

IVY LEAF CARE LIMITED

# Ivybank Care Home

## Inspection report

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## Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Requires Improvement 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This comprehensive inspection took place 27 and 28 September 2017. At the last inspection completed in April 2017 we identified improvements were required within the service. We gave a rating of 'requires improvement.' We carried out this inspection to see if the provider had made improvements and to respond to concerns about staff moving and handling practice, food hygiene standards and changes to the environment.

The home is registered to provide nursing care and accommodation for up to 38 older people, some of whom may be living with dementia or have complex healthcare needs. There were 36 people living at the home on the days of our inspection visit.

The registered manager had left their post in July 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. We were informed that the general manager who was also the current nominated individual would be applying to be the registered manager. A new clinical care manager had also been recruited who was responsible for the nursing care.

We found new audit and quality assurance systems had been introduced into the service. However, we found these systems were still not adequately identifying the areas of improvement required within the service. We found the provider was not meeting the regulations around the effective management of the service. Further improvements were needed and we are considering what further action to take.

We saw there were systems and processes in place to protect people from the risk of harm but the assessment of risk needed to be more robust. Risk assessments and care plans in place identified the assistance people needed with their mobility and in relation to the risk of falls. However we saw that these needed improvement to make sure staff had sufficient information on how to support people safely and in line with their risk assessments. The majority of people we spoke with told us they felt safe in the home and told us how the staff made sure they were kept safe. People were protected by a staff team who understood how to recognise and report any signs of potential abuse or mistreatment of people.

Effective recruitment and selection procedures were in place and checks had been undertaken before new staff began work. New staff received induction training but this was not always suitable to their role. Training was provided but additional training was needed to ensure staff had the knowledge and skills needed to support people. Where gaps in training had been identified we were informed plans were in place to schedule this.

We reviewed the systems for the management of medicines and found that people received their medicines safely but some improvements were needed.

Sufficient numbers staff were available to safely meet people's needs. People's needs had been assessed and care plans developed to inform staff how to support people appropriately. Staff demonstrated an understanding of people's individual needs and preferences but did not always demonstrate an awareness of how to meet people's dementia care needs. Practice from staff was not always consistent to ensure that all people were always treated with care and respect.

People were offered a range of food, drinks and snacks that met their cultural, dietary and health needs but the location had received a poor food hygiene rating following an Environmental Health Officer inspection. People had access to a range of healthcare when this was required.

The manager was taking action to improve systems to ensure deprivations to people's liberty were identified and that the appropriate applications made to the supervisory body.

The provider had an on-going programme of refurbishment of the environment. Recent changes to the environment had reduced the communal space available to people and this had also resulted in the temporary loss of private communal space for visitors.

There was a programme of activities available within the home which involved various group activities and less frequently, activities on an individual basis. At the time of our inspection the planned activity schedule was not being followed as the activity co-ordinator was away from work. The provider had taken prompt action so that a new activity co-ordinator was due to commence working at the service in the next few days.

People who lived at the home and their relatives were encouraged to share their opinions about the quality of the service. We saw that the provider had a system in place for dealing with people's concerns and complaints. People and their relatives said they knew how to raise any concerns and most were confident that these would be taken seriously and looked into.

You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement** ●

The service was not consistently safe.

Risks people lived with had not been fully assessed to ensure that people received the support they needed to stay safe.

People were protected by a staff team who understood how to protect them from potential abuse and risks such as accident or injury.

People were supported by sufficient numbers of staff who had been recruited safely. People received their medicines safely and as prescribed.

### Is the service effective?

**Requires Improvement** ●

The service was not consistently effective.

Further training was needed to ensure staff had the knowledge and skills to support people who used the service.

The manager was taking action to improve systems to ensure deprivations to people's liberty were identified and that the appropriate applications made to the supervisory body.

People had access to healthcare when needed. Food was provided that helped people stay well nourished.

Recent changes to the environment had reduced the communal space available to people.

### Is the service caring?

**Requires Improvement** ●

The service was not consistently caring.

Practice from staff was not always consistent to ensure that all people were always treated with care and respect.

Staff had positive caring relationships with people using the service. Staff knew the people who used the service well and knew what was important in their lives.

### Is the service responsive?

Good 

The service was responsive.

People who used the service had their needs assessed and received individualised support.

People had access to activities that they enjoyed.

People and their relatives knew how to raise concerns and most were confident that these would be taken seriously and looked into.

### Is the service well-led?

Requires Improvement 

The service was not consistently well led.

Some audits and checks had been completed but improvement was needed to make sure the systems were consistently effective.

People living at the home, their relatives and staff were supported to contribute their views.

# Ivybank Care Home

## **Detailed findings**

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visit took place 27 and 28 September 2017. The first day was unannounced and was undertaken by one inspector, an expert by experience and a specialist advisor. The second day was undertaken by one inspector. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The specialist advisor had experience of providing nursing care to people who use this type of service.

As part of the inspection we reviewed information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us by law. The inspection considered information that was shared from the local authority and Clinical Commissioning Group.

We spoke with 13 people who lived at the home, and with three relatives. We also spoke with a friend of one person. We observed how staff supported people throughout the day and also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of those people using the service who could not talk with us.

We spoke with the clinical care manager, nominated individual, company director, the cook, two nurses (including the deputy manager), four care staff and the administrator. We looked at some of the care records of four people, the medicine records for six people and records about staffing, training and the quality of the service.

# Is the service safe?

## Our findings

At the last inspection we completed in April 2017, we found the provider needed to make improvements under the key question of 'is the service safe' because staff were not always effectively deployed and risks to people were not always well managed. This inspection found that improvements had been made to the deployment of staff but further improvement was needed to manage risks to people.

At this inspection, systems to ensure risks to people were reviewed and action taken to minimise the likelihood of the reoccurrence of injury from accidents effectively were not in place. We saw an audit of accidents had recently been completed. The clinical care manager had identified that one person had experienced three recent falls but had failed to identify that the falls had not been witnessed. This indicated that staff were not providing the 'close observation' as identified as needed in the person's risk assessment. This meant there was a lost opportunity to evaluate the full circumstances of the falls and take appropriate action to reduce the risk of further falls.

Our last inspection in April 2017 had identified that the information in place for staff, on the safe use of the hoist, lacked satisfactory detail. This inspection identified that this issue had not yet been addressed. Following our visit we were sent evidence to show that action was being taken to rectify this issue.

Care plans and risk assessments were being reviewed and updated to ensure people's needs were being met. Care records were improved but these were not yet of a consistent standard. For example one staff member told us about some of the factors that increased the risk of a person having a fall and how these were managed. However this valuable staff knowledge was not reflected in the information in the person's care plans and risk assessment. This meant there was a risk that not all staff were aware of some of the factors that increased the risks for this person and so may not be able to offer consistent care and minimise the risk.

People confirmed they felt safe living at Ivybank. One person told us, "Yes, I feel safe." One person had some anxiety about another person who sometimes walked into their bedroom and took their personal possessions. Discussions with the provider and the clinical care manager showed that they were taking action to try and resolve this and to relieve the person's anxiety. Relatives we spoke with confirmed they felt their family member was safe at the home.

Staff we spoke with demonstrated a low tolerance for abuse and poor care. Staff understood how to act as 'whistleblowers' and report concerns outside the organisation if their managers did not take action. Staff told us they had received safeguarding training. Information was available on display within the home to remind staff of their responsibilities to safeguard people and the agencies they could contact.

People who lived at the home and their relatives had mixed views about whether there were enough staff to meet their needs. The majority of relatives thought there were sufficient staff available but we did receive some comments that staffing could be improved. One relative told us, "There are always staff about, [however] there are only occasional delays." In April 2017, we identified there were times when people in

lounges were left unattended without the means or ability to seek staff support and some people did not have call bells in their rooms. This inspection found that staff were available to respond to immediate requests for assistance. Action had been taken to ensure people in their bedrooms had call bells in their reach and we did not see that communal lounges were left unattended by staff for any significant periods of time. .

The clinical care manager had made some significant changes to how staff were deployed. A member of staff told us, "Staffing levels have increased and we now have more time to spend with people. People and staff are now much happier." A second member of staff commented, "Staffing is good at the moment."

Whilst care records did not always effectively demonstrate that risks had been fully investigated, our discussions with staff and observations of staff practice showed they were aware of, and managed risks to people. For example; staff could describe how they kept people safe when they ate and drank, and when they mobilised. One member of staff told us how it had been identified that bed rails had been a potential risk to a person and so these had been removed and alternative measures put in place. We observed that people who were at risk of developing sore skin were being regularly supported to move and change position. This meant that the risk of people developing sore skin was reduced. We saw emergency evacuation plans were in place for people. These were written records that recorded the support each person would need in the event of a fire. Staff we spoke with confirmed they had received training to help ensure they knew how to respond in the event of a fire.

Many of the people we met were unable to stand or walk independently and relied on the support of staff and specialist equipment to change position or to move. Staff were able to describe how they safely used the hoist. We observed staff working with people to help them mobilise. The interactions of the staff were kind and encouraging. We saw staff use the hoist to lift people. The staff undertook these manoeuvres carefully and while offering reassurance to the person. One person told us, "I'm well strapped in."

We looked at how the provider was recruiting new staff members. We saw that safe recruitment practices were being used to ensure that staff were safe and appropriate to work with the people who used the service. A range of pre-employment checks were being completed prior to new staff members starting work. This included identity, reference and Disclosure and Barring Service (DBS) checks. DBS checks are used by employers to review a potential employee's criminal history to ensure they are appropriate for employment.

We looked at the way medicines were stored, administered and recorded. People told us they got their medicines on time. Medicines were administered by the nurses who had received training to refresh their knowledge and competency checks were being planned. We saw one of the nurses administering medicine and this was done safely. Records suggested that people had received their medicines as prescribed. Some people had their medicines via skin patches. Body maps should be used showing both the dates of application and removal. The dates of removal were not recorded on the maps when the patches were removed. This meant that there was potential of patches being left on the body. Following our inspection visit, the manager sent evidence to show that these issues were being addressed to help ensure people were not at risk of harm occurring.

Medicines were securely stored in lockable trolleys or cupboards as appropriate in a dedicated treatment room. This kept people safe from accessing medicine inappropriately. We discussed with the manager that the medicine trolley was not fastened to the wall in line with the home's policy. Assurance was given that this would be rectified. The administration of medicines was checked through auditing processes to ensure people were protected unsafe medicine practice.



## Is the service effective?

### Our findings

At the last inspection we completed in April 2017, we assessed the service as 'good' in this key question. This inspection found this standard had not been maintained.

Prior to our inspection visit we had received a concern that recent changes to the environment had a negative impact on the communal space available to people. During our inspection visit the provider told us it was planned to increase the capacity of the home to fund additional staffing levels. The first floor lounge and dining room had been converted into three extra bedrooms. In its place a much smaller room was now being used as a lounge area. On the ground floor there had also been some changes and this had resulted in the temporary loss of a visitor's room, however the refurbishment of a replacement room was in progress.

During the lunch time meal we saw there was a lack of space where some people were eating their meals. The home now had only one designated dining areas and some people ate in lounge areas. In one of the lounge areas staff brought the meals into the room in a serving trolley and this resulted in some people having to move to accommodate the trolley. Staff helped some people to eat but had to do so by kneeling on the floor as there was no space for them to sit next to the person they were assisting. This looked neither comfortable nor dignified for the parties involved. Several staff told us they had concerns about the recent environmental changes. One member of staff told us, "We are trying to adjust to the building change, it's been three to four weeks and space is an issue. I don't think it has been thought through, it's all trial and error at the moment." One staff commented, "I do not think they have considered what will happen at Christmas when people will all want dinner with their partners, but the owner does listen and I think he will try and find solutions."

Signage in the home was not suitable to help people living with dementia orientate themselves in their surroundings and get around independently. Some bathrooms had pictures on the doors to help people to orientate but not all rooms had clear signage. There were also no suitable orientation boards in communal areas to help people know which day and month it was or the time of day. The manager told us that some signage had been taken down during redecoration of the premises and had not been put back up. We were informed there were also plans in place to purchase new orientation boards.

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 Act 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA. We found that applications had been made to the local supervisory body for DoLS as required and in line with the legislation. However for one person their authorisation had expired. The provider told us there had been an issue as they had not

received the original authorisation from the local authority. Following our inspection visit the manager provided evidence that a new tracking system had been introduced to ensure all applications would be followed up and renewed. Staff had received training in the MCA and DoLS and were aware that applications had been submitted and approved for people.

Care staff regularly sought consent from people before attending to their daily living needs, for example by seeking people's consent before they assisted them to wear an apron at lunch time. Care records included assessments of people's capacity to make decisions. The records showed that where people lacked capacity to make certain decisions, their relatives and those who know them well have been involved in 'best interest meetings'. The manager made us aware that one person had been refusing their medication. Where it was considered that a person lacked capacity to understand the consequences of their refusal, administering medication covertly was used as a contingency measure in the 'Best Interest' of the person. Records showed involvement of the Pharmacist, GP and relatives. There was a care plan in place and this had the agreement of the pharmacist and doctor and also the method of administration. This was reviewed monthly. However the provider's assessment form for covert medication was not completed. Therefore important information such as what alternatives were considered and whether it was the least restrictive way to treat the person were not recorded. The manager told us she would ensure this was rectified.

People we spoke with praised the staff and said that staff knew how to look after them. One relative told us, "They have constant regular carers, they are marvellous." Staff showed a general understanding of how to help meet people's needs. Further work was underway to help staff become more familiar with the full needs of people they supported, for example, through additional training in topics such as end of life care. We were informed that falls prevention training was also being planned although at our inspection in April 2017 this had been planned by the previous manager but had not taken place.

We found that staff did not always demonstrate effective approaches in maintaining an appropriate environment for people living with dementia. In two lounges the environment was noisy and potentially confusing to people. We brought this to the attention of the clinical nurse manager who told us she would ensure this was addressed.

We asked staff about their induction, training and development. All staff undertook an induction at the start of their employment at the home. We saw that in some instances staff had not completed an induction that was suitable to their role, for example a catering assistant had completed an induction that was specific to the role of a care assistant. This meant there was a risk they would not be fully aware of their roles and responsibilities. One newer member of staff told us their induction had included working alongside experienced staff and that they had felt well supported. The provider had arrangements in place so that new staff who needed it could complete the Care Certificate. This is a nationally recognised certificate that sets the standard for the fundamental skills, knowledge, values and behaviours expected from staff within a care environment.

Staff we spoke with told us that they received sufficient training to enable them to carry out their job effectively. However not all staff had received training that was specific to the needs of the people they supported. Where gaps in training had been identified we were informed plans were in place to schedule this.

People were consulted about the menu and changes made based on people's preferences and suggestions. Whilst we received some negative comments most people were complimentary about the meals. One person told us, "The food is lovely. We've a very good cook. The choice is good ". Another person told us, "It's very good. You can't grumble about the food. If you don't like something you get something else." Some

people were supported to eat their meals in their bedroom if this was their preference. We saw people were offered a choice of drinks with their meal and were offered regular drinks throughout the inspection visit. People who liked to spend time in their bedrooms had fluids within their reach. Records were kept of people's fluid intake although in some cases these had not been fully completed to show that people had received the fluid they needed to stay well although there was no evidence to show that people were not receiving adequate fluids.

The cook and care staff we spoke with had a clear understanding of people who needed supplements in their diet or needed a soft diet. Staff had completed nutritional risk assessments and people had been weighed regularly as required. Where needed, advice had been sought from relevant health care professionals in regards to weight loss. We saw one person had their food fortified with cream and butter, was prescribed food nutrients and had regular snacks. These actions had meant an improvement in the person's weight.

People could be confident they would be supported to maintain and achieve good health. Records showed that people have regular access to health checks from other professionals like the dentist, chiropodist, optician and dietician.

We looked at the health care of people with some specific health conditions. People were protected from the risk of developing pressure ulcers. Staff knew how and when to refer people to the local NHS tissue viability nurse in order to get advice about the prevention and management of pressure ulcers. When needed, people received support in the management of diabetes. The records showed that the people's condition was stable and under control. The nurse told me that the people had regular annual physical checks including checks for diabetic retinopathy, but this was not on record. A nurse told us, "The GP keeps his own record about the annual checks". Information should be on records for the home staff to ensure that the annual checks have been carried out.

## Is the service caring?

### Our findings

At the last inspection we completed in April 2017, we assessed the service as 'good' in this key question. This inspection found this standard had not been maintained.

People who lived at the home indicated that staff were caring. One person told us, "The staff are friendly and pleasant." Another person told us, "I get on alright with the staff." Relatives we spoke with confirmed that staff were kind and caring. Whilst individual staff members were reported and observed to be caring, we found that some aspects of the care being provided to people were not always caring.

We saw that staff did not always give consideration to people's communication needs, and at times a lack of understanding of the needs of people living with dementia. For example, when staff asked a person if they were 'okay' and received no response they simply continued to repeat the same question and did not try other forms of communication which may have been more suitable to the person's individual needs. We did not see the consistent use of visual aids. The menu on display was in very small print but we saw staff offered verbal meal choices. Some staff showed people the meals that were on offer so they could make a choice but this practice was not consistent. We were shown that as part of the provider's action plan for improvements picture cards to aid communication were on order.

Some improvements were needed to help make sure people experienced a pleasurable dining experience. For example some people were left waiting at the dining table for thirty-five minutes before their meal was served and this caused some people anxiety. One person commented, "When are we going to get dinner, that's what I want to know." Staff did not offer people salt and pepper and gravy was poured onto people's meals without consultation. One person was not provided with an adapted plate and had to use their fingers to load food onto their spoon. Adapted cutlery or a plate may have assisted the person to eat in a more dignified manner.

We observed one member of staff place a cup of tea next to a person, but out of reach. The person spent some time trying to reach for their drink and from their facial expression were quite frustrated and upset they could not reach it. They then made several attempts to get the drink by trying to drag the table nearer to them. A staff member explained to us that the drink had deliberately been placed out of the person's reach as it was too hot to drink. They had not considered that the person could become anxious and distressed by not being able to reach their drink or consider providing the person with a drink of suitable temperature.

We did however, also see many examples of kind and considerate staff interactions with people. For example, when giving medicines to a person the nurse knocked on the bedroom door before going in, introduced themselves and explained to the person what they were doing. When talking they knelt in order to get close to the person and maintained eye contact. They did not rush the person and allowed them to take one tablet at a time. Afterwards they checked with the person, "Are you in any pain or discomfort? Do you need anything for pain? The person had a smile indicating they had found the interaction to be a positive one.

We saw that people were able to develop and maintain social relationships that were important to them. There were frequent visitors to the home and work was in progress to provide a private visitor's room to replace a previous room that had been converted to a bedroom. People who lived at the home and their relatives told us that visitors were made welcome.

It was evident from the staff we spoke with that they knew the people who used the service well and had learned their likes and dislikes. A 'resident of the day' initiative was in place. Every day staff spoke with one person to check that they were happy with the service and if any would like any aspects of their support changed.

We observed care staff working in ways that promoted the privacy of people and we saw that staff did not enter people's rooms without knocking first. We saw toilet doors were closed after staff had assisted people to the toilet and staff knocked the door before they re-entered. We saw that screens were in use where people shared a bedroom, or to provide cover when receiving support in the communal areas. We saw that care staff were careful to ensure people were covered when using a hoist or when they sat in the communal areas to maintain their dignity.

## Is the service responsive?

### Our findings

At the last inspection we completed in April 2017, we assessed the service as 'good' in this key question.

People received care and support from staff who knew them and had information which enabled them to provide care in line with people's preferences. People's needs were discussed when the staff team shift changed and we saw that this information was recorded and used by staff on their shift to ensure people got the care needed and preferred. Care plans included information for staff so they could provide support which reflected people's personal history, individual preferences and interests.

We looked at the arrangements for supporting people to participate in activities and maintain their interests and hobbies. There was a programme of activities available within the home which included various group activities but less frequently, activities on an individual basis. At the time of our inspection the planned activity schedule was not being followed as the activity co-ordinator was not at work due to sickness. People and staff we spoke with told us that when the activity co-ordinator was at work they was a good range of enjoyable activities on offer.

The provider had taken reasonable steps to arrange for some alternative activities to take place. This included various entertainers visiting the home twice weekly. People told us they had enjoyed these events. Staff were also providing some activities to people and we saw activities that included painting and nail care, however staff confirmed that they only supported people to engage in these activities when they were not required to undertake any care duties. The provider had recognised that alternative arrangements were needed to ensure activities were regularly available and so an additional activity co-ordinator had been recruited to commence work in the next few days.

We looked at the systems for raising concerns or complaints. People who lived at the home were aware they could tell staff if they were unhappy. People said if there were any issues they would talk to staff or the manager. The relatives that we spoke with were confident to make a complaint. Records we looked at showed that the provider had sought and received feedback from people which was mostly positive.

Information on how to make a complaint was on display in the home. Our discussions with the provider showed that they viewed concerns and complaints as an opportunity to help improve the care that people received. People could be confident their concerns would be taken seriously, investigated and detailed feedback provided.

## Is the service well-led?

### Our findings

At the last inspection we completed in April 2017, we found the provider needed to make improvements under the key question of 'is the service well-led'. This inspection found that improvements were still required to the monitoring of the service.

The systems in place for audits and checks had not always been effective at identifying areas that needed attention. The clinical care manager had commenced a new system of audits however further improvement was needed to make sure the systems were consistently effective. System for auditing accidents and incidents needed to be more robust and audits had not yet been completed in all key areas. Other issues such as the poor recording and monitoring of DoLS applications and lack of proper recording of the fluid balance charts was not spotted and acted on. The provider's quality monitoring systems had not always been used effectively to implement or sustain improvements made, and where shortfalls had been identified, the provider had not always responded to these in a timely manner.

During our inspection the manager told us that the maintenance officer had left and a new one was being recruited. We saw that some audits that had previously been completed on a regular basis were now overdue. This included checks of water temperatures in the home and of window safety. The provider had not ensured alternative arrangements had been put in place to undertake these audits. This meant there was a risk of some health and safety issues not being identified and acted on.

Some issues we identified at the last inspection had not yet been acted on. At our inspection in April 2017 the registered manager had told us they would consider introducing formal competency assessments, however this had still to be done. One nurse told us that they last had their medicines competency assessed seven years previously. Satisfactory improvements had also not been made in regards to information on the safe use of the hoists. Discussions with the clinical care manager and the manual handling trainer showed they were not aware of the Health and Safety Executive's guidance on the safe use of the hoist. The provider had not had an effective system in place to ensure this area of improvement had been addressed.

At our last inspection in April 2017 the service had been awarded a three star food hygiene rating by the local authority. This meant that some improvements had been required. The local authority had since re-inspected the service and found some concerns resulting in a one star rating being awarded. This indicated that the provider had not kept sufficient oversight of the food hygiene standards. We saw some actions had been taken and the clinical nurse manager had completed a recent food hygiene audit to help make sure standards were now being maintained. However, we were not assured this would be sustained.

Throughout our inspection we found that the manager was receptive to feedback and had taken some actions during our inspection to address concerns. However this was a reactive approach to issues that should have been identified and addressed through the provider's own quality monitoring processes.

The provider had not ensured effective systems were in place to monitor the quality and safety of the service being provided to people. Improvements required were not always identified therefore action was not

always taken where needed. Failure to ensure that systems and processes always operated effectively and improved the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider is required to employ a registered manager as part of the conditions of their registration. Since our last inspection the registered manager had left the service. A new manager had been recruited who was responsible for the nursing care. We were informed that the general manager who was also the current nominated individual would be applying to be the registered manager. Our discussions with the manager indicated they had an understanding of the improvements that were needed at the home. These plans were underway and would help to address inconsistent practice and concerns reflected in some people's feedback and experiences at the home. Staff told us that the manager was approachable and that they felt able to raise any concerns or suggestions. One member of staff told us, "The new manager has been very supportive. It's a good place to work. The team work is good and management is very supportive". Staff were positive about the service and told us they could see the improvements being made. One staff member told us, "There has been a lot of improvement and investment in the place." Another staff commented, "The new manager has done so much [improvements] in a short time."

Meetings were held with people at the home where they were informed and consulted about some aspects of the running of the home. These meetings were also open for relative's to attend. Other ways that the management team had tried to involve people included a suggestions box in the foyer where people could leave comments or feedback. One relative told us, "They do seek our views and opinions. The owner welcomes and listens to our views."

We spoke with the provider during our inspection. They acknowledged there were still improvements to be made within the service. However, they demonstrated a commitment to address the areas of improvements required and to develop a consistently good service.

Registered providers are legally required to display the rating awarded by the Care Quality Commission. The most recent rating was on display within the home and on the provider's website. The current food hygiene rating was also on display. This indicated the provider being transparent by providing people who use services, and the public, with a clear statement about the quality and safety of the care provided.



This section is primarily information for the provider

## Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

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 effective systems were in place to monitor the quality and safety of the service being provided to people. Improvements required were not always identified therefore action was not always taken where needed. Failure to ensure that systems and processes always operated effectively and improved the quality and safety of the service is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>

### **The enforcement action we took:**

We imposed a condition on the providers registration telling them what action they needed to take in order to become compliant with this regulation.