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

Aston Hall Care Limited

in respect of

Aston Hall Care Limited

Lower Aston Hall Lane
Hawarden
Deeside
CH5 3EX

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

Priority Action Notice
Identified at this inspection dated: 9 October 2023
Our Ref: NONCO-00017592-HDMG

Non-compliance has been identified with Regulation 15
The specific sub-regulatory failures relate to: 15(1)

The service provider has not ensured personal plans accurately reflect people's care and support needs, their personal outcomes and the steps required to mitigate identified risks.

Regulatory Failings

15(1) The service provider must prepare a plan for the individual which sets out -
(a) how on a day to day basis the individual's care and support needs will be met,
(b) how the individual will be supported to achieve their personal outcomes,
(c) the steps which will be taken to mitigate any identified risks to the individual's well-being, and
(d) the steps which will be taken to support positive risk-taking and independence, where it has been determined this is appropriate.

Evidence

On the day of inspection, 9 October 2023, the provider was not compliant with regulation 15 (1) (a). This is because, the registered provider has not ensured care plans detail how people's day to day care and support needs are met. We case tracked four people and found care plans are not clear how best to support people with specific needs, including mental health, diabetes and dementia.

Personal plans for health conditions are unclear on how the condition effects the person and how to support people to manage the condition [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

On the day of inspection, 9 October 2023, the provider was not compliant with regulation 15 (1, b). This is because it is not clear within the personal plans, how people will be supported to achieve their outcomes. The outcomes for people are not person centred, they are staff and task focussed. Following feedback, the provider forwarded updated care plans and the outcomes remain staff and task focussed. For example, with [redacted], it lists the desired outcomes as 'For all decisions made, to be respected by staff, if staff unsure they will seek further advice from management', 'Staff to gain consent prior to delivering any care', 'For staff to promote decision making in the areas identified and promote decision making'

and 'For staff to promote decision making at every opportunity.' [redacted] 'Staff to ensure any concerns are investigated and appropriate action taken' [redacted] This means people may not receive care and support in line with their views, wishes and aspirations.

On the day of inspection, the provider was not compliant with regulation 15 (1) (C). This is because it was not clear on the steps required to mitigate risks. [redacted] The diabetes care plans are unclear on how to reduce risks, such as hypoglycaemia. [redacted] Each plan states to minimise hypoglycaemia and ketoacidosis, but not what signs/symptoms to look for. Following feedback, the provider forwarded updated diabetes care plans which detail what causes hypoglycaemia and ketoacidosis episodes, but did not include the symptoms to look for. This means, people are at risk of not receiving the correct treatment as it is not clear to care staff of the symptoms.

[redacted] However, this was not up to date. The risk assessment said in order to reduce the risks a sensor mat was in place. However, this was no longer the case due to the mat being a trip hazard. The manager confirmed to CIW during the inspection, the sensor mat was deemed a trip hazard and was removed. If the wrong information is in the risk assessment, there is a risk a sensor mat may be put in place and leading to a risk of a fall.

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	
If care plans are not clear on how best to support people, people are at risk of not receiving the right care and support. This could have a negative impact on their overall health and well-being.	
Timescale for completion	09 April 2024