

Runwood Homes Limited

Ivy Court

Inspection report

Greenfield Lane

Balby

Doncaster

South Yorkshire

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Tel: 01302853122

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Ivy Court is a residential care home built over 2 floors. Each floor has dining and lounge areas. The service provides care to older people and younger adults, people living with dementia, sensory impairment and those with a physical disability. The service can support up to 70 people. At the time of inspection 48 people were using the service.

People's experience of using this service and what we found

Some people did not receive appropriate support at lunchtime, and specialised diets were not always provided to those who needed them. People's daily records did not always match the care provided to them. The management team told us they would address these concerns.

There had been some changes in the management of the service in the past year and there was a new manager, who had very recently come into post. The quality assurance systems in the service had been disrupted to some extent and had failed to identify the concerns we saw at the inspection.

We asked the management team to refer concerns raised with us by people who used the service to the local authority safeguarding team. Although, most people felt safe living at Ivy Court and where risks to people had been identified there was good guidance in place for staff.

There were enough to keep people safe and recruitment and selection procedures were in place to make sure suitable staff were employed. People received their medicines safely and as prescribed. The environment was spacious, well laid out and clean and tidy.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Staff worked closely with relevant health care professionals to make sure people received appropriate care when they needed it. Systems were in place which enabled people, their relatives, and staff to provide feedback on the service and suggestions for improvements. Information from feedback was used to develop and improve the service.

For more details, please see the full report which is on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published 10 February 2023).

Why we inspected

The inspection was prompted in part by notification of an incident in which a person who used the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident showed potential concerns about the management of risk of scalds. This inspection examined those risks.

We found no evidence during this inspection that people were at risk of harm from this concern. Please see the safe section of this full report.

This report only covers our findings in relation to the key questions safe and well-led which contain those requirements. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ivy Court on our website at www.cqc.org.uk.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement and Recommendations

The overall rating for the service has changed from good to requires improvement. This is based on the findings of this inspection. Please see the safe and well-led sections of this full report.

We have found evidence that the provider needs to make improvements. We have identified breaches of regulation in relation to the safety and management of the service.

You can see what action we have asked the provider to take at the end of this full report.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement ●

Ivy Court

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

The inspection was completed by 3 inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Ivy Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under 1 contractual agreement dependent on their registration with us. Ivy Court Care Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager

This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had been recruited and very recently commenced in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority contracts and safeguarding teams who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection

We spoke with 11 members of staff including care staff, senior care staff, laundry assistant, handy person, admin assistant, the deputy manager, and the new manager. As the manager was new in post, a manager from another of the provider's homes attended to provide support. We spoke with 9 people who used the service, 7 visiting relatives and observed interactions between people who used the service and staff. We also spoke with 2 visiting health care professionals who regularly visits the service.

We looked around the home to review the facilities available for people and the infection prevention and control procedures in place. We also looked at a range of documentation including care files and daily records for 7 people and medication administration records for 3 people. We looked at 3 staff files for recruitment and reviewed documentation relating to the management and running of the service such as staff rotas, training records, monitoring records and audits.



Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement: This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- There were aspects of some people's nutritional needs which were not met.
- Our observation at lunchtime showed some people's specific needs were not met in relation to their meals. Some people who were assessed as at significant risk regarding their weight and nutrition. They had not been weighed as often as stated in their care plans. This meant accurate monitoring of their weight was not possible, leaving them at risk of harm.
- We looked at the risk assessments, care plans and nutrition records for 2 people who needed support from staff at mealtimes in relation to living with dementia, and other needs, such as deteriorating vision. When we observed people's lunchtime experience, we saw neither person received the support they needed from staff. This led to most of their lunch being taken away uneaten. The monitoring records we saw of what they had eaten for lunch did not provide a true reflection of what we saw they had eaten.
- One person who at risk regarding their nutrition had a care plan that included their food should be presented in a particular way, to support them to eat. We saw the meal provided was not suitable for the person's needs and, as a consequence they were struggling to eat. Previous records showed other instances when the person was given food that was not suitable for their needs.

People's care plans in relation to their nutritional needs were not always followed. This placed people at risk of harm. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our inspection, the manager took appropriate action to ensure improvement in this area.

- To help maintain the safety of the building and equipment, the provider had a central health and safety team, including a regional facilities manager who visited at least monthly, for example for fire safety inspection.

Staffing and recruitment

- Overall, there were enough staff to keep people safe and the manager told us there were systems in place to review and adjust staffing levels, as needed.
- We received mixed feedback about staffing. Some people and relatives felt there were not always enough staff to meet people's needs. A relative said, "Not enough staff at times." Whereas a person using the service told us, "It's very good. Everyone is very helpful. Staff come and check on me and see to my needs."
- Some staff told us there had been staffing cuts. Since then, there were times they felt under extreme pressure, and unable to fulfil their roles as they would like to. This was particularly at key times of the day. A

staff member said, "I don't feel there are enough staff for the people living with dementia. Some people need 1 to 1 staffing. We can't spend time with people, and it feels like we're letting them down."

- We saw times when people were left unsupported in communal lounges while staff undertook other care duties. Some people did not require support, while others would have benefitted from more social interaction. We were assured the manager reviewed their deployment of staff to make sure all aspects of the service operated in line with current good practice guidance.

- Systems were in place to ensure the safe recruitment of staff. To help make sure any agency staff used were suitable, the provider made sure profiles of their skills and training were received from the supplying agency.

Learning lessons when things go wrong

- The provider made sure risks to people's safety and wellbeing were assessed. Risk assessments and care plans were regularly reviewed and updated.

- We saw lessons had been learned and shared with staff in relation to an incident that occurred in April 2023. Further guidance had been provided to staff and they were undertaking their first aid training again. In addition, the management team had prioritised discussing lessons learned with staff, as part of their individual supervision.

- Monitoring systems were in place and lessons learned were shared with staff during regular meetings.

- The provider reviewed fire safety processes to ensure they remained effective in providing timely support to everyone who used the service.

- The provider ensured the safety of the building and equipment through regular maintenance and servicing.

Systems and processes to safeguard people from the risk of abuse

- The provider had policies and procedures in adult safeguarding and whistle blowing, for staff to follow to safeguard people.

- Two people who used the service raised concerns with us during the inspection. We asked the manager to refer these concerns to the local authority, via their safeguarding process. We were assured the people concerned would be supported appropriately and their concerns addressed.

- Staff had attended adult safeguarding training and the staff we spoke with knew their role in identifying safeguarding concerns and how to report them.

- Safeguarding concerns had been reported to relevant professionals and appropriate action had been taken by the provider.

Using medicines safely

- People received their medicines safely and as prescribed.

- Protocols were in place for people's PRN (as and when required) medicines. This helped to make sure staff knew how to administer people's PRN medicines.

- The management team and senior staff undertook checks and audits of medicines and medicines administration records (MARs). This helped to quickly identify and rectify any shortfalls in medicine management.

Preventing and controlling infection

- We were assured the provider was preventing visitors from catching and spreading infections.

- We were assured the provider was supporting people living at the service to minimise the spread of infection.

- We were assured the provider was admitting people safely to the service

- We were assured the provider was using PPE effectively and safely.
- We were assured the provider was responding effectively to risks and signs of infection.
- We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured the provider's infection prevention and control policy was up to date.

Visiting in care homes

- People were supported to have visitors and to maintain important relationships through face to face meetings, trips out and phone calls. The provider was working in line with national guidance.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

- We found the service was working within the principles of the MCA and where needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.



Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had quality assurance systems in place to monitor the quality and the safety of the service. However, these systems had not picked up shortfalls in people's care we identified during the inspection.
- There had been a period of change in the management team. The new manager had been in post less than 2 weeks and since April 2022, the service had periods without a manager in post. There had also been a change of regional manager. This had led to some disruption in the quality assurance system. For instance, the service's last health and safety audit was some months overdue.

The provider had not ensured systems and processes operated effectively to monitor and mitigate the risks relating to the health and welfare of people and to improve the quality and safety of the service provided. This is a breach of Regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Continuous learning and improving care

- Records showed, where shortfalls were identified, the provider took prompt action to address them, and to make improvements.
- Systems in place to monitor accidents and incidents showed how information was used to support learning, both in the home and across the provider's services.
- People's daily records did not always match the actual care provided to them. We raised this with the manager who told us they would monitor this and work with staff to ensure accurate and consistent recording.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people:

- The provider promoted a caring culture, and the service had a commitment to meeting people's individual needs and providing person-centred care.
- One person told us, "It's wonderful here, they really look after you." A relative said, "I come here very regularly and [my relative] gets well looked after. The staff take a real interest in [my relative]."
- Most care staff we spoke with felt the management changes since April 2022 had not adversely affected their training, supervision, learning and development or engagement. This was due to good contingency planning from regional managers and the deputy manager. However, they felt there had been a negative effect on staff morale. We fed this back to members of the management team during our initial feedback.

- Most staff were committed to their roles and had built positive relationships with people. Staff understood people's individual care and communication needs. This helped to make sure people received care and support that promoted their well-being. We discussed with the management team some specific concerns we saw, and which were raised with us. We were assured these concerns were addressed as a matter of priority.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Systems were in place to gather the feedback of people who used the service, their relatives, staff and visiting professionals. These included regular meetings and questionnaires.
- A staff member had the role of wellbeing lead. They told us, "When new people are admitted, I send out a life history questionnaire and a welcome pack, and then discuss the resident's interest, and hobbies with them and their family. I produce a weekly activity sheet and any special events. I organise monthly resident and relative meetings, which are minuted."
- People's relatives told us the management team were approachable. Their comments included, "I know [manager's name], the new manager, and she outlined some of her plans going forward" and, "The new manager has promised to discuss changes with families".
- We saw staff sought people's views throughout the day and people were confident to raise issues with staff.
- Staff told us they had the opportunity to comment on the service and the provider encouraged them to make suggestions to improve practice.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Working in partnership with others

- The provider had a system in place to promote the duty of candour and the management team understood the need to be open and honest.
- The management team and staff engaged with healthcare professionals about people's needs to promote good outcomes. Referrals were made to relevant professionals when required.
- We received positive feedback from visiting healthcare professionals. One visiting professional said, "The staff make referrals to us appropriately. Usually, seniors will give people's history and support throughout our visits. Staff know people really well and recognise when things are not quite right. They are on the ball. I've never had any concerns. It's well organised and people are looked after."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>People's care plans in relation to their nutritional needs were not always followed. This placed people at risk of harm.</p> <p>This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	<p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>The provider had not ensured systems and processes operated effectively to monitor and mitigate the risks relating to the health and welfare of people and to improve the quality and safety of the service provided.</p> <p>This is a breach of Regulation 17(1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>