Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report on

Tŷ Bargoed Newydd Residential Home

Tŷ Bargoed Newydd
Williams Terrace
Treharris
CF46 5HH

Date Inspection Completed

22 July 2020

About Ty Bargoed Newydd Residential Home

Type of care provided	Care Home Service Adults Without Nursing
Registered Provider	Merthyr Tydfil County Borough Council Adults and Children's Services
Registered places	32
Language of the service	English
Previous Care Inspectorate Wales inspection	15 August 2019
Type of Inspection	Full
Does this service provide the Welsh Language active offer?	This is a service that provides an 'Active Offer' of the Welsh language. It provides a service that anticipates, identifies and meets the Welsh language and cultural needs of people who use, or may use, the service.

Summary

Tŷ Bargoed Newydd Residential Home is located in Merthyr Tydfil and is operated by Merthyr Tydfil County Borough Council. The Responsible Individual (RI) for the service is Angela Edevane. A manager is also in place to oversee the daily running of the home who is suitably qualified and registered. The home can accommodate up to 32 residents with personal care and/or dementia care needs.

Well-being

People enjoy a good standard of care and support. They feel safe, well cared for and are complimentary of the care workers. People's general emotional and psychological needs are met. The provider is appointing an activities coordinator to give people more opportunities to become occupied and engaged. People access care from the right professionals when they need it. Personal plans need more information regarding how risks are to be managed and reviews need more detail. Systems are in place to ensure the safe management of medication and infection control. The home has relevant policies, but some need reviewing. Processes are in place for protecting people from the risk of harm and abuse. But, staff training is lacking, so people cannot feel confident all care workers will know how to follow those processes correctly.

The home is clean, free of malodours and appropriately maintained. Residents, relatives and a professional we spoke with all shared positive feedback, commenting on the home's cleanliness and presentation. People can personalise their bedrooms and there are suitable facilities and equipment to enable people live safely and well. Management ensure the home's health and safety requirements are met.

Governance and quality monitoring needs improving. The care workers we spoke with shared positive experiences of working at the home. They feel it is well-managed and that they work well together; but we found not all care workers receive regular supervision. Daily handover records are kept which show effective communication between care workers when they change shift. Turnover of care workers is low, which helps promote good continuity for residents. There are deficits in training which need immediate attention. The RI's oversight of the quality and performance of the service needs to improve. This includes obtaining the views of people connected with the service more regularly. The home has clear aims, objectives and relevant policies, but written information needs reviewing.

Care and Support

People receive a good level of care and they access health services when needed. We spoke with people using the service, relatives and a healthcare professional. They all told us the standard of care and support was good. They described care workers as caring and friendly. Turnover of workers is low which promotes good continuity for residents. Care records show people receive appropriate care and support, but mouth care records should be completed more fully to show where people have received support, or where they have met their own needs. Care workers communicate well with each other and with the residents. Relatives experience a warm welcome when they visit. People's general emotional and social needs are met, but there could be more opportunities for people to become occupied and stimulated. The provider is addressing this through the appointment of an activities coordinator.

People have individual care plans, but reviews are basic and guidance for care workers about managing risks needs more detail. People's plans set out their care needs and contain guidance for care workers in how to meet them. Short-term care plans are used to help people work towards temporary goals (e.g. recovering from a short-term illness). Guidance for care workers about managing risks needs more detail. Evidence suggests that people and their relatives are more involved with their care planning needs, but reviews need more detail to make them meaningful.

People are treated as individuals. All residents we spoke with told us they felt safe and happy with the care they received. They gave us positive feedback about the care workers, variety and quality of meals and felt their preferences were respected. People exercise choice day to day, for example choice of food, where to spend their time and when to go to bed and awake. Appropriate arrangements are in place for residents with limited cognition to make important decisions about their care and well-being. Relatives told us people are treated with care and respect.

Measures for managing medicines and reducing risks of cross-infection are in place. Medicines are stored adequately, safe from unauthorised access, but some aspects relating to storage need addressing. Record keeping of medicines is satisfactory. The home uses an external auditor to help monitor and maintain good practices. A medication policy is in place. There are written procedures for infection control, but they could be clearer for care workers. The majority of care workers wore personal protective equipment (PPE) appropriately. We spoke with provider about monitoring care workers' use of facemasks to ensure they are at all times worn in line with relevant guidance.

Protocols for protecting people from the risk of harm and abuse are in place, but due to a lack of staff training, not all care workers may be familiar with them. Policies and procedures for whistleblowing and safeguarding vulnerable people are present. All residents and relatives spoken with knew who to contact if they had any concerns. There is

evidence the home raises concerns with relevant professionals in a timely way, to help protect people. As indicated in the ‘Leadership and Management’ section below, training for care workers, which includes safeguarding, needs improving. This means people cannot feel confident all care workers will have an up to date awareness of important policies and protocols.

Environment

The home is clean, tidy and welcoming for people who live there and visit. Ty Bargoed Newydd is a purpose-built care home which is spacious and modern inside. Its layout and décor is suitable for the people living there and consistent with what is described in the home's written information. People personalise their bedrooms as they choose and there is a good amount of space for them to enjoy, inside and out. At the time the inspection took place, relatives had started revisiting, following the COVID-19 lockdown. The provider has arrangements for enabling these visits to take place in a safe way. This is supported by a new policy. Areas in the home where only staff are allowed to access (e.g. due to confidentiality or potential risk to residents) are secure. There is a secure front access system and a record of visitors is kept.

The home's management ensure it is a safe place for people to live, work and visit. We looked at a range of documentation relating to health, safety and maintenance. They show appropriate checks and servicing is carried out to ensure facilities and equipment are safe. Fire safety records are kept which evidence regular fire drills and servicing. Residents have individual emergency evacuations plans. There is a fire safety risk assessment and the service provider told us they are working towards making some improvements.

Leadership and Management

Written information about the home is present, but it needs updating. The home's aims and objectives are clear and relatives told us they received written information about the home. Policies and procedures support the running of the home, but some needed reviewing. We were unable to access the incident and accident records at our visit as the manager was not present. We will look at these at the next inspection. We saw, from information we already held, that the provider had been notifying us appropriately of events.

Training and supervision for care workers needs improving. Care workers spoke highly of the home's manager and considered they worked well together. They told us they felt well-supported, but records we viewed showed many care workers did not receive supervision regularly enough. Since the last inspection, the provider has introduced a training and development policy. We informed the service provider at our last inspection that training needed improving. Discussions with staff and examination of records at this inspection showed this remained the case. There is a lack of evidence that management monitor staff training effectively and have a clear training programme in place. We were made aware of a recent incident that had occurred in which care workers failed to follow correct protocols to safeguard people, resulting in a significant infringement to a resident's privacy and dignity. People are unable to have confidence that all care workers will have an up to date understanding of important policies and protocols. Because of the impact of this, we have issued a priority action (non-compliance) notice. The provider must address this and we will carry out another inspection to follow it up.

There is satisfactory information in place regarding people working at the home. Documentation had improved since our last inspection. Overall, we are satisfied there is sufficient information and/or documentation in place relating to people working at the home. The service provider needs to ensure though that employment histories are always documented fully.

Standards of governance and quality monitoring need to be improved. There is evidence the RI oversees how the service is running to an extent, but they need to visit and speak with people more frequently. There is a lack of consideration in the RI's monitoring of training and how deficits will be addressed. In addition, the quality of the service provided to people is not reviewed as often as it needs to be. This means feedback from people connected with the service (e.g. residents, relatives, care workers and commissioners) is not sought and evaluated regularly. This is important to enable the RI to give assurances about the home's safety and performance, and to allow it to continually learn and improve.

Areas for improvement and action at the previous inspection		
Ensure full and satisfactory information and/or documentation is available for people working at the home.	Regulation 35(2)(d)	Achieved
Ensure care workers receive ongoing training appropriate to the work they perform.	Regulation 36(2)(d)	Not achieved

We found an individual had experienced a poor outcome and there were potential risks to the well-being of other residents. Therefore, we have issued a priority action (non-compliance) notice. We expect the provider to take immediate steps to address this and make improvements.

Areas where immediate action is required	
Ensure care workers receive appropriate ongoing training	Regulation 36(2)(d)

Areas where improvement is required	
Ensure personal plans take sufficient account of risks to the individual's well-being and measures for managing them	Regulation 15(7)(e)
Ensure personal plans are reviewed with residents and relatives at least every three months and consider the extent to which people achieve their personal outcomes	Regulation 16(1)-(4)
Ensure all persons working at the service receive appropriate supervision	Regulation 36(2)(c)
Ensure the RI visits the service at least every three months to speak with residents and care workers	Regulation 73(1)
Ensure the RI maintains a system for monitoring, reviewing and improving the quality of care and support at least every six months	Regulation 80(2)

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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 our website
www.careinspectorate.wales

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

Leadership and Management	Our Ref: NONCO-00009547-NRCS
Non-compliance identified at this inspection	
Timescale for completion	**21 September 2020**
Description of non-compliance/Action to be taken	**Regulation number**
Ensure care workers receive appropriate ongoing training	Regulation 36(2)(d)

Evidence

The service provider is not compliant Regulation 36(2)(d) of The Regulated Services (Service Providers and Responsible Individual) (Wales) Regulations 2017.

This is because it has failed to ensure all care workers maintain appropriate training.

Evidence:

- Staff training records indicated high numbers of staff who had either outdated key training (e.g. where they last received it 3 -8 years ago) or where there was no evidence key training had been provided. This included training in safeguarding (approximately 60% of staff); infection control (approximately 73% of staff); health and safety (approximately 71% of staff); and medication (approximately 36% of staff).
- Three staff spoken with were uncertain when they last received safeguarding training. Their training records showed no up to date safeguarding training had been received. Records for one person reflected safeguarding training over 6 years ago.
- At the last inspection on 15 August 2019 the service provider was informed it was non-compliant with Regulation 36(2)(d) (staff training). Evidence at this inspection indicates this remains the case.
- We were made aware of an incident which had occurred in the home whereby two care workers failed to correctly follow adult safeguarding protocols, which would have been outlined in safeguarding training, resulting in a significant infringement on a resident's privacy and dignity.
- We looked at supervision records for three staff who had notable gaps in their training. There was insufficient consideration of these training deficits during their supervisions and how they were to be addressed.
- We examined RI visit reports dated October 2019 and February 2020. We found six monthly quality of care reviews had not been maintained in line with Regulation 80 since the service registered under the Regulation and Inspection of Social Care (Wales) Act 2016. These demonstrated a lack of RI oversight of the training deficiencies within the

service and there was no robust action plan for addressing them.

Impact on people using the service:
There is evidence the privacy and dignity of a resident has been significantly implicated as a result of a lack of robust governance in the service. Where staff fail to receive regular training, it places other residents at potential risk as staff may not know how to respond correctly to concerns, in line with the service's policies and procedures.