Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

The Waverley Care Centre

Waverley Care Centre, 122-124, Plymouth Road, Penarth, CF64 5DN

02920705282

waverley care centre

Date(s) of inspection visit(s):

15/04/2025, 23/04/2025, 30/05/2025, 10/04/2025

Service Information:

Operated by:	The Waverley Care Centre Ltd
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 mental health
Registered places:	129
Main language(s):	English
Promotion of Welsh language and culture:	The service 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 Improvement
Environment	Requires Improvement
Leadership & Management	Requires Significant Improvement

Summary:

The Waverley Care Home is based in Penarth and can accommodate 129 residents with a range of nursing and personal care needs. Care documentation is not always robust and reflective of people's care needs and requires improvements. Although care staffing levels are good, care delivery is not always provided in a timely manner and care staff do not always have a good understanding of people's needs. People live in an environment which requires improvements. The home is currently undergoing an extensive schedule of works which is impacting on people's wellbeing, safety and needs to be reviewed. The Responsible Individual (RI) visits the service regularly, but improvements are required regarding the quality assurance monitoring systems in place. Due to recent changes in leadership, management and staffing arrangements, people are not always living in an environment that is safe and clean. Improvements are required to ensure the service works with external agencies and notifies the Regulator of incidents and safeguarding matters in a timely manner to ensure the service is acting in people's best interests.
We have issued a priority action report to the service provider, and we expect immediate.

action to be taken

Findings:

Well-being — Requires Improvement

People do not always have the support they need to maintain their physical, mental, and emotional health and their needs are not always anticipated. We looked at a sample of care documentation and found some information was unclear and had not been reviewed appropriately. Care files are important documents which should outline a person's entire needs, and the actions required from staff to meet those identified needs. We found the documentation lacked important information to guide care staff in relation to people's preferences, personal care needs and medical conditions. Personal plans also lacked guidance on personal likes and dislikes, social interests, daily routines, as well as all the aspects of life the person needed support with. Documentation needs to better reflect the care and health needs of people living at the home,

People are mostly protected from harm and abuse. Although the home has a robust safeguarding policy in place and staff receive training in the safeguarding of adults at risk of abuse, we identified several incidents when referrals had not been made to the Local Authority team when required and Care Inspectorate Wales had not been notified of incidents as set out within the Regulations. Care staff we spoke with told us they are mostly happy working at the service and feel supported by the Responsible Individual. People do not always have control over their lives. Although the Waverley Care Home offers some activities this area requires consistency and improvement in accordance people's interests. We observed some people appeared bored and under stimulated and saw when staff did have the opportunity to sit and spend time with people this opportunity was often overlooked and missed by care staff

The home environment is secure but urgent attention and oversight is required throughout the entire home to maintain people's safety. There are ongoing building works being undertaken externally but currently affecting the interior of the home. Attention is required to prevent any adverse impact for staff, visitors and people living at the home. Infection control arrangements require improvement to reduce the risk of infectious diseases being spread throughout the home.

People mostly receive care and support from a friendly staff team; and we were told there are enough staff to help with arrangements in place to cover any shortfalls. People sometimes receive a range of social and recreational support in accordance with their interests, however this area requires consistency and improvement.

Care & Support — Requires Improvement

People do not always have a voice to make choices about their day-to-day care. We saw staff not always responding promptly to people's needs throughout the visit. We saw several people calling out to staff from their rooms, with no staff presence and many did not have access to a call bell. Several people required assistance to maintain their dignity and cleanliness. However, when we asked staff to assist, we saw people were not always acknowledged and engaged with to ensure their emotional needs and wishes were met. We saw instances when care staff walked past individuals when it was evident assistance was required to support their comfort and dignity. Several residents had soiled clothing which we notified care staff of during the visits. These incidents had not been identified or readily responded to by staff working in the areas at the time. This does not ensure care is person-centred and to meet people's needs and expectations.

Whilst personal care documentation contained some of the required information, it did not always accurately reflect the day to day needs and wishes of individuals living at the home. We found one personal care plan did not contain any guidance for oral care to be carried out and saw the documentation was blank. We saw information regarding recent falls contained conflicting entries in the documentation. Staff did not know whether one person wore glasses or not and no information documented on the electronic care file. We found the person had a recent prescription for glasses which were in the person's room when should be worn. We observed several people to be isolated in bed in the afternoon during our visits and some individuals sitting sleeping in communal areas but could find no information on the personal plan on how the person wished to spend their day, therefore, this could be regarded as restrictive practice.

We saw evidence in care files of support from other visiting professionals such as GP and dietician. People are encouraged to have visitors to the home and during our visit we spoke with visitors who told us *"We are happy with the care provided".* People have a choice of meals and drinks to support their nutritional needs. Consideration needs to be given to ensure support is provided for people who remain in their own rooms. Also, people who need encouragement and support within the communal areas with drinks and fluids, especially during the warmer weather. We saw some instances where staff were very caring and understood how best to communicate with people living at the home. Others appeared to lack the confidence and competence to interpret the meaning of behaviour exhibited by some people. We saw many instances of people being repeatedly asking to sit back down. This was re-enforced with the use of chair alarms which detonated and resulted in staff rushing to the person requiring them to sit without explanation. The individuals could see other people moving freely in the room and at least three people expressed a wish to leave their chairs, becoming more distressed when unable to do so. One member of staff entered the room and saw one of the people attempting to stand and immediately assisted them to do so safely. The impact on the person was profound and positive.

We discussed the findings with the interim manager who agreed and told us the matters would be

addressed immediately. Outcomes for people require improvement because the provider has failed to ensure adequate oversight of the service. We expect the provider to take immediate action to address this issue.

Environment — Requires Improvement

People cannot always be assured they live in a suitable environment. The Waverley care home is in Penarth with local amenities and views of the seacoast within walking distance. The home can accommodate up to 129 people over several floors made up of small communities. On arrival, we were asked to sign the visitors book and identification checks carried out before we were permitted entry. We carried out a tour of the building and found several areas where improvements are required. We saw hazardous fluids and personal items stored in bathrooms and not locked away safely as required, in areas where people with dementia were walking around. We found several areas of the home including corridors and bathrooms to be malodourous and established this was due to bins in communal bathrooms not being emptied. On two of our visits, we saw communal toilets heavily soiled with faeces, being accessed by people with dementia. At this time, the service does not have appropriate infection control measures in place to reduce and prevent the spread of infectious diseases and we advised regular audits of the environmental issues identified to ensure the environment is safe be carried out.

The environment is not best used to allow people to benefit from each other's company. We saw, in some parts of the service, some people are accommodated together without consideration of their compatibility to live alongside others without compromise. People who like to walk extensively, throughout the day, are often limited to compartmentalised areas secured with door restrictions. We saw a few exceptions where people were assisted to walk up and down the corridors, with staff or relatives. The weather outside was wonderful and time walking in the garden or in the areas surrounding the service would have been very beneficial.

People's needs are not always met because the providers systems for monitoring and maintaining the physical environment and equipment in the home requires strengthening. Extensive building works are being undertaken which is sometimes impacting the wellbeing of people living at the home. We found several bedroom views had been obstructed by rubble and building works being undertaken throughout various parts of the home occupied by vulnerable and unwell individuals. Windows had been left open in several bedrooms and a potential risk identified regarding construction dust. Curtains were kept closed to attempt to reduce the impact of the view, but this served to disorientate people who struggled to differentiate day and night. There are gardens available but found these areas require decluttering to enable people to spend time outdoors comfortably in the warmer weather.

Service equipment such as hoists are tested regularly to ensure they are fit for use, but we found items including shower chairs required replacing. The home has communal space throughout including spacious lounges and dining areas that facilitate people spending time together. Although we saw various areas affected during the refurbishments phase, we saw visitors welcomed into the home throughout each visit.

Staff who spoke with us felt the environment had unduly compromised the enjoyment of people at

the service, particularly the loss of the ‘coffee shop’ and namaste room, although a few appreciated ‘it should be nice when it’s completed’.

The Food Standard Agency (FSA) has awarded the service a rating of five (very good). The provider acknowledges our findings identified during the inspection visit and told us they have already commenced action to remedy the issues to mitigate potential risks to health and safety.

Outcomes for people require improvement because the provider has failed to ensure adequate oversight of the service. We expect the provider to take immediate action to address this issue.

Leadership & Management

Requires Significant Improvement

People are at risk because the provider's systems for identifying, capturing, and managing organisational risks and contingency planning are ineffective, and some legal requirements are not met or are poorly understood by staff. At the time of the inspection, we were told of significant recent changes to the leadership and management arrangements at the home. This information should have been shared with CIW at the time of these events occurring or as soon as is reasonable after. The absence of consistent management has led to deficits and a lack of direction within the home. This in turn has resulted in people not receiving their required care in a timely manner. An interim manager has been appointed, supported by the general manager. The directors, general manager and interim manager shared their disappointment at the performance of the service during the inspection days and agreed significant improvement must and would be made.

We found instances where the service provider has failed to notify the relevant authorities in the event of significant incidents, such as accidents, injuries or safeguarding issues. We identified several incidents and accidents that had not been reported appropriately and with candour. Furthermore, we identified serious issues which had not been shared with the Adult Safeguarding team. We were told that auditing had already commenced to establish exactly how many notifications the service had failed to share with external professionals by key members of the workforce and RI.

The RI regularly visits the home and engages with individuals and residents, and we saw a quality-of-care review had been completed. However, we found this had been ineffectual in highlighting matters of concern. The management team acknowledged this must be strengthened to ensure there is true oversight of the service in place at this time of management uncertainty.

Recruitment processes are mostly robust, and checklists are carried out to ensure the required information and/or documentation is present and correct. We identified one person's recruitment file did not contain the appropriate identification checks of the applicant. Aside from this, the provider demonstrates safe recruitment practices. The management of whistleblowing, grievance and disciplinary action was not, however, effectively evidenced. Care staff are provided with training in areas including dementia care, manual handling and fire safety. This is not always transferred to practice, since we saw several instances where staff struggled to understand how best to meet the needs of people living with dementia. The provider should consider care documentation training for all care staff due to deficits identified in personal care plans we viewed.

Whilst the responsible individual (RI) was present, the day-to-day management requires more stringent measures for the smooth running of the home. They must ensure suitable arrangements are in place to ensure systems and processes are continually reviewed to enable them to identify where quality and /or safety is being or may be compromised and to respond appropriately without delay. The good care experiences some people living in some parts of the home were not equally

experienced by others. The provider has started to take reactive steps to address the differences.

Outcomes for people require significant improvement 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
The provider must ensure that the service that the premises, facilities and equipment are suitable for the service, having regards to the statement of purpose for the service.	10/04/25
The provider must ensure that care and support is provided in a way that protects, promotes and maintains the safety and wellbeing of individuals.	10/04/25
The service provider must ensure that there are effective arrangements in place for the monitoring, reviewing and improving the quality of care and support provided by the service.	10/04/25

Summary of areas for Priority Action	Date identified
The service provider must ensure that there are effective systems in place to record incidents, complaints and matters on which notifications must be made in accordance with regulations 60 to 62 and 84.	10/04/25