Care Inspectorate Wales

Regulation and Inspection of Social Care (Wales) Act 2016

The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017

Priority Action Report

A1 Care Services Ltd

in respect of

A1 Care Services trading as Ty Ceirios Nursing Home

A1 Care Services Ltd
Ty Ceiros Nursing Home
Pontypool
NP4 6TJ

This report contains notices where priority action must be taken by the registered person in respect of identified non-compliance 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 report is a serious matter. The notices contained within the report have been issued in accordance with our Securing Improvement and Enforcement Policy. Failure to achieve compliance will result in Care Inspectorate Wales taking action in line with this policy.

A copy of the Securing Improvement and Enforcement Policy is available on our website

Further advice and information is available on our website
www.careinspectorate.wales

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Priority Action Notice
Identified at this inspection dated: 18 October 2023
Our Ref: NONCO-00017584-YQNN

Non-compliance has been identified with Regulation 21
The specific sub-regulatory failures relate to: 21(1)

Individuals are at risk from poor and unsafe care and support because there are insufficient systems to protect them.

Regulatory Failings

21(1) The service provider must ensure that care and support is provided in a way which protects, promotes and maintains the safety and well-being of individuals.

Evidence

People do not have a voice. We visited the service on 18/10/23 and found there had been no improvements made to people's care planning systems or reviews. Despite areas for improvement set at our last inspection. Individuals and their relatives are still not involved in drawing up of personal plans or reviewing them.

People's care is not being delivered in accordance with their likes and or preferences as these are not included in people's plans.

The service cannot assess if people's outcomes are being met as they have not been recorded.

People are at risk of poor and unsafe care and support. In one community, UC, staff were unable to fully access individuals' care plans. This affected 11 people. 3 staff working in this area were new to the service/ systems. They were unable to access information about how to assist, support individuals with all aspects of their care and support. The management team were unaware of this difficulty.

Staff recordings are not always consistent. Pressure relief is recorded exactly to the hour which questions whether this is an accurate recording of the time when the relief is provided.
Recording documented that a resident was "agitated and wandering" with a smiley face next to it.
There are no behaviour support plans for people despite there being incidents of aggression.
We observed no clear process at mealtimes to ensure the correct people had the right dietary texture of food.
PEEP's use a generic format and do not specify what support an individual would need in the event of a fire. 3 people do not have a PEEP in place but have been living at the service for over a month.

We considered the provision of staff and skill mix to meet individuals' needs. There has been a large turnover of staff since our last inspection. This includes a change of RI, manager, and clinical lead. There have been changes in all designations of staff including nurses, care workers and ancillary staff. 15 new recruits have recently been appointed. [redacted] is working on the floor to supplement the team taking away from administration duties. [redacted] told us

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this was the reason PEEP's/covert medication forms had not been completed. One nurse is on duty for 40 people living at the service. We discussed the sufficiency of nurse cover with the RI.

Due to staff movement, continuity of care for individuals has not been considered. The RI stated that they have not failed to cover the rota. Relatives discussed how important loved ones having familiar carers is and communication deficiencies due to staffing were acknowledged during the last quality of care review.

There have been delays in people being referred for necessary aids and adaptations. We were assured individuals are now being referred to OT/ physiotherapists. However, some people are needing to be cared for in bed due to lack of equipment. During our visit, we saw a lady sat in the lounge for the first time in months following OT/ staff receiving manual handling training.

Impact on and / or risk to the health and well-being of people:

We have assessed the potential risk and / or impact on people's health and well-being as a result of this non-compliance as Moderate and there is likely reoccurrence.

Outcomes for People	
People at the service are not receiving safe and consistent care to meet their needs.	
Timescale for completion	01 February 2024

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