Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Arthur Jenkins

Arthur Jenkins Residential Home
Coed Cae Road Blaenavon
Pontypool
NP4 9PP

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

25/06/2024

About Arthur Jenkins

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Hafod Housing Association Ltd
Registered places	29
Language of the service	Both
Previous Care Inspectorate Wales inspection	07 June 2023
Does this service promote Welsh language and culture?	This service is working towards providing an 'Active Offer' of the Welsh language and demonstrates a significant effort to promoting the use of the Welsh language and culture.

Summary

People at Arthur Jenkins offered positive feedback about the care and support provided. People are treated with respect by a familiar staff team. An improved activities programme provides people with a range of suitable and meaningful activities to keep them stimulated. Personal plans are mostly written from the individual's perspective and provide person-centred detail. People's loved ones are involved in their care and are encouraged to visit them as frequently as possible.

Although care and support is delivered in a dignified way, it is not always delivered in-line with people's personal plans and individual needs. Clinical input is not always sought in a timely way when peoples' health deteriorates. Medication management is poor and people do not consistently receive their medication in-line with their prescriptions. Occasional insufficient staffing numbers have put people at risk.

The service provider does not consistently ensure the service is provided with sufficient care, competence, and skill, having regard to the Statement of Purpose (SoP). Governance arrangements and quality assurance is not robust, meaning there is a lack of sufficient oversight of the service provided. The responsible individual (RI) does not effectively supervise the management of the service. This lack of oversight has resulted in people's well-being being impacted. We have therefore issued several priority action notices which we expect the service provider to take immediate action to address.

The service provider offered as assurance that immediate actions would be taken to improve oversight of the service provided and to mitigate any further risk to people.

Well-being

People have some control over their day-to-day lives. A reader-friendly Service User Guide (SUG) outlines what people can expect from the service provided and what opportunities are available to them, to help them achieve well-being. People can personalise their living space. Bedrooms are decorated in colours and styles of people's choosing. People's personal trinkets, photographs, and artwork are displayed to make their bedrooms more homely. People's language preferences are identified in-line with the Welsh Active Offer, and they can receive support through the medium of Welsh, if they choose to.

People can mostly do the things that matter to them. An improved activities programme offers varied and suitable recreational activities. Recent activities have included visits from local school children, themed evenings, quizzes, and entertainers visiting the service, which people told us they enjoy. People are regularly supported on day trips around the local community, which enhances their community presence. On the days of our inspection, we observed people engaging in and enjoying the activities on offer. This included communal games in the lounge area, which most people at the service joined in.

Family and personal relationships are encouraged. People's relatives and friends are encouraged to visit the service at any time. The manager and staff team are familiar with people's loved ones and engage with them in a positive way.

People do not live in a home that consistently supports them to achieve well-being. People offered positive feedback about the service provided and the care workers who support them. People told us they are *'Happy'* and *'Satisfied'* by the care and support they receive. However, the service is not consistently staffed at a safe level, meaning people may be at risk of not receiving as required medication or prompt care when they need it.

People are not always supported to get the right care and support, in a timely manner, to stay healthy and happy. Some people's care is not delivered in-line with their personal plans to ensure their well-being. Clinical and professional input is not consistently sought in a timely way when people's health deteriorates. Medication is not always administered as per people's prescription. This has significantly impacted some people's physical and emotional wellbeing. The service provider offered us assurance that immediate action would be taken to mitigate any further risks to people's well-being and safety.

Care and Support

People are treated with dignity and respect by a familiar and stable staff team. Care workers interact with people in a meaningful way. People have built up strong and positive relationships with their care workers. One person described care workers as *'Nice'*, whilst another person told us the care provided is *'Very satisfactory.'* People are supported with their personal development and have access to a range of activities and opportunities that make them happy and improve their well-being. Some people have meaningful personal outcomes, which care workers support them to achieve. These outcomes act as goals for people to work towards, to help them reach their full potential and do the things that matter to them. Some people do not have meaningful personal outcomes, which may impact their well-being.

People's personal plans are mostly person-centred. This means they are written from the individual's perspective. Most personal plans contain a good level of social history and outline people's key likes and dislikes, meaning care workers have sufficient information to deliver person-centred care. We observed care workers using this information to engage people in conversation about topics that interest them. This had a positive impact on people's emotional well-being.

The service provider has not ensured care and support is delivered in a way that protects, promotes, and maintains the health and safety of individuals. People's personal plans do not always contain sufficient information to enable care workers to provide care to help them achieve physical well-being. Important information about individuals' health needs is not always included in personal plans. This means care workers do not always have access to the information needed to deliver safe and effective care and may not know how to respond if health needs change. People's care is not consistently delivered in-line with their personal plans and individual care needs, meaning they are at risk of harm and ill-health. Medical advice and professional help is not always sought in a timely manner when peoples' health deteriorates. We identified several instances where unsafe care delivery has significantly impacted people's physical and emotional well-being, and we have therefore issued a priority action notice. The service provider must take immediate action to address this.

The service provider does not have robust arrangements in place to ensure peoples' medicines are stored and administered safely. Some care workers do not undergo the appropriate competency checks which allow them to administer medication safely. We identified significant discrepancies in daily medication counts which indicate people have not received medication in-line with their prescriptions. Poor medication management has impacted peoples' well-being, and we have therefore issued a priority action notice. The service provider must take immediate action to address this.

The service provider has not provided a service that ensures people are protected from neglect and improper treatment. Whilst we did not identify any concerns relating to wilful abuse or harm, we found people have been put at unnecessary risk of neglect. Some

people’s care is not delivered in-line with their individual needs and their medication is not administered as per their prescription, which has significantly impacted their well-being. Unsafe staffing numbers at night mean people may not always have access to as required medication or prompt care. Some safeguarding incidents have not been logged or reported in-line with safeguarding protocols. Some care workers are overdue Safeguarding of Vulnerable Adults training, meaning they may not understand their responsibility to safeguard and protect vulnerable adults. This is placing people’s well-being at risk, and we have therefore issued a priority action notice. The service provider must take immediate action to address this issue.

We note that the service provider offered us assurance that immediate actions would be taken to mitigate any further risks to people.

Environment

This theme was not considered in full, but we note the service provider has provided an environment which is mostly suitable to help people achieve well-being. Appropriate

facilities and equipment are provided so that people can be supported with their individual needs. The service appeared clean and tidy on the days of our inspection. Peoples' bedrooms are personalised and offer sufficient space. Communal areas offer space for people to socialise. Dining areas are clean and well-presented for mealtimes. There is a menu in the dining room which displays the days menu, including alternative options. External areas are well-maintained. The service employs a permanent maintenance technician to oversee health and safety. On the days of our inspection, we observed them testing the fire alarm and undertaking health and safety audits.

Leadership and Management

The service provider does not have robust governance arrangements in place to support the smooth and effective running of the service. High quality care and support is not consistently delivered to people, to enable them to achieve best possible outcomes and well-being. Whilst the service's SoP is comprehensive and its internal policies are robust,

care is not always delivered in line with these. People's health and well-being have been impacted as a result, and we have therefore issued a priority action notice. The service provider must take immediate action to address this issue.

There is insufficient managerial oversight of the day-to-day running of the service. The manager does not utilise effective quality assurance tools to enable them effective oversight of the service provided. Some people's health deterioration has gone unnoticed as a result. Medication management is poor. Existing medication audits had failed to detect significant concerns identified at our inspection. Some incidents of a safeguarding nature have not been handled in-line with appropriate safeguarding protocols.

The RI does not have robust processes to enable them to supervise the management of the service. The RI completes their regulatory visits and reports in-line with the regulations. Improved recordings of their visits are comprehensive and evidence they are obtaining feedback from people, care workers, and relatives. Some audits, such as care planning and medication audits, are completed as part of their regulatory visits, but these have failed to identify significant areas of concern we identified at our inspection. This is placing people's health and well-being at risk, and we have therefore issued a priority action notice. The RI must take immediate action to address this issue.

People are not consistently supported by appropriate numbers of staff who have the right competencies to provide the level of care needed to help them achieve personal outcomes and well-being. Care workers raised concerns that the service is not sufficiently staffed. Insufficient staffing numbers at night have sometimes put people at risk of not receiving prompt care or as required medication, if needed. Care workers are not always appropriately supported or developed. Staff training compliance is mostly up to date, but care worker supervision compliance continues to be poor. Supervisions are basic in quality. Whilst no immediate action is needed, this continues to be an area for improvement and we expect the service provider to take action.

Care workers offered mixed feedback about their employment. Some care workers offered positive feedback. One care worker described the service as feeling like *'home'* and said they *'Have only positive things to say'* about the service. Other care workers told us they are not happy with working conditions and feel the quality of the service has deteriorated. One care worker described their role as *'Stressful'.* Another care worker told us they do not feel supported by management.

The service provider offered us assurance that immediate actions would be taken to introduce more robust governance and quality arrangements, which will provide better oversight of the service provided.

Summary of Non-Compliance	
Status	**What each means**
New	This non-compliance was identified at this inspection.
Reviewed	Compliance was reviewed at this inspection and was not achieved. The target date for compliance is in the future and will be tested at next inspection.
Not Achieved	Compliance was tested at this inspection and was not achieved.
Achieved	Compliance was tested at this inspection and was achieved.

We respond to non-compliance with regulations where poor outcomes for people, and / or risk to people's well-being are identified by issuing Priority Action Notice (s).

The provider must take immediate steps to address this and make improvements. Where providers fail to take priority action by the target date we may escalate the matter to an Improvement and Enforcement Panel.

Priority Action Notice(s)		
Regulation	Summary	Status
58	The service provider does not have robust arrangements in place to ensure that individual's medicines are stored and administered safely.	New
26	The service provider does not have robust measures and protocols to ensure people are safeguarded from harm and neglect.	New
6	The service provider has not ensured that the service is provided with sufficient care, competence, and skill so that people can achieve well-being.	New
21	People cannot be assured they will receive consistent care and support.	Not Achieved
66	The RI must supervise the management of the service to ensure people are safe and achieve well-being.	Not Achieved

Where we find non-compliance with regulations but no immediate or significant risk for people using the service is identified we highlight these as Areas for Improvement.

We expect the provider to take action to rectify this and we will follow this up at the next inspection. Where the provider has failed to make the necessary improvements we will escalate the matter by issuing a Priority Action Notice.

Area(s) for Improvement		
Regulation	Summary	Status
N/A	No non-compliance of this type was identified at this inspection	N/A
36	The supervision of care workers is not always taking place at the required frequency to meet regulatory compliance.	Not Achieved

Was this report helpful?

We want to hear your views and experiences of reading our inspection reports. This will help us understand whether our reports provide clear and valuable information to you.

To share your views on our reports please visit the following link to complete a short survey:

- Inspection report survey

If you wish to provide general feedback about a service, please visit our Feedback surveys page.

Date Published 29/07/2024