Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

3D care (Cardiff) Ltd

Alexandra Gate Business Centre Ltd, 2 Alexandra Gate, Ffordd Pengam, Cardiff, CF24 2SA

02920894860

The inspection visits for this service took place between 03/06/2026 and 23/06/2026

Service Information:

Operated by:	3D Care (Cardiff) Ltd
Care Type:	Domiciliary Support Service
Provision for:	Supported Living
Registered places:	0
Main language(s):	English
Promotion of Welsh language and culture:	The provider promotes, anticipates, identifies, and meets the Welsh language and culture needs of people.

Ratings:

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

Summary:

3D Care Cardiff provides care and support to people in their own home in the East of Cardiff, including individuals with complex physical and emotional needs.

'Well-being' is rated as 'Requires significant improvement'. While some people and their families shared positive experiences, particularly regarding relationships with individual care workers, these are not yet consistent across the service. A number of people reported challenges such as late calls, incomplete tasks, and concerns that have not always been fully resolved. These issues indicate there are opportunities to strengthen overall well-being outcomes through improved coordination and service responsiveness.

'Care and support' is also rated as 'Requires significant improvement'. Although care is being delivered, key processes such as assessments, risk assessments, and care planning are not always sufficiently detailed or completed by suitably trained staff. This affects the consistency with which people's health, safety, and personal needs are met. Some people experience late, missed, or shortened visits which can increase risk.

'Leadership and management' is rated as 'Requires significant improvement'. Current quality assurance and governance arrangements have not yet been fully effective in identifying and addressing areas for development. Strengthening leadership oversight, regulatory understanding, and staff support systems will be key to driving improvement. Workforce stability remains a challenge, impacting continuity of care and people's overall experience.

Findings:

Well-being

Requires Significant Improvement

People's wellbeing outcomes show some positive elements but require improvement. The service supports people to remain in their own homes, which promotes familiarity and independence; however, this is not yet consistently delivered in a way that maximises safety, control, and achievement of personal outcomes. Information such as the statement of purpose and complaints procedures is available, although improvements are needed to ensure accuracy and accessibility for informed decision-making. A small number of the people we spoke with reported satisfaction with the care they receive. The service has yet to develop the 'Active Offer' of the Welsh language though some documentation can be made available in Welsh if required.

Choice and independence are encouraged in principle, but this is not always consistently reflected in practice. For example, one relative told us a person experienced restrictions on their independence, being supported in bed despite being able to mobilise. This highlights the need to embed more person-centred care starting with assessments of what the person can do for themselves.

Communication presents an important area for development. Some people and their families described limited involvement in decisions and inconsistent information sharing. One relative said, "*A manager turned up to do an assessment… we were not privy to or had opportunity to be part of this*." Others highlighted that messages are not always passed on effectively, leading to confusion and variability in care.

Reliability of care delivery also affects people's emotional wellbeing. While many expressed trust in individual care workers, they felt less confident in the consistency of the service overall. Comments included, "*They are late for my morning calls, I've had enough*," and "*Regularly late… if they haven't arrived, X is stressed*." These inconsistencies can understandably lead to anxiety.
Some people reported feeling frustrated when issues such as missed calls, rushed visits, or incomplete care were not fully resolved. These experiences are impacting dignity and trust in the service.

Health needs are supported in some instances, with families noting that staff often communicate when concerns arise. In addition, there are examples of long-term, positive care relationships built by a few dedicated staff who know people well. However, these positive practices are not consistently underpinned by robust care planning, risk management systems and oversight.

Care & Support

Requires Significant Improvement

The quality of care and support demonstrates some positive intentions but requires significant improvement to ensure consistent and safe outcomes. Assessments are undertaken; however, they are not always sufficiently comprehensive or completed by staff with the appropriate level of training. This can result in important health conditions and risks not being fully captured or translated into care planning.

Risk assessment processes require strengthening. Where risks are identified, there is not always clear guidance on how to manage or mitigate them, particularly for people with complex needs such as diabetes, mobility limitations, or behaviours that challenge. This can make it more difficult for care staff to deliver safe and consistent care.

Care plans provide some basic information, such as preferred call times, but often lack the depth and person-centred detail needed to guide practice effectively. Opportunities exist to better reflect people's preferences, strengths, and desired outcomes. Reviews are completed but tend to focus on satisfaction rather than thorough reassessment, limiting their effectiveness in responding to changing needs.

Consistency of care delivery remains a key area for improvement. People reported late, shortened, or missed visits, as well as scheduling issues that can affect nutrition, medication, and personal care. There are also ongoing reports of insufficient staffing, and we saw call records showing occasions where two carers were required but only one attended.

Recording systems are in place but are fragmented between paper and electronic formats. This can lead to gaps in documentation and limited oversight. Families reported that records, including food and fluid charts, are sometimes incomplete, and access to records has reduced despite previous assurances.

Safeguarding arrangements are not yet consistently robust. Some concerns that may meet safeguarding thresholds have not been appropriately escalated, and complaints are not always recorded or resolved effectively. Communication around concerns could be strengthened to build trust and transparency.

People's experiences highlight areas where care quality can improve, including medication administration, hygiene, nutrition support, and infection control. While care workers are frequently described as *"Kind*," there is a need to further develop skills, confidence, and support, particularly in caring for people living with dementia.

Overall people are at risk as systemic improvements in assessment, planning, staffing, and monitoring are required. A priority action notice has been issued to support the provider in making

timely and meaningful improvements, and we expect action to be taken immediately.

Leadership & Management

Requires Significant Improvement

The service provider is not ensuring effective governance is in place. Current systems do not yet consistently identify or address key issues affecting care quality and safety. Strengthening accountability, clarity of roles, and understanding of regulatory responsibilities is required. The responsible individual (RI) and management team need to develop in areas such as quality monitoring, data analysis, and compliance. Existing quality assurance processes do not capture important information, including call times and duration, or staff competency. While an electronic calls monitoring system is in place, its full potential has not yet been realised, preventing identification of issues. Reports lack the depth needed to provide a clear picture of service performance and actions to ensure pathways to improvement can be navigated.

There are opportunities to improve openness and transparency. Complaints are not always consistently recorded or reflected in reporting, despite individuals raising concerns. Feedback suggests that while some issues are addressed temporarily, improvements are not always sustained. The service has policies and procedures, but leaders are not always clear on the content, preventing them recognising issues, including medication administration.

Recruitment processes have partly improved but oversight of staff requires strengthening. We found references for care workers in place, but these are weak and not verified. Supervision processes are in place but lack depth and do not consistently address performance, learning needs, or service risks. One staff member noted they had "*Never had a supervision meeting*," highlighting inconsistency in staff support. We did not receive full information on the registration of care staff with the workforce regulator when requested. Aligning recorded processes with actual practice will be an important step forward.

Staffing remains a challenge, with high turnover and shortages impacting continuity of care. Staff described pressures such as working extended hours or attending double-handed calls alone. While leaders tell us they cover the gaps in care provision, this is not reflected in call records, and some records show care staff attending people at different times, when two should be present. While some care workers recognised that management are "*trying*" to resolve issues, there is a need for more consistent and safe workforce planning, alongside recorded actual management support to provide care.

Training arrangements include mandatory courses and some additional learning are in place, but a more structured, needs-led approach is required. There is currently no comprehensive training

needs analysis or robust competency framework to ensure staff are fully prepared for their roles. Efforts to strengthen training are underway but not yet fully embedded.

Culture within the service would benefit from development. While steps have been taken to appoint managers, further support is required to ensure they have the skills required to effectively lead. Some staff described a challenging working environment and concerns regarding management approach, contributing to turnover. However, many staff remain committed to the people they support, which provides a continuity for some.

Areas for development identified at the previous inspection remain relevant, including monitoring, but particularly in relation to strengthening oversight by the responsible individual. A priority action notice has been issued as the regulator is not satisfied sufficient progress is being made and new findings suggest the service has deteriorated. The provider is expected to take immediate action. Progress will be reviewed at 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.

Summary of Areas for Improvement	Date identified
People may be at risk of poor care and support as there is a lack of knowledge to inform effective monitoring systems, and monitoring systems currently in place are ineffective. While this was not fully tested at this inspection, we did not see sufficient progress to consider the actions required have been met. This will be tested in full at the next inspection.	15/09/25
People may be at risk of receiving poor care and support as the provider is not ensuring the responsible individual has the training, knowledge and understanding to effectively monitor and improve the service. While this was not fully tested at this inspection, we did not see sufficient progress to consider the actions required have been met. This will be tested in full at the next inspection.	19/08/24

Summary of areas for Priority Action	Date identified
The service provider is not ensuring people's health and safety are considered when operating the service.	03/06/26
People are at risk of poor outcomes as the responsible individual (RI) is not ensuring effective management of the service, including management of concerns and complaints.	03/06/26

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