Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

Dolywern

Leonard Cheshire, Dolywern Pontfadog, Llangollen, LL20 7AF

01691437002

The inspection visit took place on 26/01/2026

Service Information:

Operated by:	Hayes Healthcare Limited
Care Type:	Care Home Service Adults With Nursing
Provision for:	Care home for adults - with nursing, Care home for adults - with personal care, Provision for learning disability
Registered places:	31
Main language(s):	Welsh and 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 Significant Improvement
Care & Support	Requires Significant Improvement
Environment	Requires Improvement
Leadership & Management	Requires Significant Improvement

Summary:

Dolywern is in a small rural village near to Llangollen and Chirk. It provides personal care and nursing care to adults.

The new manager is visible and approachable, and people and relatives described some positive changes, particularly to the physical environment and responsiveness of management. However, these improvements have not yet resulted in sustained positive outcomes for people.

People continue to experience poor well-being due to a poor culture in the service and inconsistent respect and sensitivity shown towards people's rights and needs. We found poor outcomes for people because issues remain with care and support often delayed and not delivered following people's preferred or planned care.

People experience poor outcomes because of weaknesses in the RI's leadership, oversight and in quality review systems. This has resulted in some people feeling unsafe, unheard, or distressed, and in some cases has led to reported harm. We have issued priority action notices where outcomes for people require significant improvement, and we expect the provider to take immediate action to address these issues.

Findings:

Well-being

Requires Significant Improvement

The provider promotes Welsh language and culture in the home, celebrating Welsh cultural festivals and events, and through themed activities. During our inspection, the activity coordinator was delivering a group session about St Dwynwen, and people were learning the history of the saint through watching videos and discussing traditions associated with the saint's day. This led to discussions and watching videos about Welsh castles. Other cultures are also recognised through activities and themed events. We saw people helping to prepare vegetables ready for a Burns Night meal. We saw pictures of younger residents going clubbing, pantomimes held in the home, and visiting entertainers as part of celebrations in the run up to Christmas recently.

Care staff support people to attend medical appointments and access healthcare advice. Visitors are welcomed to the home and in response to feedback from relatives and people, the manager has implemented a staff photo board, so people know the names of everyone on duty. We also saw a new notice board in the main entrance stating "Welcome to our home" with pictures of people on it. This fosters a positive sense of community in the home for people and visitors.

Pictures and posters on the walls in corridors celebrate people's achievements, including a wall display of one resident's artwork, and another showing all the local charities people and events in the home have raised money for.

While some people told us they have positive experiences in the home, we found well-being outcomes for many people require significant improvement because people's dignity, emotional well-being and sense of control over their lives are not consistently protected. People described waiting lengthy periods for help with personal care and being told they must wait because care staff who respond are "not in their section." People told us this left them feeling undignified and distressed. People's preferences for care and support, including who supports them with personal care, are not always respected. One person told us care staff respond with "*this is how we've always done it*" when they have requested their care is delivered in a particular way. In one instance this led to care staff causing harm to that person by not listening to a person's needs and preferences for care. People describe care staff whispering about people within earshot and questioning them after they raise concerns with management if their needs are not being met. People told us staff do not always listen when they explain what they need, including when people have specialist knowledge of their own bodies. These issues have impacted on people's sense of safety and control over their day-to-day lives and left people feeling excluded, judged, and uncomfortable in their own home. This is an ongoing issue since the last inspection, which has impacted on well-being outcomes for people and places them at risk of harm. Where providers fail to take priority action, we will take enforcement action.

Care & Support

Requires Significant Improvement

The new manager has made progress with updating people's care and support plans and risk assessments to ensure they are personalised and meet commissioners and regulatory requirements. We saw updated plans are personalised and give clear instruction. Associated care records have some gaps and inconsistencies in them, and we raised this with the manager who told us they would address it. We saw good records of incidents and accidents, and feedback from commissioners about the improvements made by the manager is positive. We saw the home is clean and there are good hygienic processes in place for processing laundry. Records in the home show accidents and incidents are recorded appropriately, and care is escalated in a timely way when required. The manager ensures reporting on potential safeguarding incidents is timely and thorough.

Care and support in the service requires significant improvement because care staff do not deliver it to people in a consistently safe, respectful, and person-centred way. Although we saw good numbers of staff in the home during our visit and some good staff interactions with people receiving support to eat and drink or take medications, many people we spoke to told us call bells usually go unanswered for prolonged periods. They told us care staff were being more attentive and responsive than usual because CIW were in the home that day.

People described care that is often task-focused, with care staff prioritising routines over people's need. People described incidents of unsafe delays in care of up to one hour when using the bathroom and being refused support when a member of staff responded to their call bell; the member of staff told them to call again in ten minutes because it was near the end of their shift. We spoke with other people living at the service who told us about their experiences of receiving care that was not in line with their care plans, wishes or preferences and of the impact this had on their wellbeing and safety. We observed elements of task-based care and staff not listening to the preferences of people during this inspection.

These incidents show care staff do not deliver person-centred, respectful, dignified care, that consistently adheres to people's planned care and as a result people are at risk of feeling under-valued as individuals and of being harmed. This is ongoing since the last inspection and has impacted people's well-being outcomes, and has caused physical harm to one person, and placed another at risk of physical harm. We have therefore issued a priority action notice. The provider must take immediate action to address this issue.

Environment — Requires Improvement

We have not considered this theme, in full.

The home is warm and welcoming, with large communal areas and wide corridors that accommodate wheelchairs and specialist equipment easily. The dining room is well laid out to provide family-style dining for those who prefer it. There are two lounges, one of which is large and can accommodate multiple wheelchairs and seating options. The home has a computer room where people can freely access IT equipment and the internet, and there are two large mobile tablets available in the smaller front lounge. We saw bilingual and pictorial signage throughout the home to help people orientate themselves.
Some progress has been made towards meeting the regulations for the environment, but we did not look at this theme in full at this inspection to allow a suitable timescale for the extent of works required, particularly in the grounds and gardens.

People's bedrooms are highly personalised, clean, and homely, but can be cluttered due to the number of belongings people have acquired over the many years they have lived in the home. We saw some people lack adequate storage space for their belongings, however records and individual risk assessments for people acknowledge this and give clear guidance to care staff on how to reduce risks to people. There is dedicated storage space for equipment and people's wheelchairs. We saw evidence of decoration and refurbishment of some rooms has been completed. People told us they value their rooms and the improvements made so far. Feedback from relatives' meetings supports this.

We found health and safety management and monitoring systems are in place to keep people, staff, and visitors safe, including staff training in health and safety, visitors log, and the allocation of multiple staff as fire marshals so each shift is covered.

Although maintenance systems are now in place, action planning in relation to repairs and maintenance still lacks clear timescales. More time is needed for the provider to achieve the improvements required, and this remains an area for improvement that we expect the provider to address fully.

Leadership & Management

Requires Significant Improvement

The new manager has made many positive changes and is well regarded by people and relatives. Care staff told us staff morale has improved since the new manager, and her team came into post. They have implemented a regular system of audits of the care delivered in the home and maintain good working relationships with commissioners and other professionals visiting the home.

Outcomes for people require significant improvement because service leaders have not effectively protected people or driven improvements and have failed to ensure compliance with the regulations. Previous issues we found with RI oversight, quality of care review processes and reporting by the RI, and medication management policy accuracy have not been addressed. The RI told us they are in the home multiple times a week and speak to people and staff during each visit. However, care staff told us they do not regularly see or speak to the RI. They told us they would like more communication from the management team about the direction and developments in the home. Records in the home do not evidence that feedback from people and staff is collected through in-person communication with the RI. The manager issued quality assurance questionnaires to staff, people, and their representatives in December 2025. We found the records of the RI's quality monitoring in the service do not demonstrate their critical analysis of the feedback results, or that they routinely review a selection of records including complaints and safeguardings as part of this process. The lack of effective oversight, including meaningful engagement with people and staff, analysis of feedback, or robust action planning, has resulted in missed opportunities to identify and promptly address the poor staff culture and unsafe practices. This has allowed issues affecting people's dignity, safety and well-being to persist. This is still having an impact on outcomes for people and placing them at risk. Where providers fail to take priority action, we will take enforcement action.

There has been a reduction in the use of agency staff since the last inspection. The manager is currently recruiting more permanent staff to ensure cover in the event of unexpected absences and annual leave. Records show recently appointed staff are appropriately supported through shadowing and induction. Staff report they receive face to face training in some aspects of care and support, including moving and handling which is delivered in-house. However, they told us most mandatory training is delivered online. This is supported by records of the mandatory training tracker. The tracker does not currently show how frequently each course needs to be renewed or when they expire and shows kitchen and cleaning staff have not been allocated mandatory safeguarding training, even though they work in a care setting. We raised this with the manager and RI who assured us this is mandatory training for all staff. The manager showed us improvements they have made to the tracker for manual handling practical training to demonstrate their plans to improve their oversight of all mandatory and specialist training.

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
Inconsistently dignified, respectful, and person-centred care practices in the home are placing people's emotional and psychological well-being and autonomy and confidence at risk of harm.	26/01/26
People experience poor well-being in the service because the provider has not adequately audited the environment of the service to ensure issues are identified and addressed in a timely and satisfactory way.	01/10/25

Summary of areas for Priority Action	Date identified
People do not receive consistently person-centred care and support that meets their needs and preferences and supports them to achieve their personal outcomes. This has resulted in avoidable distress, harm and unmet outcomes for people, placing their well-being outcomes at risk.	01/10/25
People have experienced poor well-being and harm because the provider has not ensured adequate improvements that ensure the service is delivered in line with their Statement of Purpose, and with sufficient care and competence.	01/10/25
People experience poor well-being outcomes and increased risk of harm because the Responsible Individual has not ensured effective arrangements are in place to monitor, review and improve the quality of care and support provided by the service.	07/05/25
Outcomes for people require significant improvement because the Responsible Individual has been ineffective in their oversight of the management, quality and effectiveness of the service.	01/10/25

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