Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

Thornbury Community Services Wales (North Wales)

Thornbury Community Services Wales (North Wales), The Pavilions, Bristol, BS99 6ZZ

03451205310

http://www.thornburycommunityservices.co.uk/

The inspection visits for this service took place between 27/07/2026 and 17/08/2026

Service Information:

Operated by:	Independent Clinical Services Limited
Care Type:	Domiciliary Support Service
Provision for:	Supported Living
Registered places:	0
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
Leadership & Management	Requires Improvement

Summary:

Thornbury Community Services is a domiciliary care provider based in Bristol and registered to provide services across North Wales. During this inspection, we found people are supported by a stable staff team that promotes choice, independence and involvement in day-to-day decisions. Care staff know people well and respond appropriately when concerns arise about their well-being. However, we identified areas requiring improvement relating to care planning, outcome-focused support and provider oversight.

People are treated with dignity and respect and are supported to maintain independence and exercise choice and control over their lives. Staff promote positive relationships and support people to access advocacy where required. However, support is not consistently planned and delivered in a way that enables people to achieve their identified goals and personal outcomes and well-being requires improvement. As a result, Well-being requires improvement.

Staff respond to people's changing needs and work with other professionals to promote well-being. However, assessment processes, care planning and record keeping are not consistently effective. Care plans do not always provide sufficient guidance to support consistent practice or demonstrate how people's outcomes will be achieved. These shortcomings resulted in the issue of a Priority Action Notice and Care and Support requires significant improvement.

There are established management and quality assurance arrangements in place. However, provider oversight has not been sufficiently effective in identifying and addressing concerns relating to care planning, documentation and regulatory compliance. Governance and quality assurance systems have not consistently ensured that concerns are identified, scrutinised and addressed in a timely manner. As a result, the Leadership and Management requires improvement.

Findings:

Well-being — Requires Improvement

Thornbury Community Services supports people through care staff who are kind, caring and respectful. During our inspection, we observed warm and positive interactions between care staff and people. People told us they have developed trusting relationships with staff and identified specific staff members they value and rely upon for support. Care staff promote people's rights and independence and understand the importance of enabling people to make their own choices. We saw records that evidenced staff balancing people's well-being and safety with their rights to take informed risks.

The provider ensures people have access to advocacy services when required and has supported individuals to access independent advocacy where concerns about their well-being have arisen. Daily records demonstrate care staff work with external agencies, including community mental health services, social workers and the police, to manage risks and promote people's safety. The provider is working towards the active offer of the Welsh language. This includes making key documents available bilingually and ensuring senior managers actively champion and encourage the learning and use of Welsh.

People are generally supported to maintain important relationships. Staff encourage contact with family members, and some care records reflect people's identity, culture, life experiences and trauma histories. However, care records do not always promote dignity and respect, and we found examples of inappropriate and undignified language. This does not reflect person-centred practice or the values expected within the service.

The provider does not always ensure people receive support that consistently promotes their well-being outcomes. We found limited evidence that some identified outcomes, including community participation, confidence-building, meal planning and reducing social isolation, are translated into structured and purposeful support. Activity planning is not always meaningful or outcome focused and records do not indicate that plans are always followed. Although people have set outcomes to increase community involvement, there is no evidence to demonstrate regular opportunities to achieve this.

Some care planning documentation contains limited information about how care staff should support people when their mental health deteriorates. We see positive examples of trauma-informed care planning, with some support plans providing clear guidance on individuals' needs, triggers and strategies to promote well-being. However, this approach is not applied consistently across the service. Whilst staff recognise changes in people's well-being and seek professional support when required, support plans do not always provide sufficient guidance regarding warning

signs, coping strategies and interventions for all individuals. This reduces assurance that people receive a consistent and trauma-informed approach during periods of emotional distress.

Care & Support

Requires Significant Improvement

People receive support from care staff who respond to changing needs and seek assistance from healthcare professionals when concerns arise. We saw some examples of staff identifying deteriorations in people's well-being, seeking medical advice and involving relevant professionals to support positive outcomes. The provider undertakes transition work before people move into their home, including visits, introductory meetings and planning meetings.

Care staff and managers undertake effective infection prevention and control arrangements, such as cleaning schedules, and staff demonstrated awareness of their responsibilities in this area. Audits are in place to ensure that standards are maintained.

Medication is mostly managed in line with recommended guidelines. People's medication, including controlled drugs, is stored securely and staff undertake regular stock checks to ensure that they are managing medication safely. We found evidence in recording and stock levels that people generally receive their medication in line with their prescribed health needs. Medication ordering and administration errors were noted during inspection, however, these were recognised by the provider through their existing monitoring processes, and appropriate action was taken to address and resolve each issue at the time it occurred.

People do not always receive care and support that is fully informed by accurate and up-to-date personal plans. We found examples of care plans, risk assessments and health records containing contradictory, incomplete or outdated information. In some cases, personal plans had not been sufficiently reviewed following commencement of the service and still referred to previous placements or future arrangements that were no longer relevant. Information relating to mobility, continence, diabetes management, support arrangements and health needs was inconsistent across records. While information on individuals is obtained prior to services commencing, there is no evidence of a formal assessment process that has informed the providers judgement on whether a service could be provided. As a result, staff could not always rely upon documentation to guide safe and consistent practice.

We found evidence that some people were not consistently supported to achieve their identified outcomes. Goals relating to meal planning, community access, confidence-building and independent living skills were not supported through structured interventions. Records show occasions where support is delayed or delivered differently from documented plans.
As a result of these identified issues during inspection outcomes for people require significant improvement and we have therefore issued a priority action notice. The provider must take immediate action to address this.

Leadership & Management Requires Improvement

There are established management arrangements in place to support the service. A 24-hour on-call system is available and records demonstrated that care staff utilise this. Staffing levels observed are sufficient to meet people's immediate needs. There is a suitable management structure in place which enables effective escalation of issues.

The provider ensures that care staff are recruited diligently, ensuring the safety of people using the service. We saw evidence of Disclosure and Barring Service (DBS) checks, reference requests and right to work checks. Care staff are mostly trained as outlined by the providers statement of purpose in areas relevant to the service being delivered. We spoke to care staff who described the training offer as a positive of working for the provider, and that bespoke training was required when individual circumstances required it. While care staff feel adequately trained there are still gaps in training that the provider outlines in their statement of purpose.

There are some governance systems in place that support the oversight of the service. The provider routinely holds a quality, safety and workforce meetings which analyses trends in incidents and safeguarding concerns with associated actions. We saw evidence of some audits such as medication audits which allow oversight. The provider also carries out internal inspections to report on the quality of the service to the wider organisation. Whilst some governance processes are established, they have not been sufficiently effective in identifying and addressing concerns relating to care quality and outcomes. Although audits are undertaken, issues relating to personal planning, medication management, record keeping and outcome-focused support remain present.

There is currently no Responsible Individual in place; however, there is a delegated individual within the service that is performing this role while an application is ongoing. The provider has undertaken visits to the operational office and spoke to individuals and staff within the regulatory timescales. However, these visits do not evidence sufficient scrutiny over assessments, care records and outcomes for people. The service provider has failed to submit an annual return. It is a requirement for a provider to submit an annual return within the timescales set out by the regulation. In addition, the provider has not submitted notifications to us (the regulator) in all appropriate circumstances. As a result, outcomes for people require improvement and we expect the provider to make improvements.

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 are at risk because oversight and supervision of the service are not sufficiently effective to identify, assess and address issues within the service, resulting in shortcomings in care planning, record-keeping and regulatory compliance remaining unresolved.	27/07/26

Summary of areas for Priority Action	Date identified
People are at risk of receiving unsafe or inappropriate care because care and support plans do not consistently provide accurate, up-to-date, and person-centred guidance, and there is limited evidence that identified outcomes are being actively supported and achieved.	27/07/26

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