Arolygiaeth Gofal Cymru
Care Inspectorate Wales

Inspection Report

The Ivy

Barry

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Date of Inspection Visits: 26.02.2026 & 03.03.2026

Service Information:

Operated by:	The Cedars Care Services Ltd
Care Type:	Care Home Service Adults Without Nursing
Provision for:	Care home for adults - with personal care, Provision for learning disability
Registered places:	4
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 cultural Needs of the people or is working towards a bi-lingual service.

Ratings:

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

Summary:

The Ivy is a small residential care home in the Vale of Glamorgan. It provides care and support for four people with complex needs, including learning disabilities and autism.

People's well-being requires improvement. We observed care delivered with kindness, respect and compassion. However, the service did not consistently support people to maximise their independence, choice and meaningful engagement.

Care and support requires improvement. Ongoing staffing pressures meant people did not always receive person-centred care in line with their personal plans. Personal plans were not consistently up to date, individualised or regularly reviewed. Records did not always evidence people's involvement in reviews. This limited assurance that care reflected people's wishes and created challenges for newer staff in understanding people's needs.

The environment requires improvement. The layout and limited communal space restricted opportunities for people to spend time together outside their bedrooms. Some health and safety

checks were out of date. This reduced assurance that risks were consistently identified and managed to support people's safety and well-being.

Leadership and management require improvement. Governance and oversight arrangements were not consistently effective. Leaders missed opportunities to identify issues promptly and take timely action. Staff delegation, supervision and development also require strengthening to ensure staff have the skills, knowledge and support they need to meet people's needs safely and consistently.

We identified areas for improvement during this inspection and expect the provider to make improvements to achieve better outcomes for people.

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Findings:

Well-being — Requires Improvement

People are treated with dignity and respect. We observed positive and respectful interactions between care staff and people. People appeared relaxed and at ease. Staff listened to people, advocated on their behalf. However, opportunities for meaningful engagement were limited. Outcomes for people require improvement because the service did not consistently maximise opportunities for meaningful interaction, independence, choices and engagement. We observed people spending extended periods in their bedrooms. Staff focused much of their time on general household and administrative tasks and relied on monitoring equipment rather than engaging socially with people. This limited people's day-to-day experiences and well-being. We expect the provider to make improvements.

Bedrooms and bathrooms contain suitable furnishings and equipment to meet people's needs and preferences. This includes specialist beds and appropriate moving and handling equipment. Bathrooms promote privacy, dignity, safety and accessibility. However, communal areas offered limited space and facilities for people to spend time together. Although staff told us people preferred spending quiet time in their bedrooms, this was not consistently reflected in care documentation. This limited assurance that people were actively supported to access shared spaces and social opportunities.

People's voices were not always fully represented. Records did not evidence how people were supported to access advocacy services when needed to support their rights and entitlements. Risk assessments were not reviewed consistently. Some lacked sufficient detail to clearly describe people's needs and known risks, which limited staff understanding and risk management.

People live in a clean and generally warm environment, which supports comfort. However, we found some areas of the home were draughty, which could cause discomfort. Health and safety monitoring systems were in place, but these were not sufficiently robust to reliably identify, prioritise and address environmental issues that could affect people's well-being.

People are generally safeguarded from abuse and neglect. Systems are in place to identify and manage risks, including safeguarding training for staff. However, safeguarding arrangements required strengthening. We identified an incident that had not been reported through the correct channels in a timely way. This indicated gaps in staff knowledge, management oversight and

escalation processes.

Outcomes for people require improvement because safeguarding systems do not consistently ensure risks were identified, escalated and addressed promptly. We expect the provider to make improvements. Communication and escalation arrangements also required strengthening. While senior oversight was evident and lessons learned were identified, progress against required actions was slow. This contributed to inconsistent practice and limited assurance that people's well-being was effectively overseen.

Care & Support — Requires Improvement

People receive care that is kind, attentive and responsive to their individual needs. We observed care staff provide reassurance appropriately. We observed warm, respectful interactions from care staff that reflected people's preferences. People access specialist health advice when needed. The manager has long-standing knowledge of people and works closely with professionals to support people's physical health and well-being.

Outcomes for people require improvement because care planning and record-keeping systems were not consistently effective in supporting personalised and safe care. Inaccurate, limited or outdated records reduces staff understanding of people's needs and preferences. We found care documentation was disorganised and not always up to date. Care documentation did not consistently evidence people's or their representatives' involvement in key choices, including decisions about when to wake up, go to bed, and how to spend their time during the day. There was limited evidence to show people were supported to access advocacy services when needed or involvement with people's representatives during reviews and decision making. During the inspection, management began updating and streamlining records to better reflect people's views, choices and preferences. However, this remained an area of development and requires consistent oversight to ensure improvements are sustained.

Outcomes for people require improvement because staffing arrangements did not always align with assessed needs. Staff delegation and time pressures has affected people's daily experiences, because people have received less support to engage in meaningful activities during staff changes. We observed staff spending significant time completing administrative and household tasks, which reduced opportunities for social interaction and meaningful engagement with people. This limited flexibility in how care was delivered and reduced opportunities for person-centred support. Staffing levels have increased recently, and improvements are already being made; however, we will consider the impact of this on people's experiences and access to meaningful activities at the next inspection.

People's medicines are generally managed safely. People received their medication as prescribed. Staff complete medication training and had their competency assessed. However, medication governance requires strengthening. Staff had not consistently completed medication audits, and competency checks were not always up to date. Care documentation does not clearly demonstrate decision-making about medication timing, particularly where this could affect people's sleep or daily routines. We expect the provider to make improvements.

Environment — Requires Improvement

People live in an environment that is generally clean, homely and personalised. Bedrooms are homely and reflect people's individual preferences. People choose their own décor, including photographs, ornaments and paint colours. Some bedrooms have en-suite facilities, which supports privacy and dignity when people receive personal care.

People access the mobility equipment they need to move around the home. Recent improvements to laundry equipment mean staff no longer dry laundry in communal areas. This has increased available shared space for people. Personal Emergency Evacuation Plans are up to date and give staff clear guidance on how to support people safely during an emergency.

Outcomes for people require improvement because the environment is not consistently safe, accessible and well maintained. Gaps in environmental oversight has affected people's accessibility.

The layout and available space within the home present ongoing challenges. The garden is not fully accessible for people who use a wheelchair. This limits opportunities for them to spend time outdoors. There is limited space for people to spend private time with visitors, and most people spend most of their time in their bedrooms. Communal areas are not fully accessible to everyone. Staff store some equipment in shared living areas, which reduces social space and creates potential safety risks. The recent upgrade to washing and drying equipment has eliminated the need for laundry to be dried in communal areas, which is positive for people, as this reduced space for people. During the inspection we saw the small living area being used to store wheelchairs and to dry laundry on freestanding laundry airer. We observed the living area was frequently used as a thoroughfare for staff and deliveries. This resulted in ongoing disturbance and notable draughts, which can affect people's comfort. Some areas within the home showed scuffing and damage and require repair or replacement.

Oversight of health and safety arrangements is not effective. We found fire extinguishers were not securely mounted to walls. This remained an outstanding action from previous audits and indicates weaknesses in follow-through and monitoring. Systems to monitor and maintain the environment and equipment were in place, but these were not consistently implemented.

Leadership & Management Requires Improvement

Leadership within the service shows positive interpersonal strengths. Care staff and visiting professionals consistently described the manager as caring, supportive and people-focused. Professionals told us the service works closely with them to help meet people's health needs. These strengths support positive working relationships and contribute to a generally supportive culture. However, leadership and governance arrangements were not consistently effective in ensuring safe systems and regulatory compliance.

Outcomes for people require improvement because organisational oversight is not sufficiently effective to ensure safeguarding concerns are consistently identified and reported. Staff did not appropriately report a safeguarding concern, highlighting gaps in safeguarding knowledge, escalation processes and the effective implementation of safeguarding policies. We expect the provider to make improvements.

Outcomes for people require improvement because systems, documentation and the management of notifiable incidents are not consistently effective or in line with regulatory requirements. Gaps in management oversight and knowledge mean issues are not always identified, recorded or escalated appropriately. We expect the provider to make improvements.

The responsible individual completes quality assurance checks and reports; however, these are not sufficiently robust to meet regulatory requirements. Oversight processes did not consistently test practice or identify gaps in service provision and did not reliably ensure compliance with regulatory responsibilities.

Outcomes for people require improvement because staff training and induction arrangements are not consistently effective, increasing the risk that care staff are not adequately prepared to carry out delegated care tasks safely. Training records showed some mandatory and delegated health task training was out of date. We expect the provider to make improvements.

Staffing arrangements is being strengthened to support positive outcomes for people. Care staff told us time pressures and task-driven demands limited opportunities for meaningful engagement, increasing the risk of care becoming task-focused rather than person-centred. The provider has addressed this and staffing arrangements are improving. Care staff receive regular supervision, but

records did not consistently evidence reflective practice or professional development. Staff new to the senior roles were unclear about the induction progress during the inspection.

Leaders acted immediately on issues identified during the inspection, but this demonstrated a reactive approach to governance. Several issues had been recognised internally but were not addressed in a timely way. Stronger, proactive monitoring and quicker action for people is required to ensure risks are identified early and people consistently experience safe, person-centred care.

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
Outcomes for people require improvement because the management team did not act promptly to address known issues, and there have been gaps in manager presence and oversight at the service. Delays in resolving shortfalls in documentation, oversight, and meaningful choices and activities affect people's experiences. We are assured the provider is now taking the required actions. We expect leadership to ensure issues are resolved quickly so people receive consistent, person-centred care.	26/02/26
The environment requires improvement because it is not currently suitable or fully equipped to meet the needs of the people using the service. The provider must ensure the environment is safe, well-maintained, and fit for purpose so that people can experience care and support in surroundings that promote their well-being and independence.	26/02/26
Outcomes for people require improvement because staffing pressures have reduced people's access to meaningful engagement and activities. People's choices have been restricted, and care provided has not consistently aligned with their personal outcomes. Care documentation needs be streamlined and updated, to guide staff and fully involve people or their representatives in decisions about their care.	26/02/26

CIW has not issued any Priority action notices following this inspection.

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