Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Ty Mawr Ltd

TY MAWR NURSING HOME
CAEHOPKIN ABERCRAVE
SWANSEA
SA9 1TP

Mae'r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh

Date Inspection Completed

29/03/2021

About Ty Mawr Ltd

Type of care provided	Care Home Service Adults With Nursing
Registered Provider	TY Mawr LTD
Registered places	54
Language of the service	Both
Previous Care Inspectorate Wales inspection	23/01/2020 & 27/01/2020
Does this service provide the Welsh Language active offer?	The service 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.

Summary

This was a focused inspection based around the leadership, management and oversight of the service by the Responsible Individual (RI). We found that the RI has poor systems and checks in place to ensure the service is safe and meets people's needs. There is a lack of consultation with people, their representatives, staff and key stakeholders to equip the RI with the appropriate overview and the required knowledge of the service. The decisions made by the RI about the operational management of the service and the lack of strategies and contingency planning puts people living in the service at risk.

Well-being

The oversight, monitoring and governance arrangements of the service by the RI are poor and need to be improved. People's individual circumstances, choices and needs are not being recognised, respected or met. People's personal care and support needs are not being identified with the person or their representative and they are not always being involved in the planning and review of their care. This includes when a person likes to get up in the morning. The Responsible Individual (RI) has not been conducting regular reviews of the service or consulting with people and / or their representatives to obtain their views to contribute to and influence the quality review process. This is compounded by the lack of clear leadership and management oversight of the service that contributes to the risk of people receiving poor care that does not reflect their needs.

People cannot be assured they are protected from harm. We found appropriate infection control measures in place, staff have received training and there is an up to date infection, prevention and control policy for staff to refer to. Staff were seen to be following current Public Health Wales (PHW) guidance and using the correct personal protective equipment (PPE). However, the clear lack of oversight and monitoring of the services, staff practices and the experiences of people living in home cannot guarantee that individuals are not vulnerable to harm.

Care and Support

This was a focused inspection and on this occasion, we did not consider care and support in detail. We can make the follow observations. The staff we spoke to demonstrated that they were passionate about caring for the people living in the home. We also saw positive and caring interactions between staff and people living in the home.

We are not confident, however, that people's individual needs and choices are being met. The care plans we read did not have evidence of them being developed or reviewed with the individual or their representative. The RI is not obtaining people's views and choices as part of his quality monitoring. The lack of leadership, oversight and monitoring of the service demonstrates that there is insufficient scrutiny to ensure that people receive the individual care they need.

Environment

This was a focused inspection and on this occasion, we did not consider environment in detail.

Leadership and Management

The leadership, governance and oversight of the service does not operate in a way to ensure people achieve their personal outcomes and receive a high quality of care. Neither does it value or support those working in the service.

The Responsible Individual (RI) has not conducted any visits to the service (including virtual) during the period of the Covid -19 Pandemic. Whilst he has conversations with members of the management team and certain care workers, he has failed to conduct robust and inclusive quality assurance visits.

Staff told us that the RI has not spoken to them for significant periods to gather their views of the service. One staff member told us "*I don't feel valued by the company".* Commissioners, relatives and some people living in the service also told us that they too have not been approached by the RI for their views of the service. The care records we read showed that people's individual choices are not being recorded and we could not find evidence of the individual and/or their representative being involved in their care planning and reviews. The Service Review Report produced by the RI in December 2020 also demonstrated that he has not consulted with key stakeholders of the service.

The RI has made significant changes to the leadership and management of the service since December 2020 with no clear strategy in place to offset the disruption, concern and uncertainty this has caused. The changes have led to a period of confusion as to who is in charge of the service. The Acting Manager has not received an induction, one to one supervision or clarity of the expectations of their role since taking up the temporary position. There are also no management contingency plans in place during this difficult period.

Non-Compliance notices issued in the last two inspections highlighted that staff were not receiving supervision. This continues to be a problem as the RI advised CIW that a number of staff had not received regular supervision. Some staff told us that whilst they have recently received supervision by the Acting Manager, they question the regularity, value and effectiveness of them.

We also found, contrary to what the RI had advised CIW, staff have not received an annual appraisal. The staff we spoke with, through returned staff questionnaires and looking at three staff records corroborated this. The RI has not provided some information requested for the purpose of this inspection. Due to the lack of sound governance and oversight of the service, we have issued priority action (non-compliance) notices and the provider must take immediate action to address these issues.

Areas for improvement and action at, or since, the previous inspection. Achieved	
The manager has failed to register with Social Care Wales. The registered persons must ensure that the manager achieves the required qualification and is registered with Social Care Wales.	Regulation 67(2)(d)
The manager has failed to ensure that care workers receive supervision at least every three months. The registered persons must ensure that all care workers receive three monthly supervision.	Regulation 36(2)(c)

Areas for improvement and action at, or since, the previous inspection. Achieved	
The person conducting the role of the Responsible Individual (RI) has not registered with Care Inspectorate Wales. The registered persons must make arrangements for the change of Responsible Individual to be registered with Care Inspectorate Wales.	Regulation 73(1)(a) Regulation 73(1)(b) Regulation 73(3)

Where providers fail to improve we will escalate the matter by issuing a priority action notice. Where providers fail to take priority action we may escalate the matter to an Improvement and Enforcement Panel.

Areas where priority action is required	
Care workers have not received supervision or an annual appraisal within the required timescales.	Regulation 36(2)(c) Regulation 36(2)(c)
The arrangements for the oversight and governance of the service are ineffective.	Regulation 8(2) Regulation 8(1) Regulation 8(2)(a) Regulation 8(2)(b) Regulation 8(2)(d) Regulation 8(2)(e) Regulation 8(3)(a) Regulation 8(3)(b)

We found poor outcomes for people, and / or risk to people's wellbeing. Therefore, we have issued a priority action notice and expect the provider to take immediate steps to address this and make improvements.

Areas where improvement is required	
None	

Date Published 21/07/2021

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