to duty to appoint a manager; further details can be found in the attached notices.

People receive care and support from staff, who have access to regular core training; however, improvement is needed in relation to specific training to meet people's individual needs. We reviewed staff training documentation and saw staff had completed training relating to safeguarding, deprivation of liberty safeguards (DoLS), mental capacity, manual handling, first aid, fire, medication, food hygiene, COSHH, infection control and health and safety. Staff spoken with had a good knowledge of the above topics and what good practice was. We were told that refresher training was provided every year and staff were satisfied with the frequent and quality of the training. Despite regular training being provided to staff, we saw that at times, between two to four training topics had been completed on the same day. We strongly recommend the service provider invest in looking to complete more detailed and in depth training sessions in the future. It was also noted that many of the people living in the home had complex mental health needs, challenging behaviour, learning disabilities and three people we case tracked had diabetes. Despite this we did not evidence staff had received training in mental health, learning disabilities or diabetes and only two staff members had completed training in challenging behaviour. The statement of purpose (SOP) states 'staff are trained by experienced and qualified senior staff, utilising both in house and external training methods. Mental health training is carried out to ensure the best possible care for each individual is met'. The SOP also states that training in 'fluid and nutrition' and 'learning disabilities'; is carried out, we did not evidence this. This area requires improvement. It was also noted that staff do not receive competency assessment for the management of medicines on a regular basis. This should be implemented immediately to ensure staff are competent to handle medication in a safe and effective manner on an ongoing basis. We conclude staff do not always have access to specific training to provide care and support in-line with people's individual needs.

People benefit from a service where staff are safely recruited, however improvement is needed in relation to staff supervision. We reviewed four staff files and found the required recruitment process were being followed. This included obtaining all the required pre-employment checks, such as, references from previous employers and checks with the Disclosure and Barring Scheme (DBS) all were found to be satisfactory. We reviewed the 'staff supervision and appraisal planner 2019' and saw that not all staff had received supervision in line with legislation. We discussed this with The RI who stated that supervisions had been completed. Despite this records did not evidence this. For example eight staff members on the planner have not received any supervisions what so ever and the remaining staff have, but with significant gaps over the year. We saw some good practice in relation to staff annual appraisals, which provided staff with feedback on their performance. This practice should relate to all staff. We conclude that, although staff feel supported in their role, documentation did not always evidence this. This area requires improvement.

The service provider does not have clear arrangements for the oversight and governance of the service. We did not evidence that the RI had put suitable arrangements in place to establish and maintain a system for monitoring, reviewing and improving the quality of care and support provided by the service. We reviewed 'residents satisfaction questionnaires' completed in September 2019, all of which were positive. However, we did not evidence the RI had engaged and received feedback from relatives/representatives of the people receiving a service, staff or commissioners. On completion of the 'residents satisfaction questionnaires' we did not evidence that a report had been completed or any follow ups on the responses received, from people using the service to drive continuous improvement. We did not evidence that staff were underpinned by professional development, to meet the care and support needs of individuals and there was no evidence of any quality and audit systems to review progress, and inform the development of the service. Staff and people living in the home told us that they see the RI on a "*daily basis*" and we did see a log of when the RI visits the home. The RI had completed a formal visit in March 2019, but we could not evidence a visit had been conducted since re-registering under the new legislation in May 2019. The RI must inspect the premises, a selection of records of events and any complaints records every three months. Such visits must ensure systems are in place to provide evidence that visits are fully documented. We conclude the service provider has not put sufficient governance arrangements in place, to support the smooth operation of the service, and to ensure there is a sound base for providing high quality care and support for the individuals using the service, and to enable them to achieve their personal outcomes. This area requires improvement.

We conclude the service provider does not provide assurances that the service is well run and complies with regulations. As a result, we have issued a non-compliance notice in relation to supervision of management of the service; further details can be found in the attached notices.

5. Improvements required and recommended following this inspection

5.1 Areas of non compliance from previous inspections

None

5.2 Recommendations for improvement

We have identified the following breaches in regulation, which the register provider must address.

- Regulation 21 in relation to standards of care and support. The service provider must ensure that the care and support is provided in a way, which protects, promotes and maintains the safety and well-being of individuals.

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

- Regulation 66 in relation to supervision of management of the service. The service provider must have systems and processes in place to enable proper oversight on the management, quality, safety and effectiveness of the service.

- Regulation 67 in relation to duty to appoint a manager. The service provider must appoint a person to manage the service who is appropriately qualified, is registered as a social care manager with Social Care Wales and is experienced in managing care services and in the provision of the type of care being provided.

We recommend the following:

- The statement of purpose needs to be updated to ensure all relevant information is included and it provides sufficient information to accurately reflect the service.

- A British National Formulary (BNF) must be available within the home. This information will provide staff with specific facts and details about medication.

- Staff must receive competency assessment for the management of medicines. This will ensure staff are competent to handle medication in a safe and effective manner on an ongoing basis.

- We recommend the provider considers enrolling onto the Cartrefu, Age Cymru arts in care homes project, which focuses on empowering care home staff to improve the range and quality of creative provision in their service.

- The service provider must notify the service regulator of the events specified in Parts 1 and 2 of schedule 3. Notifications must be made without delay, usually within 24 hours of the event occurring.

- Old furniture and mattresses should be disposed of correctly.

- Hot water and heating system must be reviewed on a regular basis to ensure people have access to hot water and warmth at all times.

- The service provider must invest in paper towels to reduce the risk of cross infection.

6. How we undertook this inspection

This was a full inspection undertaken as part of our inspection programme. Two inspectors made an unannounced visit to the home on 12 August 2019 between 9:00 am and 4:30 pm.

The following regulations were considered as part of this inspection:

- The Regulated Services (Services Providers and Responsible Individuals) (Wales) Regulations 2017.The following methods were used;
- We used the Short Observational Framework for Inspection (SOFI). The SOFI tool enables inspectors to observe and record care to help us understand the experience of people who cannot communicate with us.
- We toured the building and looked in 10 bedrooms.
- We spoke to 10 people living in the home, five staff members, RI and two external professionals.
- We gave feedback to the RI the day after the inspection.
- Additional information was obtained from the previous CIW inspection report.
- We looked at information contained in recent concerns sent to CIW anonymously.
- We looked at a wide range of records. We focused of three care files and associated documentation, four staff files, supervision and appraisal documentation, training documentation, staffing rotas, a selection of policies and procedures, health & safety files, infection control and fire safety file.
- We reviewed medication practices within the service.
- We reviewed the SOP and compared it with the service we observed.
- We issued questionnaires to people receiving a service, relatives, staff and professionals. We did not receive any questionnaires back.

CIW is committed to promoting and upholding the rights of people who use care and support services. In undertaking this inspection, we actively sought to uphold people's legal human rights

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

About the service

Type of care provided	**Care Home Service**
Service Provider	**Mair Goddard**
Registered maximum number of places	**26**
Date of previous Care Inspectorate Wales inspection	**06/12/18**
Dates of this Inspection visit(s)	**09/09/2019**
Operating Language of the service	**Both**
Does this service provide the Welsh Language active offer?	This is a service that does not provide an 'Active Offer' of the Welsh language. We recommend that the service provider considers the Welsh Government's 'More *Than Just Words follow on strategic guidance for Welsh language in social care'.*
Additional Information:	

Date Published 04/10/2019

Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

Non Compliance Notice

Care Home Service

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

Dyserth Care

The Old Manor
Waterfall Road
Dyserth
Rhyl
LL18 6DB

Date of publication: Friday, 4 October 2019

Care and Support	Our Ref: NONCO-00008404-PRLH
Non-compliance identified at this inspection	
Timescale for completion	**04/11/19**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with 'The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017' 21 (1) in relation to care and support.	21(1)

Evidence

- The service provider is not compliant with regulation 21 (1).

- This is because the service provider has failed to ensure that care and support is provided in a way, which protects, promotes and maintains the safety and well-being of individuals.

- The evidence:

We did not evidence that the senior carer or carer had received training in carrying out of assessments.

We reviewed person A's care file:

- Pre-assessment documentation was insufficiently completed.
- We did not evidence any personal plan in relation to pain in oesophagus when swallowing despite this being states in their pre-assessment.
- They had a diagnosis on borderline personality disorder, we did not evidence that staff had received training in mental health or training specifically around borderline personality disorder. Staff spoken with confirmed that they had not received specific training in relation to this individual.
- We did not evidence a personal plan in relation to their type two diabetes.
- Personal plan for psychological and emotional needs was blank. Personal plan evaluations were being completed but it is unsure what staff were evaluating. Plan did not contain information about their specific mental health diagnosis.
- Personal plan for nutrition (food and drink) stated ‘sugar needs to be monitored’. We did not evidence any monitoring documentation. Staff spoken with confirm this is not monitored on any documentation.
- We did not evidence any personal plan for challenging behaviour.
- Personal plan for skin integrity stated ‘high risk, staff to support X to reposition at night or check has repositioned themselves’. Night checks by staff only stated either asleep or

awake. We did not evidence any re-positioning chart in place.
- Falls multifactorial assessment and falls history was blank. Evaluation did not consider all falls. No evaluation following latest falls.

We reviewed person B's care file:
- No pre-assessment had been undertaken.
- Personal plan for psychological and emotional needs stated ‘emotional when have appointments and likes staff to attend’. Feels nauseous before appointments. Outcome to be achieved – Support X when becomes emotional. Personal plan evaluation on the 24 July 2019 stated ‘X missed a hospital appointment due to being sick from feeling anxious, waiting for new appointment to come through’. The personal plan did not provide specific guidance for staff, to follow when person B gets anxious.
- Personal plan for nutrition food and drink stated ‘I have a normal diet, but I do have a sweet tooth and enjoy my desserts. X is insulin diabetic district nurse have advised only one desert a day as blood sugars were high’. The personal plan did not include monitoring diet or monthly weights to be documented despite Betsi Cadwaladr University Health Board (BCUHB) integrated care and support plan stating ‘carers to monitor what X eats to ensure diabetes is under control. Monthly weights to be documented. X would like to loose weight and is supported with this. This is not reflected in nutrition care plan. Staff spoke with confirmed that person B’s diet is monitored but it is not documented anywhere.
- Personal plan for skin tissue viability and wounds stated ‘I am insulin dependant diabetic, I have good skin tissue viability and don’t have any wounds. I can sometimes become sore under my stomach and groin area. Outcome: Staff to check X regularly for any redness to affected areas. GP will be called for topical creams if any soreness occurs’. We did not evidence that staff were checking person B’s skin.
- Basic falls risk assessment completed monthly with a total score for July and August 2019 was 6 (at high risk) despite this there was no personal plan, in depth risk assessment or guidance in place for staff to follow to reduce the risk of falls.
- We did not evidence that staff had received diabetes training. Staff spoken with confirmed they had not received this training.
- Personal plan for cognition and mental capacity stated 'I have learning difficulties'. We did not evidence staff had received training in learning disabilities.

We reviewed person C’s care file:
- Pre-assessment documentation was insufficiently completed. Assessment does not refer to any behaviour issues.
- They had a diagnosis bipolar affective disorder, we did not evidence that staff had received training in mental health or training specifically around bipolar effective disorder. Staff spoken with confirmed that they had not received specified training in relation to this individual.
- Discharge advice letter stated ‘escalating behaviour both with staff and in public’. We did not evidence staff had receive training in relation to challenging behaviour. Important information in relation to this individual that was stated in their discharge advice letter was

not transferred into their personal plans. Staff spoken with not fully aware of diagnosis or symptoms.

- Personal plan for cognition and mental capacity was blank. Personal plan for psychological and emotional needs was blank. Personal plan for personal care and oral care was blank. Personal plan for medical conditions and medication was blank. Personal plan for falls was blank. Personal plan for hobbies and interests was black. Personal plan for family and future wishes was blank.
- Personal plan for mobility and foot care was not dated singed or had an outcome to be achieved.
- Personal plan for nutrition was not dated, singed or had an outcome to be achieved. Their plan did not include information about their diabetes. We did not evidence that staff had received diabetes training. Staff spoken with confirmed they had not received this training.
- Personal plan for skin tissue viability stated ‘X has psoriasis, cream that is prescribed is to be applied to areas affected1 twice daily’. The plan was not dated, singed or had an outcome to be achieved. We reviewed person C’s medication administration record we did not evidence cream application’. Information from staff was unclear. Staff stated “cream application is not their responsibility and the person doing medication applies and records cream”.

The impact of people using the service is they cannot be assured, that their personal plans include sufficient detail, to inform and enable staff, to meet the individual's care and support needs, and support individuals to achieve the best possible outcome.

Environment	Our Ref: NONCO-00008412-PKKX
Non-compliance identified at this inspection	
Timescale for completion	**04/11/19**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with 'The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017' 57 in relation to health and safety.	57

Evidence

The registered person is not compliant with regulation 57.

This is because fire safety within the home is inconsistent.

The evidence:

- Four bedroom doors were seen to be wedged opened with ornaments, flip-flops and personal items for example moisturise tub.
- We did not evidence the service had a specific fire risk assessment in place for Dyserth Care.
- We did not evidence the service had a specific fire risk assessment for the smoking room adjoined to the main lounge.
- The last fire risk assessment audit was dated 2016 but it is unclear what the audit was based on.
- The SOP states 'a fire exercise is carried out periodically; this ensures all staff and service users have a comprehensive understanding of their responsibilities'. We did not evidence that fire evacuations and drills had been conducted throughout the year.

The impact on people using the service is they cannot be assured the service provider is following safe fire safety practices.

Leadership and Management	Our Ref: NONCO-00008419-VKLF
Non-compliance identified at this inspection	
Timescale for completion	**04/11/19**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with 'The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017' 66 in relation to supervision of management of the service.	66

Evidence

The registered provider is not compliant with regulation 66.

This is because people using the service do not benefit from a service provider who has effective systems and processes, to enable proper oversight of the management, quality, safety and effectiveness of the service.

The evidence:

- The service provider has not made suitable arrangements in place to ensure, that the service is managed effectively. Regulation 72.
- The statement of purpose (SOP) is a legal document, which should accurately reflect the services provided by the home. The SOP is not compliant with schedule 2 and is referring to another service. Regulation 7.
- We did not evidence the service provider had clear arrangement for an ongoing of quality assurance and review to provide assurances that the service operates in line with legal requirements. Regulation 80.
- The RI has not ensured that systems are in place to provide evidence that visits are logged and documented. Regulation 73.
- The service provider does not have sound management structure to oversee and monitor the service in order to ensure, that it operates safety and effectively for the individuals receiving care and support.
- We did not evidence the service had a complaints policy and procedure. Staff spoken with were not clear of the complaints procedure. The service provider must have a clear complaints policy and procedure available in the home, which is well publicised, readily available and accessible to individuals using the service, their families, significant others, visitors, staff and others working in the service. A written report must be provided to the complainant setting out the outcome of the complaint and any action to be taken. Records of any complaints and outcomes must be documented and kept securely at the service.

Regulation 64.

- Policies and procedures were either out of date, referring to the wrong regulations or were specific to other care home associated with the service provider. Regulation 79. For example:

Health and Safety policy was referring to another service associated with the service provider.
First aid policy was referring to another service associated with the service provider.
Challenging behaviour policy had not been up-dated since March 2018. This policy must be up-dated to ensure staff have access to an up-to-date policy, aligned to current legislation and national guidance, which will support them in their role.
Whistle blowing policy was referring to another service associated with the service provider and had not been up-dated, since August 2018. This policy must be up-dated to ensure staff have access to an up-to-date policy, aligned to current legislation and national guidance.
Personal protective equipment was referring to another service associated with the service provider.
Admission of residents' procedure was referring to anther service associated with the service provider.

- We did not evidence any staff meetings. Staff informed us that one had been undertaken a few weeks ago. Documentation around this meeting could not be found on the day of inspection.
- We did not evidence all staff had received one-to-one supervision. For example eight staff members on the 'supervision and appraisal planner' had not received any supervisions what so ever and the remaining staff had but with significant gaps over the year. Regulation 36.
- We saw a sample of completed supervision notes had been completed by a carer who is not a more senior member of staff.
- We did not evidence any residents meetings.

The impact on people using the service is that they cannot be confident that the service provider has clear arrangements for the oversight and governance of the service in order to establish, develop and embed a culture which ensures that they receive the best possible outcomes.

Leadership and Management	Our Ref: NONCO-00008424-BPST
Non-compliance identified at this inspection	
Timescale for completion	**04/11/19**
Description of non-compliance/Action to be taken	**Regulation number**
The service provider is not compliant with 'The Regulated Services (Service Providers and Responsible Individuals (Wales) Regulations 2017' 67 in relation to duty to appoint a manager.	67(1)

Evidence

The service provider is not complaint with regulation 67.

This is because the service provider has not appointed a person to manage the service.

The evidence;

- On the day of inspection the service was operating without an appointed manager to manage the delivery of the service on a day-to-day basis.
- We did not evidence the RI had made suitable arrangement in place in relation to the management of the home.
- The service has not had a manager in post who is appropriately qualified, registered with Social Care Wales or had the relevant experience in managing care services since May 2018. Previous to this the manager was on long term leave and therefore the service has not had an effective and competent deputising system to provide leadership on a day-to-day basis since 2017.

- The impact on people using the service is they cannot be assured that the service provider has sound structure in place to provide leadership on a day-to-day basis.