Care Quality Commission

Brighterkind Health Care Group Limited

Ivybank House 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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 1 March 2017 and was unannounced. The last full inspection took place in January 2016 and, at that time, one breach of the Health and Social Care (Regulated Activities) Regulations 2014 was found in relation to safe care and treatment. This breach was followed up as part of our inspection. The service was rated 'Good.'

Ivybank Care Home is registered to provide accommodation and personal care for up to 43 people. At the time of our inspection there were 35 people living at the service.

There was no registered manager in post at the time of inspection. 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. The current manager has been in post since December 2016. They told us that they intend to process their registered manager's application form.

Since the previous inspection in January 2016 there have been two changes of home manager. The high turnover of home managers has affected the level of service. The provider had failed to fully implement the actions in their plan from the previous inspection to ensure they were no longer acting in breach of the regulations. As well as not implementing the stated actions in the plan we found further breaches of the regulations.

Medicines were not managed safely. The senior carer responsible for medicines did not know about the specifics of administering some medicines.

Risks to people using the service were not in all cases managed appropriately. Risk assessment plans were not always up-dated when required.

Staff were not consistently supported through an effective training and supervision programme.

People's records were not always monitored to manage their health conditions. Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. Although recorded fluid intake was not consistently totalled and it was not clear whether concerns were escalated.

Care plans were not consistently written in conjunction with people or their representative. Some people had little understanding of their care planning and some told us that they had never seen their care plan.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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 MCA. At the time of the inspection no one was subject to a DoLS authorisation. The manager demonstrated an understanding of the procedures that needed to be followed to apply for a deprivation of liberty, if required.

Staff in the main understood their responsibilities with regard to safeguarding people from abuse.

People told us that the staff were kind and caring. Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. They were aware of people's personal histories and interests.

People had access to a wide range of activities. They included; yoga, music, tea and a natter, a reading group, hand massage and relaxation, knit and a natter, gentle exercise to music, a sewing bee and a range of one to one activities. Peoples' spiritual needs were met. Services were held at the service twice a week.

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this 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 always safe.

Medicines were not managed safely.

Risks to people using the service were not in all cases managed appropriately.

People told us they felt safe living at the service.

Is the service effective?

Requires Improvement

The service was not as effective as it should be.

Staff were not supported through an effective training and supervision programme.

The recorded monitoring of people's diet and fluid needs was not always in place.

People were assessed for their nutritional needs, and when people required specialist support this was sought appropriately.

People's rights were in the main upheld in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People told us that the staff were kind and caring.

Staff were knowledgeable about people's needs and told us they aimed to provide personal, individual care to people.

Where support was needed it was provided in a dignified, unobtrusive way.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were not consistently written in conjunction with people or their representative.

People had access to a wide range of activities.

The provider had systems in place to receive and monitor any complaints that were made.

Is the service well-led?

Requires Improvement

The service was not well-led.

The provider had failed to fully implement the actions in their plan from the previous inspection to ensure they were no longer acting in breach of the regulations.

The high turnover of home managers had resulted in a negative impact on the level of service.

The new manager had a priority plan in place which identified similar concerns found at the inspection.

Care Quality Commission

Ivybank House 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.

This inspection took place on 1 March 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert-by-experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of service.

Before the inspection we reviewed the information we held about the service. This included previous inspection reports, statutory notifications (issues providers are legally required to notify us about) other enquiries from and about the provider and other key information we hold about the service.

We spoke with nine people, two relatives and nine members of staff. We also spoke with the manager and the clinical facilitator.

We reviewed the care plans and associated records of 13 people. We also reviewed the Medicines Administration Records (MAR) of the people who lived at the home. We also reviewed documents in relation to the quality and safety of the service, staff recruitment, training and supervision.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection we found that medicines were not always managed safely. The provider sent us an action plan telling us what they were going to do to become compliant with regulations. We found that insufficient improvements had been made.

We observed a medicines round. The senior carer responsible for medicines did not know about the specifics of administering some medicines. Three people were prescribed a medicine to slow and steady the heart. The prescribed medicine should not be administered to an adult if their pulse is 60 beats or less per minute. None of these people had any record of their pulse being assessed or recorded prior to administration.

One person was prescribed an antibiotic three times a day. The Medicine Administration Record (MAR) instructed 'space doses evenly'. The MAR sheet highlighted that there had been a four hour gap, an eight hour gap and a twelve hour gap over a 24 hour period. Some people's medicines should be administered specifically within a certain time frame before food. This was not instructed on the MAR and the senior carer was unaware of this requirement.

It was noted for one person that they had not been given their eye drops because they were asleep on several occasions. These drops reduce pressure in the eyes and therefore should not be omitted. The person often refused them and this was not reported.

Topical medicine records (TMARs) were in place, but they had not in all cases been consistently signed by staff to indicate that people had their lotions and creams applied as prescribed. In some cases the instructions were not clear. The senior carer told us that they had recently written to the GP requesting clear explicit topical instructions for each person. It was therefore difficult to assess whether people were receiving the appropriate topical medicines when required. For example one person had four separate topical records. Their records showed that two topical medicines had not been available since 11 and 24 February, one topical medicine had been applied occasionally and there was no record of the application of the fourth topical medicine. Staff also told us that topical creams were not always available. Some staff had also not received the appropriate training regarding the administration of topical medicines.

PRN (as required) protocols were not consistently in place to inform staff when people might require additional medicines. Some PRN protocols for people lacked instructions and clarification for administration. They did not include information about when to administer and the maximum dosage.

The medicines policy stated that; "Care staff witnessing controlled drug administration must have completed a specific competency assessment." Staff had not received specific training or assessments. The service was not acting in accordance with the provider's medicines policy.

Following our previous inspection the former manager told us they were going to introduce two new documents for their medicine administration. One was a check list for staff to complete after each

medication round. The other was a training plan which we were told would be used to train all staff that administer medicine. The service had not implemented these documents. Following our inspection they were sent to the new manager for information.

Internal medication audits were undertaken. The last audit was completed on 30 December 2016, but the issues we found during the inspection had not been identified.

There continues to be a breach Regulation 12 (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people using the service were not in all cases managed appropriately. Examples of risk assessments that we saw were falls, skin integrity, moving and handling, choking and nutrition. Risk assessment plans were not always updated when required. One person had a fall on the 12 and 28 February but there had been no re-evaluation of their falls risk assessment. Their mobility review stated; "He mobilises well using tripod and wearing his leg brace." In June 2016 one person's falls risk was judged to be high. The plan reported that the person had been suffering with a painful hip exacerbating their risk of falls. On 1 September 2016 the person had a hip replacement and they had four falls in October and two in January. There was nothing in their care plan reflecting either a change in falls risk following their hip replacement or subsequent falls. We also noted in a recent report conducted by an external body that falls were not always recorded in the falls diary. The report stated that this carried over into the falls risk assessment where the person was designated a lower risk than their actual risk.

This is a breach Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The current manager had appropriate arrangements in place for reporting and reviewing accidents and incidents. Accident and incident forms identified the nature of the incident, immediate actions taken and whether any further actions were required, such as the need to increase observations for one person. Before the current manager's appointment it had been noted in the regional support manager's report dated 31 January 2017 that a number of incidents remained outstanding as no investigation had been undertaken.

Staffing levels were assessed by following the Care Home Equation for Safe Staffing (CHESS) dependency tool. The manager told us that they aim to have one senior care assistant and five care assistants on duty during the day. The night time cover should consist of one senior care assistant and two care assistants. Staffing rotas viewed from 23 January to 5 March demonstrated that staffing levels were in the main maintained in accordance with the assessed dependency needs of the people who used the service. We did note two exceptional days where the staffing level was only one senior care assistant and three care assistants. On several days there were four care assistants on duty, instead of five. One member of staff told us; "The staffing levels are manageable, if at the correct level." The manager told us the service is currently undertaking a recruitment drive to appoint more care and kitchen staff. The care staff were also working together to provide assistance in the kitchen, when required.

People told us that they felt that there were enough staff to support them. We observed that people were receiving the care they needed. Staff were visiting rooms, sitting chatting to people and had a presence in communal areas. At lunch time there were enough staff to support people who chose to eat in their rooms.

Records showed that a range of checks had been carried out on staff to determine their suitability for work. This included obtaining references and undertaking a Disclosure and Barring Service (DBS) check. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal background and whether they were barred from working with vulnerable adults. We did note that some of

the reviewed personnel files only held one reference instead of the required two. We also identified a potential risk which required close management and supervision during the staff member's probationary period. The manager agreed to review this matter.

Staff in the main understood their responsibilities with regard to safeguarding people from abuse. Once prompted with a scenario they were able to explain the actions they would take if they suspected a person was being abused. Staff demonstrated a basic understanding of the term 'whistleblowing'. The provider had a policy in place to support people who wished to raise concerns in this way. Some of the staff we spoke with had yet to undertake their safeguarding training. Following our inspection the manager told us that safeguarding training was booked for 31 March 2017.

People told us they felt safe living at the service. Comments included; "I feel very safe here quite happy. It's very good I like it"; "Very pleased it's good, I'm safe well and looked after"; "It's alright as far as safety goes, the carers look out for me."

Requires Improvement

Is the service effective?

Our findings

Staff were not supported through an effective training and supervision programme. The provider's supervision of staff policy was not being adhered to. According to their policy supervision should take place every eight weeks or six times per year. Supervision is where staff meet one to one with their line manager. One member of staff told us; "Supervisions are not held regularly. There have been quite a few changes." The staff files viewed reflected this position. The manager was aware of this issue and had introduced a supervision matrix with the view that they will be held more regularly.

New staff undertook an induction and mandatory training programme before starting to care for people on their own. However, the training records demonstrated that staff mandatory training for existing staff was out of date and required updating. One member of staff told us; "We are not up to date with our training and refresher training is required." The December 2016 regional manager's report identified that the compliance rate for mandatory training was currently 45% against the provider's target of 95%. Training rates for some modules was poor. Examples of this included fire safety at 37%, infection prevention at 5% and moving and handling at 47%. Staff were not supported to undertake training to enable them to fulfil the requirements of their role.

This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's records were not consistently monitored to support their nutrition and hydration needs. Some people were having their food and fluid intake monitored because they had been assessed as being at risk of dehydration or malnutrition. Associated charts in relation to food intake were completed in full. However, fluid intake monitoring in some cases required improvement. Current government guidance on drinking enough to stay hydrated recommends people aim for 6 to 8 glasses of fluid each day (1500-2000mls). Although recorded fluid intake was not consistently totalled and it was not clear whether concerns were escalated. In one person's fluid chart it had been documented that they only drank 7mls over a 24hr period. Another person was recorded as having 600mls on the 27 February and 650mls the following day. One person's target fluid intake was recorded as 950mls. Over a four day period from the 25 February their fluid intake was recorded as 700mls, 900mls, 750mls and 750mls. In these cases there was no acknowledgement of this and no information recorded in their daily records of care or any subsequent action plan in response to the low fluid intake. Staff were unable to tell us how they escalated the concerns. We did observe that people had access to drinks in communal areas in their rooms. People were encouraged to drink by members of staff. Morning coffee and afternoon tea, was also served. However, the lack of monitoring meant there was a risk that people might not have enough to eat or drink.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were assessed for their nutritional needs, and when people required specialist support this was sought appropriately. Specific dietary requirements were catered for, such as diabetes. Peoples' views on

the food varied. Whilst some praised the meals others felt that it did not meet their expectations. Comments included; "Food is very good. I accept what I am given and enjoy it"; 'Snacks at any time. There are bowls of fruit, biscuits, cakes around and about"; "Excellent food"; 'The food is not really my cup of tea. It's basic.'

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. 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 MCA. At the time of the inspection no one was subject to a DoLS authorisation. The manager demonstrated an understanding of the procedures that needed to be followed to apply for a deprivation of liberty, if required. An action required in the manager's action plan states; '1. Identify if a DoLS application is required for each resident. 2. Prepare a timescale to complete each application in order of priority.'

The staff demonstrated a basic understanding of the Mental Capacity Act 2005 (the MCA). The training matrix highlighted that 8% of staff members had received MCA training. The 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. During discussions with staff, they did not demonstrate a clear understanding about the MCA and how it related to consent to care. When prompted about people they provided care for staff provided examples of how they enabled a person's independence, as far as possible. One member of staff told us; "We give choices, we always ask them. We ask them how they would like to be assisted." They told us about one person with fluctuating capacity; "She tells you whatever she wants. You use easy short questions which allow for yes or no answers." One person told us; "Staff are always asking shall we do this shall we do that? They never just do something without being asked."

People had access to healthcare services when required such as the GP, district nurse team, speech and language therapists and the foot clinic. However, one person did comment; "I had a stroke. I came here but no physio. I would like to have that. I have mentioned it but nothing happens."

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. Comments included; 'They're wonderful staff, have a good relationship with all of them"; "Good care, well looked after, good staff, no worries"; "I'm happy here and have a good life here"; "The staff are very nice. The chat to me and have time for me"; "The staff are alright"; 'The staff are very good, can't fault them"; Quite happy, everyone is brilliant here"; and "The care is very good, as good as it gets."

We observed people being treated with kindness, compassion, dignity and respect. One person entered the dining room before lunch was due to be served. Staff knew that the person liked to be early. The staff were attentive, putting an arm round her, asking her where she would like to sit and generally reassuring her. Staff returned to the person on many occasions and supported them until lunch arrived. On another occasion one person was sitting in a quiet area and was becoming very confused. A member of staff sat by the person and spent time chatting to them, reassuring them, offered snacks and making them laugh.

We observed staff carried out moving and handling tasks safely, talking to people and ensuring that their dignity was maintained. People were given choices and encouraged to make decisions. Where support was needed it was provided in a dignified, unobtrusive way. One person told us; "I get about by myself but I need someone there when I shower. It's good knowing people are there to look after you." One relative told us; "They do respect your dignity and privacy here. The staff knock on the door, wait and close the door behind them. They're very good." Another person told us; 'Respect and dignity is very good here. I've seen carers putting an arm round somebody and whispering to them. They don't shout things across the room."

Staff were knowledgeable about people's needs and told us they aimed to provide personalised care to people. Staff told us how people preferred to be cared for and demonstrated they understood the people they cared for. They were aware of people's personal histories and interests. One member of staff told us; "[Person's name] used to be war fighter pilot and has medals. [Person's name] likes their breakfast at 08.00 then likes their personal care. [Person's name] likes their breakfast early. The bed covers should be taken off at certain times. They're a perfectionist about how their bed is made. [Person's name] likes sleeping and gets confused about times. We gave him a bath and he feels nice and fresh now. He likes to be clean shaven."

Although there were sections in people's care plans for end of life care needs and preferences to be recorded these were inconsistently completed and contained minimal information. One plan highlighted GP and family discussions. The plan clearly documented the person's wishes. In people's plans it included wording such as; "to make my own decisions" and "keep it simple." There was no other detail in relation to the person's choices. This area of their work requires further development.

Requires Improvement

Is the service responsive?

Our findings

The service was not consistently responsive to people's needs. Each person had an initial assessment before they moved into the service. This was to make sure the service was appropriate to meet the people's needs and expectations. Once living at the service care plans were not consistently written in conjunction with people or their representative. Some people had little understanding of their care planning and some people told us they had never seen their care plan. One relative was aware of their relative's care plan, knew what was in it and had attended review meetings. This meant that care plans potentially did not reflect people's individualised needs. However, it was clear from care records that relatives were kept well informed about people's care.

The quality and content of care plans was variable. Although some were well written, with clear guidance for staff to follow, this was not consistent. One person had a urinary catheter in situ. The plan did not inform staff how to monitor the catheter or how to perform catheter care. The only instruction was the need to change the catheter bag every 7 days. The records show that this had not been undertaken. We noted in some cases that there had been a gap of 10 and 22 days. This increased the risk of infection. The same person's care plan contained an undated and unsigned note indicating that staff had not been undertaking stoma care appropriately. The care records plus their daily record of care since January 2017 indicated that the stoma bag had not been changed on a regular basis.

When people had been assessed as being at risk of skin breakdown, care plans were in place which contained details of how often staff should change people's position. Repositioning records were completed in accordance with people's needs. To alleviate the person's risk people used pressure relieving mattresses. However, it was not clear from the care plans what the correct mattress setting was meant to be because the information had not been documented.

This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that the service intends to re-introduce a resident of the day system which will focus on a particular person on a rotational basis. It is their intention that the person and their family will be more formally involved in the care planning process.

People had access to a wide range of activities. They included; yoga, music, tea and natter, a reading group, hand massage and relaxation, knit and natter, gentle exercise to music, a sewing bee and a range of one to one activities. Peoples' spiritual needs were met. Services were held at the service twice a week. We observed a number of activities taking place. An outside entertainer sang and played the accordion. It was much enjoyed by people who joined in at every opportunity. In the main we received a number of positive comments about the activities programme. They included; "I go to anything that is going on. I go down to whatever it is. As long as there is something going on, it's soul destroying if nothing going on"; "Love to have more men activities. Have been out to the pub but would love to have more trips out with a male driver and carer"; "I've been out on trips and really enjoyed them."

Relatives were welcomed to the service and could visit people at times that were convenient to them. People maintained contact with their family and were therefore not isolated from those people closest to them.

The provider had systems in place to receive and monitor any complaints that were made. In 2016 the service received one formal complaint and was handled in accordance with the provider's complaints handling policy. People said they knew how to complain and would feel confident to approach staff members in the first instance. Comments included; "I've got no complaints but would talk to a senior if I wasn't happy"; "The staff are very talkative. I would speak to one of them if I had a problem or a complaint"; "I know I could complain and that they [staff] would get things done."

Requires Improvement

Is the service well-led?

Our findings

Since the previous inspection in January 2016 there have been two changes of home manager. The current manager has been at the service since December 2016. The high turnover of home managers has affected the level of service. The provider had failed to fully implement the actions in their plan from the previous inspection to ensure they were no longer acting in breach of the regulations. As well as not implementing the stated actions in the plan we found that the number of breaches of regulations has increased. Medicines continued not to be managed safely. Risks to people using the service were not in all cases managed appropriately. Staff were not consistently supported through an effective training and supervision programme. People's records were not sufficiently monitored to manage their health conditions. Where a person lacked the mental capacity to make specific decisions about their care and treatment, their best interests were not established and acted upon in accordance with the Mental Capacity Act 2005. Care plans were not consistently written in conjunction with people or their representative.

The new manager acknowledged that the identified areas of concern required improvement. Owing to the recent audits they had undertaken to review areas of the service they had a priority plan in place which identified similar concerns which required development. Actions that were already progressing included the introduction of a supervision programme, the undertaking of a recruitment drive and a review of medication errors. Training has also been booked for medication, catheters and diet and fluid recording, care planning, safeguarding and the Mental Capacity Act.

Staff and people had expressed their concern regarding the turnover of home managers. Comments included; "There have been half a dozen of new managers; you never get to know them" "I don't know who the manager is"; and "There have been quite a few changes. There has been a change of managers and it's not continuous. Do not really know the new manager yet. He has introduced himself. A staff meeting was held recently."

The new manager had introduced a regular team meeting plan. They held a formal staff meeting on 1 February. Issues discussed included; dress code, sickness, vacancies, care observation and safeguarding. A staff forum had also been set-up. The forum comprised of staff representatives and the home manager and they focused on operational issues such as; rotas, sickness and absenteeism and suggestions for improvement.

At a recent residents meeting people were encouraged to provide feedback on their experience of the service. Issues discussed included; catering; gardening, activities programme and the level of care. People felt the food had greatly improved and enjoyed the activities. People provided feedback on activities they would like to engage in and made food suggestions. The manager has a resident's action plan in place to take forward peoples suggestions.

To ensure the safety of the service health and safety checks were conducted, such as checks on equipment and standard of electrical, gas and water safety had been completed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans were not consistently written in conjunction with people or their representative. This meant that care plans potentially did not reflect people's individualised needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance People's records were not consistently monitored to manage their health conditions.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not supported through an effective training and supervision programme.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not managed safely. Risks to people using the service were not in all cases managed effectively.

The enforcement action we took:

Warning Notice