Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Care and Social Services Inspectorate Wales

Care Standards Act 2000

Inspection Report

Ty'n-Y-Coed Care Ltd DCA

Milford Haven

Type of Inspection – Full
Date(s) of inspection – Monday, 11 September 2017
Date of publication – (manually entered)

Summary

About the service

Ty'n-Y-Coed Care Ltd (DCA) is registered to provide personal care for adults aged 18 years and over. The service is co-located with residential services based at Ty'n y Coed Care Home in the village of Rosemarket. The Directors of Ty'n-Y-Coed Care Ltd (DCA) are Mark Beveridge and Colin Picton and the responsible individual is also Colin Picton. And the registered manager was Gareth Bevan.

At the time of the inspection the agency provided care and support to eight people living in four supported living houses. Fourteen members of day staff are employed by the agency and two members of night staff.

What type of inspection was carried out?

An unannounced inspection was carried out on 8 September, 28 September and 5 October 2017.

The following methodologies were used to inform the inspection:

- Discussion with the Responsible Individual
- Discussion with staff
- Scrutiny of three care files
- Scrutiny of seven staff files, including recruitment and supervision records
- Viewing of various documents, including the Statement of Purpose and Service User Guide
- Viewing of induction and training information
- Viewing of electronic manager's weekly reports
- Addressing concerns raised directly with CSSIW.

What does the service do well?

We did not identify any areas of good practice, over and above the National Minimum Standards for Domiciliary Care Agencies in Wales 2004.

What has improved since the last inspection?

No areas of non compliance were identified at the last inspection.

What needs to be done to improve the service?

The registered person is not compliant with Regulation 13 (a) and (b). This is because suitable arrangements were not in place to ensure that the agency was conducted so as to ensure the safety of service users and to safeguard them from abuse.

This is a serious matter and a non compliance notice was issued to the registered person in relation to the above.

The registered person was also advised that they were not compliant with Regulation 16 2(a). This is because training records evidenced that staff required updated training in a number of areas.

A non compliance notice was not issued on this occasion as we did not identify any significant impact for people using the service.

Quality Of Life

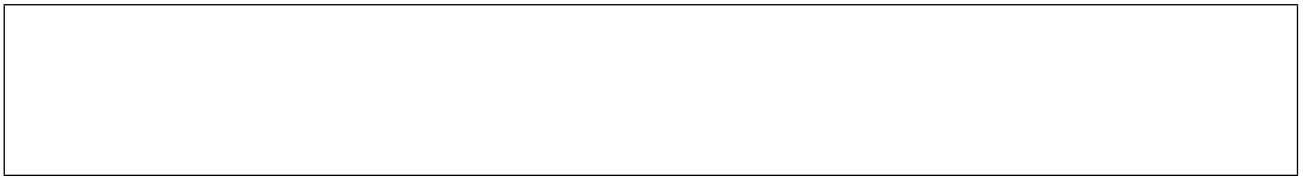
As part of the inspection we considered the care files for three people. We examined a sample of care documentation, including the service delivery plans, risk assessments and reviews.

People generally can have confidence that their preferences are respected. Care is provided to people within four supported living houses and a dedicated staff team provides support to each house. People are therefore very familiar with the staff who care for and support them and staff demonstrated through discussion that they have a good knowledge of the needs and preferences of each individual. Care is provided over a twenty four hour period with time built in for handovers. There were therefore no instances of late or missed calls.

People are supported by staff who have knowledge and understanding of their care needs and how they like to be cared for. This is because care plans viewed at this inspection provided guidance to staff on how to care for a person and were person centred. We examined three people's care plans and risk assessments. Staff we spoke with also gave good information about individuals and said that they felt that people's needs were met. Files examined had been reviewed monthly and updated appropriately. Risks associated with the delivery of care had been identified and all files examined contained detailed risk assessments which covered all aspects of the person's daily living experience, including activities undertaken within their homes and in the wider community. Local Authority care plans were contained in all files seen. A clear medical history was contained in all files observed and evidenced that people accessed a wide range of medical services appropriately. Care plans and risk assessments were focused around people's needs and abilities and there was a focus on assisting people to achieve greater independence. We spoke with a person who used the service who relayed that they valued the independence in their current living arrangement. They also conveyed that they felt that the level of support being provided was sufficient and that "the staff are great". However, serious concerns have been raised about the care practices of staff in one area of service provision and the negative impact that this has had on people. This is currently being investigated through Local Authority Safeguarding processes.

The acting manager demonstrated that they were fully aware of the support needs of the people using the service and was able to convey information which was relevant to both the service and to the person. We noted that the providers had recently attended a multi disciplinary team meeting in relation to a person using the service which gave further assurance that the person's current needs were being addressed.

People receive a consistent service with continuity of the same carers. Staff have been trained to communicate effectively with people. We viewed the use of Total Communication and were informed that four staff members were also learning British Sign Language. We observed staff communicating and interacting with people in an appropriate, respectful and sincere manner throughout the inspection.



Quality Of Staffing

Generally people are being cared for by motivated staff who are appreciated and want to make a positive difference to people's lives. We spoke with staff who told us that the management team was "*very helpful"* and that working for the organisation was *"rewarding – very good".* All staff spoken with said that they felt they had received sufficient training for them to carry out their jobs effectively. Staff received a comprehensive period of induction training. An informative staff handbook which outlines policies and procedures is provided to all staff on commencement of their employment. Staff are provided with a range of training and development opportunities. Training files demonstrated that training varied between being provided 'in house' and by external training providers. The training matrix and individual training records evidenced that most people had received up to date training in mandatory areas. Staff informed us that the provider was very responsive to any specific training requests in order to continue to meet the changing needs of people who use the service, for example, staff had been trained in positive behaviour management, diabetes care, total communications, report writing and confidentiality and four staff had pursued a course in British Sign Language in order to meet the specific needs of a service user. There were a number of instances where mandatory training had lapsed and the responsible individual, deputy manager and HR manager gave assurances that these were scheduled to be completed. Training sessions were being carried out during the inspection.

People who use the service can be assured that robust recruitment processes are in place. Six staff files were examined. All contained a recent photograph, evidence of a criminal record check and appropriate references. Each person employed was given a three month probation period and we found that staff turnover had until recently been low. As a result of the recent concerns regarding staff practices a number of staff have left the service. The registered provider has been proactive in recruiting new staff. In order to provide increased support and continuity of care the induction and probation period for all new staff has been improved. People can therefore be confident that the staff that are supporting them are properly vetted prior to commencing duties.

Staff files evidenced that staff had generally received supervision every three months but that this was not the case in every instance. In one instance there was a gap of some nine months. Where supervisions had taken place they were seen to contain pertinent information including identification of training needs. However, where staff had raised issues there was no feedback to staff regarding actions taken and on occasions there was no evidence that any action had been taken.

We noted that good relationships had been developed with a wide range of relevant professionals including the specialist occupational therapist, communication support worker, senior behaviour practitioner, consultant in epilepsy, consultant psychiatrist, GPs

and community health teams. This evidenced that staff worked proactively to ensure that people's health needs were anticipated and met in a timely manner. .

Quality Of Leadership and Management

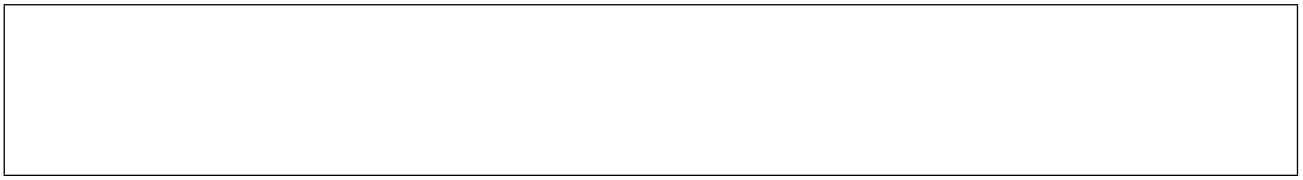
At the time of the inspection the registered manager had not worked at the service for approximately a month. The deputy manager was employed as acting manager and was being supported by the Responsible Individual.

Although the Responsible Individual visits the agency offices very frequently and is well known to staff and to service users there was no evidence that the service had been audited on a regular basis or that the Responsible individual had a system for regularly reviewing the quality of the service. The Responsible Individual described ways in which the registered provider was committed to continuous improvement but there was not able to produce evidence to support this. The registered person is therefore non compliant with Regulation 23. The Responsible Individual gave assurances that he would instigate policies and procedures to improve the ongoing monitoring and auditing of the service.

Overall people cannot be confident that staff receive effective supervision and that the concerns that they raise are acted upon appropriately. We examined supervision records of seven staff members and noted that supervision did not consistently take place.

Further, the supervision records showed that staff had raised significant concerns in December 2016 and on numerous subsequent occasions with the registered manager and that they had failed to address these. As there had been no audit of supervision documents by the responsible individual, or an appropriate person acting on his behalf, a direct consequence of the matters identified had remained unresolved, thereby placing people who use the service at potential risk of harm and therefore the registered persons had failed to make suitable arrangements to ensure that the agency is conducted so as to ensure the safety of service users and to safeguard them from abuse and is therefore in breach of Regulation 13 (a) and (b).

As a result the Responsible Individual has reviewed and amended the whistleblowing policy to ensure that staff know the correct avenues by to disclose information. We were also given assurances that all staff were to receive training updates in mandatory areas, with emphasis on Safeguarding in order for staff to have a better understanding of their responsibilities in the protection of vulnerable people. This had commenced during the period of the inspection. The Responsible Individual gave assurances that the system of supervision will be improved to ensure that concerns are acted upon and feedback provided to staff.



Quality Of The Environment

The quality of the environment was not considered at this inspection.

How we inspect and report on services

We conduct two types of inspection; baseline and focused. Both consider the experience of people using services.

- **Baseline inspections** assess whether the registration of a service is justified and whether the conditions of registration are appropriate. For most services, we carry out these inspections every three years. Exceptions are registered child minders, out of school care, sessional care, crèches and open access provision, which are every four years.

  At these inspections we check whether the service has a clear, effective Statement of Purpose and whether the service delivers on the commitments set out in its Statement of Purpose. In assessing whether registration is justified inspectors check that the service can demonstrate a history of compliance with regulations.

- **Focused inspections** consider the experience of people using services and we will look at compliance with regulations when poor outcomes for people using services are identified. We carry out these inspections in between baseline inspections. Focused inspections will always consider the quality of life of people using services and may look at other areas.

Baseline and focused inspections may be scheduled or carried out in response to concerns.

Inspectors use a variety of methods to gather information during inspections. These may include;

- Talking with people who use services and their representatives
- Talking to staff and the manager
- Looking at documentation
- Observation of staff interactions with people and of the environment
- Comments made within questionnaires returned from people who use services, staff and health and social care professionals

We inspect and report our findings under ‘Quality Themes’. Those relevant to each type of service are referred to within our inspection reports.

Further information about what we do can be found in our leaflet ‘Improving Care and Social Services in Wales’. You can download this from our website, Improving Care and Social Services in Wales or ask us to send you a copy by telephoning your local CSSIW regional office.

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Non Compliance Notice

Domiciliary Care Agency

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 CSSIW taking action in line with its enforcement policy.

Further advice and information is available on CSSIW's website
www.cssiw.org.uk

Ty'n-Y-Coed Care Ltd DCA

Milford Haven

Date of publication: **(manually entered)**

Quality Of Leadership and Management	Our Ref: NONCO-00004723-LQXL
Non-compliance identified at this inspection	
Timescale for completion	**03/12/17**
Description of non-compliance/Action to be taken	**Regulation number**
The registered persons are not compliant with Regulation 13 (a) and (b) because suitable arrangements were not in place to safeguard people from abuse.	13(a) 13(b)
Evidence	

The evidence is:

- The service had not been audited or monitored effectively.

  The Responsible Individual had not developed a system for monitoring the quality or effectiveness of the service.

  A comprehensive quality monitoring report was not available.

  There was no written evidence to demonstrate that a system was in place for effective or regular review of the service.
- Staff supervision had not been carried out consistently on a three monthly basis.

  Staff files evidenced gaps in staff supervision, in one instance supervision had not been carried out for nine months.

  Issues which had been raised by staff within supervision sessions which did take place were not addressed by the registered manager.

  The Responsible Individual said that all domiciliary care staff had not received supervision at least every three months.
- A system for reviewing the effectiveness of the manager, for example, through supervision, was not in place.

  The Responsible Individual said that there was no identified system for reviewing the service.
- Staff who had raised concerns about the safety of service users did not feel able to discuss these with the Responsible Individual or with the Directors of the service.

The impact on people using the service is that they were not protected from abuse.