Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

Balmoral House - Skyline Care Ltd

22-24, Queens Walk, Rhyl, LL18 3NG

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www.balmoralcare.com

The inspection visit took place on 11/09/2026

Service Information:

Operated by:	Skyline Care Ltd
Care Type:	Care Home Service Adults Without Nursing
Provision for:	Care and support for people living with dementia, Care and support for people requiring short-breaks or respite care, Care and support for people with a physical disability
Registered places:	18
Main language(s):	English
Promotion of Welsh language and culture:	The provider makes an effort to promote the use of the Welsh language and culture or is working towards a bilingual service.

Ratings:

Well-being	Requires Improvement
Care & Support	Requires Significant Improvement
Environment	Requires Improvement
Leadership & Management	Requires Significant Improvement

Summary:

People's well-being requires improvement as they are living in a home which does not consistently promote their well-being. Choices are not always given as there is not always enough care staff on duty. Shortcomings in the quality and maintenance of the living environment, are having a negative impact on people's comfort, dignity and overall quality of life. There is little to occupy peoples time and no outings into the community due to staff shortages. Staff morale is low as they do not feel valued.

Care and support require significant improvement as people are not consistently supported to achieve positive outcomes due to shortcomings in the dining experience, nutrition, activities provision, staffing arrangements, care planning, risk management and Welsh language provision. Insufficient staffing arrangements limit opportunities for meaningful engagement, supervision and the delivery of care that reflects people's individual needs, preferences and rights.

The environment requires improvement. The premises are not being maintained to a suitable standard and do not currently support the delivery of safe, dignified care. The service provider has failed to ensure environmental risks are consistently identified, assessed and managed. This includes risks relating to access to hazardous areas, external exits, boiler rooms and trip hazards. The provider must ensure people live in a safe, clean and well-maintained environment where risks are effectively controlled, and infection prevention and control standards are consistently maintained.

Leadership and management require significant improvement. The Responsible Individual (RI) has not ensured effective governance, oversight or organisational arrangements to support the safe and effective operation of the service or the delivery of consistently high-quality care. Staff recruitment is not robust and there is not enough staff employed in the home.

Findings:

Well-being — Requires Improvement

People do not consistently have control over their day-to-day lives. The provider does not use a dependency assessment tool to determine whether staffing levels are sufficient to meet people's needs. People told us they experience delays in receiving care and support. Opportunities to participate in meaningful activities are limited due to staffing pressures, reducing people's choice and control over how they spend their time. Meal choices are recorded after meals are served, and refreshments are not routinely offered throughout the day. We are not assured people's views are meaningfully sought or acted upon. The RI's discussions with people are generalised and do not demonstrate effective engagement or oversight of people's experiences.

People do not always receive care and support that is responsive to their changing needs. Care records do not consistently reflect people's current needs and there is no effective ongoing assessment process to identify and respond to changes. People told us care staff are kind and work hard to support them. Referrals and appointments are arranged to promote people's health and well-being. However, there is not enough care staff deployed to ensure people are monitored to ensure their safety and well-being. Medication management practices also require improvement. As a result, people cannot be assured they consistently receive care and treatment that meets their assessed needs.

Systems to protect people from harm require improvement. Governance and oversight arrangements have failed to identify a range of significant concerns found during this inspection, exposing people and staff to avoidable risks. Management are not involved in recruitment of new staff and pre-employment checks are not always carried out by the provider to ensure staff are suitable and fit to work with adults at risk. The provider has not demonstrated effective systems to consistently identify, assess and mitigate potential harm. Whilst care staff have received safeguarding training and appropriate policies are in place, these arrangements are undermined by weaknesses in recruitment, care planning, risk management, staffing levels and management oversight. The registered manager is routinely included in staffing numbers, reducing their capacity to effectively monitor practice and drive improvement.

People do not always live in accommodation that consistently meets their needs or promotes their well-being. There are insufficient domestic staffing hours to maintain the home to a consistently clean and hygienic standard. Security access in and out the home requires improvement and, whilst routine safety checks are completed, these do not provide assurance that the environment is safe, suitable and supports positive outcomes for people. Although some improvements have been made since the last inspection, including new carpeting and limited redecoration, the environment requires further investment to ensure it is comfortable. A comprehensive environmental audit is needed to identify and address areas where standards fall short. Infection prevention and control

measures also require improvement.

Care & Support

Requires Significant Improvement

People are assessed before moving into the home and personal plans are developed using information from people, their representatives and relevant professionals. However, care records are not always reviewed and updated to reflect people's current needs. We found inaccuracies and inconsistencies within care records. For example, one person's records referred to dentures and associated oral care support despite them no longer wearing dentures. A mobility care plan had not been updated to reflect changes in need, and a nutritional personal plan contained conflicting instructions regarding the use of fluid thickener. Risk assessments are not consistently in place to support the safe management of identified risks. We found limited evidence of assessments relating to bed rails, floor sensors, relationships between people living in the service, and health conditions requiring specialist support. As a result, care staff may not have sufficient guidance to provide safe and consistent care.

The lunchtime experience is not consistently person-centred. Menus are not displayed, meal choices are not always recorded before meals are served, and drink options are limited. Tables are not fully prepared, with no napkins available. Limited staffing reduces opportunities for engagement and supervision during mealtimes. People have previously raised concerns about the lack of dessert variety in a residents meeting, which has not been addressed.

The provider does not ensure people have sufficient opportunities to take part in meaningful activities or maintain community links. No organised activities took place during the inspection despite being scheduled. People tell us outings have not occurred for some time and activities within the home do not meet their needs. These concerns had previously been raised at residents' meetings, but there is no evidence of effective action being taken. The lack of consistency in care documentation, risk assessments, mealtime experience, activities and lack of staff engagement is placing people’s health and well-being at risk, and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

Improvements are required in medication management. Staff complete appropriate training and competency assessments, and people generally received their prescribed medicines. However, refrigerator temperatures for stored medicines are not monitored, some prescribed creams have illegible labels or opening dates from January 2026, and creams are accessible within bedrooms. Medication records contain gaps, medicines appear to be checked by only one member of staff on receipt, and there is limited evidence of follow-up action where medicines have been refused for prolonged periods. These findings do not demonstrate sufficiently robust medicines management arrangements. This is an area for improvement, and we expect the provider to take action.

The home does not consistently maintain appropriate standards of hygiene and infection control. Staff complete infection control training, one domestic staff member is employed and works three mornings per week, with cleaning responsibilities otherwise undertaken by care staff.

We found a number of environmental concerns, including a bathroom without suitable hand-drying facilities and a visibly unclean laundry room. Dirty laundry was stored in a bath and had to be transported through the dining room to access the laundry area, increasing the risk of cross-contamination. Cleaning equipment such as mops are significantly dirty and not used in accordance with colour-coding procedures and sinks and a call bell requires cleaning. The laundry room is visibly unclean with no washable paintwork on the walls. The service received a Food Hygiene Rating of 1 (Major Improvement Necessary) in April 2026. The provider has since made improvements and requested a re-inspection.

Environment — Requires Improvement

The home has benefited from a number of environmental improvements; however, further work is required. People told us they are generally happy with their surroundings, but we found the provider's approach to maintenance is largely reactive, with action often taken only after concerns have been raised by others. This raises questions about the effectiveness of the provider's oversight and monitoring of the service. Since the previous inspection, new carpets have been installed in some areas of the home and furniture and beds in the poorest condition have been replaced. However, concerns remain regarding the condition and suitability of some bedroom furnishings, including damaged bed frames. These issues had previously been raised with management by family members and professionals. We also found a recently decorated bedroom had not been finished to an acceptable standard, with patchwork paintwork that did not match the existing décor.

The provider does not consistently identify, assess and manage health and safety risks within the service. Appropriate systems are in place to monitor visitors entering and leaving the home, routine fire safety checks are generally completed, servicing and maintenance records for gas and electrical systems are up to date, and people have individual Personal Emergency Evacuation Plans. However, we identified several health and safety concerns during the inspection. A homemade wooden step leading from the dining room to the courtyard was damaged, with broken timber along the edge, and lacked both a graduated ramp and handrails. Warning signs are not consistently displayed when cleaning activities create slip hazards. The external door from the dining room remained unalarmed for much of the morning, providing unrestricted access to an external area and the route used for transporting soiled laundry. This meant people could potentially access/leave the area unsupervised. We also found weaknesses in access control arrangements. Although visitor checks are undertaken on arrival, the inspector and another visitor were admitted to the home by a visitor rather than a member of staff. In addition, the inspection identified an out-of-date fire extinguisher safety check in the laundry room, with records showing the last inspection had been completed in 2024. These have been identified as areas for improvement, and we expect the provider to take action. We will review these areas in the next inspection.

Leadership & Management

Requires Significant Improvement

Arrangements for the oversight and governance of the service require significant strengthening to ensure effective quality assurance, accountability and continuous improvement. The manager and deputy manager are present within the home on most days and provide direct support to people when required, this has impacted on their ability to fulfil key management responsibilities. The manager told us they do not have sufficient time to complete essential management duties, including audits, quality assurance activities, oversight of care records and monitoring of service performance. Governance systems are not operating effectively to identify, monitor and address areas of concern. The Statement of Purpose does not accurately reflect the current management and staffing arrangements within the service. In addition, the provider has failed to publish the service's annual return and quality ratings as required. The provider must ensure the Statement of Purpose is updated to reflect the service as delivered and that all required information, including the annual return and service ratings, are published and made available in accordance with regulatory requirements. This is placing people's health and well-being at risk, and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

We found a significant number of care records, risk assessments and staff records containing sensitive personal information stored in an unlocked garden shed. The shed also contained gardening equipment and decorating materials. Confidential information was not stored securely and was accessible to unauthorised individuals, placing personal data at risk. A number of issues identified during this inspection, including staffing pressures, shortcomings in care planning, storage of confidential information, medication management, activities provision, infection prevention and control, and environmental risks. Staff morale appears low and staff told us they do not feel valued and raised concerns regarding employment practices, including the absence of enhanced payments for bank holidays and perceived inequalities in the allocation of contracted hours. Some staff reported hours are prioritised for overseas workers with sponsored contracts, which had contributed to dissatisfaction within the workforce.

The RI completes three-monthly visits and produces reports detailing their findings. However, these reports do not evidence meaningful consultation with people living in the home, their representatives or staff. The reports contain generalised statements regarding satisfaction with the service but do not record who was consulted or the views expressed. This limits the provider's ability to demonstrate that people's experiences are informing service development and improvement. The RI also produces six-monthly quality of care review reports. Whilst these reports contain information relating to the service, they do not demonstrate robust analysis of complaints, audits, incidents, safeguarding concerns, staffing issues or statutory notifications. As a result, there is limited evidence that trends are being identified, lessons are being learned, or clear actions are being implemented to drive improvement. This is placing people's health and well-being at risk, and

we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

People are not consistently supported by a sufficient number of suitably recruited and vetted staff. Staff receive training and regular supervision. The manager told us they have no responsibility for recruiting staff. New staff are deployed to the service by the provider through one of their other companies. We found the provider does not always obtain satisfactory references and completed application forms before staff commence employment. In addition, Disclosure and Barring Service checks are not consistently obtained in accordance with safe recruitment requirements.

Care staff are required to undertake multiple roles during their shifts, including providing personal care, completing domestic and laundry duties, preparing and serving evening meals after the cook had finished work, supervising people in communal areas and facilitating activities where time permitted. These competing demands limited opportunities for staff to provide meaningful engagement, social interaction and person-centred care. People and staff told us there are insufficient staff available within the home. Staff described difficulties balancing care tasks with domestic and catering responsibilities, whilst people told us they often had to wait for assistance and had no opportunities to participate in activities or access the local community. This is placing people's health and well-being at risk, and we have therefore issued a priority action notice. The provider must take immediate action to address this issue.

Areas identified for improvement

Where we identify **Areas for Improvement** but we have not found outcomes for people to be at immediate or significant risk, we discuss these with the provider. We expect the provider to take action and we will follow this up at the next inspection.

Where we find outcomes for people **require significant improvement** and/or there is risk to people's well-being we identify areas for **Priority Action**. In these circumstances we issue a Priority Action Notice(s) to the Provider, and they must take immediate steps to make improvements. We will inspect again within six months to check improvements have been made and outcomes for people have improved.

The table(s) below show the area(s) for priority action and/or those for improvement we have identified.

Summary of Areas for Improvement	Date identified
People cannot be assured they are living in a safe, clean and well-maintained environment. Poor management of environmental risks, fire safety, infection prevention and control, and maintenance issues increase the risk of injury, infection, harm and reduced wellbeing. Ineffective oversight means identified concerns are not consistently addressed in a timely manner, placing people's health, safety and quality of life at risk.	11/09/26
These failings place people at risk of receiving unsafe or ineffective medicines management as people cannot be assured that medicines are stored, administered and monitored safely, placing them at risk of avoidable harm and poor health outcomes.	11/09/26

Summary of areas for Priority Action	Date identified
People cannot be assured there are sufficient suitably recruited competent and skilled staff available to meet their needs safely. Staffing shortages, ineffective deployment and weak recruitment practices increase the risk of unmet needs, inadequate supervision, inconsistent care and avoidable harm.	11/09/26
People cannot be assured the service is effectively led, managed or staffed. Weak workforce governance, poor management oversight and failures in recruitment, deployment and staff monitoring increase the risk of inconsistent care, poor outcomes and avoidable harm.	11/09/26
People cannot be assured the service is effectively managed, monitored or improved. Weak governance, ineffective oversight and poor information management increase the risk that concerns are not identified or addressed	11/09/26

promptly, placing people's safety, wellbeing, privacy and quality of care at risk.	
People cannot be assured they receive safe, person-centred care that meets their needs and preferences. Poor care planning, limited meaningful activities and ineffective risk management increase the risk of reduced wellbeing, inconsistent care and avoidable harm.	11/09/26

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