Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

Glenmore Residential Home

Glenmore Residential Home, 188-190, Stow Hill, Newport, NP20 4HB

01633258601

The inspection visit took place on 11/03/2026

Service Information:

Operated by:	BABITA DANHAWOOR
Care Type:	Care Home Service Adults Without Nursing
Provision for:	Care home for adults - with personal care, Provision for mental health
Registered places:	22
Main language(s):	English
Promotion of Welsh language and culture:	The provider is not promoting the Welsh language and culture needs of people, and this requires improvement.

Ratings:

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

Summary:

Glenmore Residential is located on the outskirts of Newport city centre. The service aims to provide a welcoming, homely, comfortable and safe environment for residents and, through an open and inclusive approach, to develop and maintain personalised plans of care for each person.

The well-being of people at Glenmore Residential requires improvement. Generally, people feel safe and content and are supported to maintain positive relationships with family and others important to them. However, people are not always supported to exercise choice, maintain independence or take part in meaningful activities.

The care and support provided require significant improvement because assessments, care

planning and risk management arrangements are not consistently effective in protecting people from harm. Care plans are not always reviewed or updated when people's needs change, which places people at ongoing risk.

The environment at Glenmore Residential requires improvement. The home is clean and well presented, décor and furnishings are of a good standard, and bedrooms are personalised. However, environmental risks are not consistently identified or managed. These include unsafe stair access, access to COSHH materials and unclear fire safety records.

Leadership and management also require significant improvement because governance and quality assurance systems do not consistently identify risks or drive improvement. Leadership presence is inconsistent, and learning from incidents is not embedded into practice.

Findings:

Well-being — Requires Improvement

Many people told us they feel safe and generally content living at Glenmore Residential. We observed positive relationships between people, their families and staff, and people are supported to maintain relationships with those important to them. Staff understand the importance of these connections and use available technology to help people stay in contact, which supports people's social and emotional well-being.

People experience mixed well-being outcomes because they are not always supported in ways that promote dignity, choice and meaningful engagement. While some aspects of well-being are supported, shortfalls limit people's ability to live independently and achieve consistently positive outcomes.

People are sometimes treated with dignity and respect in ways that promote choice and autonomy. Staffing pressures and task-focused care limit flexibility, reducing people's control over their day-to-day lives. People are not always able to make choices about daily routines, such as when to go to bed. Personal plans do not consistently reflect people's individual routines, preferences, strengths or life histories. This limits staff's ability to treat people as individuals and to support well-being outcomes effectively. Where care planning lacks detail, people's wishes and identities are not always recognised in practice. People's physical safety and confidence are also affected because risk management does not consistently support well-being. Risk assessments are not always reviewed or updated when people's needs change or when incidents occur.

People sometimes receive the support they need to maintain their physical, mental and emotional health. However, activities are limited mainly to bingo and occasional crafts. People told us they can feel bored when the activity coordinator is not present and would like more meaningful activities, such as quizzes, colouring and improved choice around food. Opportunities for engagement are limited, particularly for people who remain in their rooms.

The activity coordinator is well known within the service and supports people to engage socially and access the community. However, the coordinator works limited hours, and staff confirmed that due to staffing shortages, activities are often deprioritised, even when the coordinator is available. Activities are mainly group-based, which limits individual engagement.

People's bedrooms are personalised and reflect their identities, preferences and interests. This supports people's sense of belonging and comfort within the home. Some meaningful activities do take place and are enjoyed by people, particularly when the activity coordinator is present, and

people are supported to access the wider community during these times.

Care & Support

Requires Significant Improvement

Some people at Glenmore Residential experience respectful and compassionate interactions with staff and feel secure because staff demonstrate an understanding of safeguarding responsibilities.

People do not consistently receive safe, effective care and support because assessments, care planning, review arrangements and oversight are insufficient. This places people at risk of harm. Personal plans are reviewed periodically; however, they lack meaningful detail and do not consistently include people's life histories, routines, preferences or strengths. This limits staff's ability to fully understand people as individuals and to deliver person-centred care. Care planning is not consistently reviewed or updated following changes in people's circumstances, and people or their families are not always involved in planning how care and support needs will be met.

We saw examples where people were experiencing significant distress and repeatedly attempting to leave the service, yet personal plans did not include appropriate behavioural support guidance. Plans did not identify triggers, risks, de-escalation strategies or patterns of behaviour, despite ongoing behaviours that could place the person and others at risk. This means staff lack clear guidance to respond safely and consistently.

There is a falls record in place; however, falls management and review are poor. We found repeated falls, injuries and fractures were not followed by timely updates to personal plans or risk assessments, even when paramedics or GPs were involved. Staff actions did not always reflect the level of risk identified, increasing the likelihood of further harm. Records did not evidence learning or preventative action following incidents.

People are also supported to access healthcare professionals, which helps meet some of their health needs. However, these positive aspects are not consistently supported by effective systems, records or oversight. Daily care records are largely task-focused and repetitive. They do not consistently reflect planned interventions, outcomes or timely responses to changes in need, reducing oversight and assurance that care is delivered as planned.
Emergency planning also requires improvement. Personal Emergency Evacuation Plans were reviewed on a single date for all people but contained generic and incomplete information, such as "staffing ratio: N/A," which does not provide clear guidance in an emergency.

Care and support provided by Glenmore Residential home requires significant improvement. Systems do not ensure care is assessed, planned, delivered and reviewed in a way that protects people from harm or supports their individual needs. This is a priority action and must be addressed by the next inspection.

Environment — Requires Improvement

The environment at Glenmore Residential offers people access to a range of communal and private spaces where they can spend time alone, socialise with others and receive visitors. Communal lounges and dining areas provide opportunities for people to spend time together, while bedrooms offer private space.
Some specialised equipment is available; however, there are insufficient quantities, and equipment is not always accessible when needed or suitable for people's needs. This limits people's ability to move safely and maintain independence, particularly for those with reduced mobility or increased support needs.

We identified environmental safety risks, including an open staircase that is accessible at all times. We observed a person using the stairs unsupervised, despite known mobility risks. The laundry room was also unlocked and accessible to residents, with COSHH materials stored inside. These hazards place people at risk of injury and indicate that environmental risks are not being effectively identified or managed. This is an area for improvement which we expect to be addressed by the next inspection.

Documentation indicates fire safety checks are expected to be completed weekly; however, the most recent recorded test was dated 17 December 2025. Additional fire safety records contained dates but did not clearly identify the year. There was no clear evidence of fire evacuation practice or accessible supporting materials to guide staff and people in the event of an emergency. This limits assurance that people would be kept safe should a fire occur. Staff also told us they had requested modern mobility equipment, such as a *steady* to support safe transfers; however, this request was not supported or approved by management, further limiting people's safety and independence.

The home is generally clean, tidy and well presented, and décor and furnishings are of a good standard. Bedrooms are well furnished and personalised, reflecting people's identities, preferences and interests. The kitchen maintains a high standard of hygiene, with a food hygiene rating of 5. Window restrictors are fitted in relevant areas, supporting people's safety. These positive features provide a comfortable living environment, although further improvements are needed to ensure risks are consistently managed and people's safety and well-being are fully supported.

Leadership & Management

Requires Significant Improvement

There are some positive aspects of leadership and culture at Glenmore Residential care home. Staff described the Responsible Individual as approachable and supportive, and staff told us they feel confident in reporting safeguarding concerns. Relatives also said they feel confident raising concerns if needed.

Quality monitoring systems are not robust. Managers and leaders do not consistently monitor care quality or use information to improve practice. Oversight arrangements lack clarity, and roles, responsibilities and accountability within the service are not well defined. As a result, staff do not receive regular, constructive feedback about their performance or areas for improvement, limiting opportunities to improve care delivery.

Leadership presence within the service is inconsistent. Staff told us senior management is frequently off-site. This lack of visible leadership reduces support for staff and limits effective oversight of day-to-day practice.
Staff supervision and development arrangements are ineffective. Although staff reported that supervision takes place, supervision records contained only tick-box entries with no dates or detail. This makes it impossible to determine when supervision occurred or what support was provided. The training matrix was outdated, demonstrating insufficient scrutiny of workforce development and training needs. As a result, staff skills and competencies are not consistently monitored or enhanced.

Staff told us they feel exhausted and unsupported. Staffing levels are insufficient to meet people's needs safely. We found recurring occasions where only three staff were on duty for 19 people, including people who staff believed required 2:1 or 3:1 support. Staff reported missing breaks, struggling to meet basic care needs and feeling burnt out. Leaders have ineffective processes for reviewing staffing levels and skill mix.

Oversight of incidents and risks is poor. Falls audits are not completed, injuries are not consistently followed up with updated care plans or risk assessments, and many falls are recorded as "NR" (not reported). Body maps are not used, and spot checks do not result in sustained improvement.
The service provider does not consistently notify Care Inspectorate Wales of significant incidents, including serious falls and injuries.

Leadership and Management at Glenmore Residential Care home requires significant improvement. Ineffective governance, poor oversight and weak quality assurance systems place people at risk of harm and prevent improvement. This is a priority action notice, which must be addressed by the next inspection.

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.

CIW has no areas for improvement identified following this inspection.

Summary of areas for Priority Action	Date identified
People are at significant risk of harm because their care and support is not being reviewed or adjusted in response to known risks. People do not consistently receive care and support that protects them from harm. Known risks, including repeated falls and deteriorating mobility, are not effectively managed or reduced. As a result, some people have already experienced injuries, and there is a continued risk of further avoidable harm.	11/03/26
People do not consistently experience safe or well managed care because leadership, governance and quality assurance systems are ineffective. As a result, risks to people's health, safety and well being are not identified or addressed in a timely way. Because leaders fail to monitor care quality effectively, unsafe practices continue without challenge or improvement. Repeated incidents, including falls and injuries, are not reviewed or learned from at a management level. This means people remain	11/03/26