Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

Gwynfa

Gwynfa, 103 Station Road Llanishen, Cardiff, CF14 5UW

02920764714

www.hafod.org.uk

The inspection visits for this service took place between 10/02/2026 and 13/03/2026

Service Information:

Operated by:	Hafod Housing Association Ltd
Care Type:	Care Home Service Adults Without Nursing
Provision for:	Care home for adults - with personal care, Provision for mental health
Registered places:	17
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 Improvement
Care & Support	Requires Significant Improvement
Environment	Requires Improvement
Leadership & Management	Requires Significant Improvement

Summary:

Gwynfa is a large, three storey house which offers 24-hour care and support for 17 people with a range of ability and need, including physical or mental health support needs.

The service is spacious and has access to a secure garden and courtyard. The local community offers a range of leisure and retail activities and is easily accessible. Some people enjoy walking to the local shops and café hub.

Wellbeing is rated as requiring improvement as people's outcomes are not consistent, as not all people are supported to live with choice, control and independence.

"Care and support" is rated as requiring significant improvement as care and support systems, including documentation, are ineffective. While care workers deliver compassionate care, this is not clearly directed, placing people at risk of not receiving appropriate care and support

Environment is rated as requiring improvement because it does not consistently support people's

comfort, dignity or independence.

Leadership and management is rated as requiring significant improvement as the systems used to run and oversee the service are not strong enough to make sure everyone gets consistently good outcomes.

Findings:

Well-being — Requires Improvement

People living at Gwynfa experience some positive aspects of well-being. People told us they feel safe, value settled relationships with care staff and experience kindness from people who know them well. Several people said they are happy living at the service and enjoy trips into the community. One person told us, *"I've lived here five years. I'm happy,"* and another said, *"The carers here are amazing – they turned my life around".* However, well-being outcomes are not consistent, and not all people are supported to live with choice, control and independence. We identified a routine-led, task-focused culture which limits people's autonomy, reduces opportunities for meaningful engagement and does not always support people to achieve their personal outcomes.

Some people maintain independence. We observed people moving freely around the home, choosing where to sit and engaging in everyday conversations with others. We observed institutional practices which prioritised routines over individual preferences. For example, one person was directed when they could clear their plate after a meal rather than being supported to do this at their own pace. People told us they could only prepare food or access kitchen-related activities on specific days. One person said, *"I don't cook, but I think it's a good idea if I try – we can make our own food on a Wednesday."* Another told us, *"To make a cup of tea staff boil the kettle and pour the water in. I would like to cook."*

People told us they feel safe at the service and know who to raise concerns with. One person said, *"I know who to complain to – the manager."* Safeguarding information was visible in communal areas, and the provider demonstrated a proactive approach to making safeguarding referrals.

There are positive relationships between people and care staff. We observed a generally calm and respectful atmosphere. People were seen supporting one another and consulting each other about shared activities, such as what to watch on television. However, quieter people were not always actively engaged. These individuals often complied with routines but were not consistently approached or supported to express what they would like to do. Engagement was sometimes limited to brief checks such as, *"You okay?"*, rather than meaningful conversation.

Opportunities to build confidence, social identity and purposeful activity were inconsistent. Records showed limited evidence of people being offered a range of activities or supported to develop interests, skills or community connections. One person told us, *"I would like to lose weight,"* but there was limited evidence people were consistently supported to pursue health-related goals.

People's bedrooms are personalised and reflect individual preferences. One person told us they were proud of their room and liked the light from the windows.

The provider is working towards the Welsh offer.

Care & Support

Requires Significant Improvement

People living at Gwynfa experience kindness, familiarity and support from individual staff members. We observed care staff who know people well, use their preferred names and respond to changes in people's presentation. People spoke positively about care staff. One person told us they felt supported, saying staff *"Do my meals"* and *"Help me when I need it."* People were mostly helped with their appearance in a way they wished, and we saw some genuine, caring interactions. However, these positive experiences are not consistently supported by effective care and support practices, which affects people's ability to achieve positive outcomes reliably.

We found people are not consistently involved in planning or reviewing their care and support. Personal plans are often task-focused rather than strengths-based, and some language used was not respectful or person-centred. This means personal plans do not always clearly describe what is important to people or how care staff should support them to maintain dignity, independence and wellbeing.

Daily records focus mainly on tasks completed rather than demonstrating how staff support people with care and developing independence and how this is experienced by the individual. For example, records did not always show whether people had been supported with oral care or skin checks, where appropriate and risks were known. There is no reference to encouraging people's independence and how this is responded to. This means the provider cannot consistently evidence care is being delivered, as planned, or in response to people's individual needs.

We identified care practices did not always protect people from avoidable risk or uphold dignity. Some staff interactions were observed to be overly directive or delivered in a raised voice in communal areas, such as during mealtimes. Such practices risk undermining people's dignity and emotional wellbeing, particularly for those who may feel anxious or less confident in group settings. We found examples where health concerns were recorded repeatedly over time, but records did not show these concerns were escalated, discussed with health professionals or used to inform any required changes to care. This limits assurance care is reviewed effectively. When people's needs change and health risks increase, issues are not always addressed in a timely way.

Oral health care was not always well understood or clearly planned. In one discussion, the importance of oral care was underestimated, indicating a need to strengthen staff understanding of wider health risks, particularly for people who smoke or have complex health needs.

We found medication systems are in place, and care staff understand the importance of people receiving their prescribed medicines.

Infection prevention and control practices are inconsistent. We saw worn equipment and unclean areas posed potential infection risks.

Some people experience positive aspects of care; however, these are not consistently supported by effective care and support systems. This represents a significant risk to people's wellbeing and demonstrates that the service is not reliably delivering positive outcomes. The provider must take immediate action to ensure people receive safe, consistent and person-centred care and we are

therefore issuing a priority action notice. The provider must take immediate action to address these issues. Since the inspection visits, the RI has provided some reassurances through plans and actions to demonstrate their commitment to achieving the required improvements.

Environment — Requires Improvement

People live in a spacious home with good public transport links and nearby amenities. Resources such as games and activities were available, though some were stored out of easy reach, meaning people sometimes needed support to access them safely. People's needs are not always met because there is limited suitable space for people to have private time with visitors or spend time alone, other than in their bedroom.

We observed communal areas, including the lounge and dining room to be unclean. Furniture, soft furnishings and high-touch areas such as tables, chairs, walls, light switches and skirting boards were visibly dirty or marked. Some areas showed ongoing build-up of dirt and wear, which had not been effectively addressed through cleaning routines. We found cleaning schedules were not consistently completed or signed, meaning leaders could not demonstrate that cleaning was being monitored or maintained to an appropriate standard.

The kitchen environment required improvement to promote cleanliness, and there were limited opportunities for people to undertake everyday tasks. Some rooms and shared areas had unclean surfaces, dirty utensils, uncovered drinks and soiled tea towels, increasing the risk of infection.

The layout and condition of communal spaces do not consistently promote a homely or welcoming atmosphere.

Some spaces, including the conservatory and smoking room, were heavily marked with nicotine staining, and smoke odour travelled through parts of the building, affecting nearby bedrooms. These issues mean communal areas do not always support people's comfort, dignity or independence.

People's bedrooms are personalised and, in some cases, well cared for. People are able to lock their bedrooms to maintain privacy. However not all bedrooms were consistently clean or maintained to the same standard. Some furnishings were stained or worn and require replacement or deep cleaning. This means people's private spaces are not consistently maintained at a standard that supports dignity and well-being. Outcomes for people require improvement because people may be at risk of harm and we expect the provider to make improvements.

We are assured that the provider is taking appropriate action to address the issues identified. The provider acknowledged the areas requiring improvement and outlined clear steps already underway to strengthen cleaning arrangements, review environmental audits, and improve oversight of maintenance and infection prevention. We were provided with evidence of immediate actions taken, alongside plans to prioritise outstanding issues and monitor progress more closely. These actions give us confidence that the provider understands the concerns raised and is working constructively to improve the environment for people living at the service.

We found good safety systems in place, with regular servicing and maintenance of fire equipment and electrical items, promoting people's safety.

Leadership & Management

Requires Significant Improvement

There are positive relationships between staff and people living at the service. Care staff show commitment and care in their day-to-day work. However, the systems used to run and oversee the service are not strong enough to make sure everyone gets consistently good outcomes. We found the provider does not have effective ways to check quality, identify risks, or make improvements. Reviews and checks are not always clear about what is going well, what needs to change, or how lessons are learned. The Quality-of-Care Review gives a mainly positive picture and does not bring together information about complaints, incidents, safeguarding or audits to show what the service needs to improve.

Some areas needing improvement were identified at earlier inspections and have not yet been resolved or embedded, which means people are not benefiting from consistent improvement. Plans for improvement are not always clear, measurable or followed through, which limits the service's ability to demonstrate sustained progress. We cannot be confident that leadership systems are consistently identifying and addressing areas where care, support or safety need to improve.

Staffing arrangements are not consistently recorded or overseen. Rotas do not always clearly show who is working, in which roles, or when management support is available. This makes it difficult to demonstrate that staffing levels are always planned around people's needs. Staffing levels do not promote opportunities for developing independence or wellbeing.

While staff know people well and mostly work positively with them, supervision meetings are not used effectively to support practice, reflection and improvement. Staff meetings have not been held with sufficient regularity, reducing opportunities for shared learning and communication. We cannot be assured that staffing arrangements consistently support positive outcomes for people.
People and staff described Gwynfa as having a friendly and supportive atmosphere, and there are clear examples of kindness and compassion in everyday interactions. However, this positive culture is not yet supported by strong leadership systems. The manager is visible and involved in the service, but is often drawn into daily operational tasks, which reduces time available for oversight, planning and quality assurance.

Some public information about the service does not fully reflect current practice, which can make it harder for people to understand what they should expect from the service.

Although people often receive positive day-to-day support, failures in the systems designed to oversee and protect this care mean that risks to people's health, well-being and safety are not being effectively managed. These weaknesses require immediate action to prevent further impact on people and to ensure safe, consistent care is delivered and therefore we have issued a priority action notice. The provider must take immediate action to address these issues. Since the inspection visits, the RI has provided some reassurances through plans and actions to demonstrate their commitment to achieving the required 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
The service provider is not ensuring that the premises, facilities and equipment are suitable for the service as these are not currently supporting positive outcomes for people.	10/02/26

Summary of areas for Priority Action	Date identified
People are at risk of poor care and support because the service provider is not ensuring the service is provided with sufficient care, competence and skill.	10/02/26
People are at risk of poor care and support because the provider cannot be assured that people's safety and well being are being protected on a day to day basis.	10/02/26

Mae’r adroddiad hwn hefyd ar gael yn Gymraeg

This report is also available in Welsh