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Ivonbrook Care Home

Inspection report

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Date of inspection visit:
09 June 2016
10 June 2016
14 June 2016
15 June 2016

Date of publication:
29 November 2016

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an unannounced inspection at Ivonbrook Care Home on 9, 10, 14 and 15 June 2016.

At our last inspection in August 2015 we found the service to be rated as good in all key areas.

Ivonbrook Care Home provides accommodation with nursing and personal care for up to 40 people, some of whom were living with dementia. At the start of our inspection there were 31people living at the service.

There was no registered manager in place. 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.

People were not protected against the risks of receiving inappropriate or unsafe care; care was not planned or delivered to meet people's individual needs. Medicines were not safely managed.

There were sufficient numbers of staff on duty but they did not all have the skills, knowledge, understanding and experience to support people's needs well.

People were not protected from abuse because staff failed to recognise and report concerns appropriately. Risk assessments failed to provide information on how to reduce the risks and promote people's independence.

People's nutritional and hydration needs were not met. Sufficient quantities of fluid were not maintained for some people who required encouragement or assistance to drink.

The key requirements of the Mental Capacity Act (2005) were not fully understood and capacity assessments were incomplete. People's individual needs were not always recognised and met. This was particularly the case for people who had complex needs or who were unable to communicate their wishes verbally.

Applications for Deprivation of Liberties Safeguards had been made because the local authority requested them.

Systems to assess, evaluate and monitor the quality of the service were not effective. There was a lack of effective leadership of the service.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures."

During this inspection we found the service to be in breach of several of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People did not receive medicines as prescribed as staff did not follow correct systems and processes; medicines were not safely stored and administered.

Risks were not effectively managed and recognised.

Some staff did not have the skills, knowledge and experience to support people safely.

People did not always receive care in a timely manner.

Is the service effective?

Inadequate

The service was not always effective.

Staff did not have the knowledge and skills to meet people's needs. Staff training, including induction, was insufficient to ensure the people were supported by staff with the right knowledge to meet their needs.

People who required assistance were not supported to maintain their fluid intake.

Capacity assessments were incomplete and did not comply with the requirements of the Mental Capacity Act (2005). Applications for Deprivation of Liberties Safeguards had been made by request of the local authority.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always supported to maintain their independence and did not always have the opportunity to express choice about their care and routine.

We saw caring interactions between staff and the people who lived in the service.

Is the service responsive?

Inadequate

The service was not responsive.

People's preferences, wishes and aspirations were not identified or supported. Care plans did not provide detailed information about each person

There was an increased risk of people receiving poor or inappropriate care as information about people was inaccurate and inconsistent.

People's requests for assistance were not met in a timely manner.

Is the service well-led?

Inadequate

The service was not well led.

Systems to assess, evaluate and monitor the quality of the service were not effective.

There was no registered manager at the service; leadership at the service was not effective. An open and person centred culture was not promoted.

Appropriate notifications had not been sent to the CQC.

Ivonbrook 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 9, 10, 14 and 15 June 2016 and was unannounced. The inspection team consisted of two inspectors and a specialist advisor on the first two days and two inspectors and an inspector manager on the third and fourth days. The specialist advisor on this inspection had a background in healthcare, wound care and medicines management.

Before the inspection we reviewed the information we held about the service along with notifications that we had received from the provider. A notification is information about important events that the provider is required to send us by law. We looked at the report from the previous inspection held in August 2015.

During our inspection, we spoke with twelve people using the service, twelve relatives, two social care professionals and three visiting health care professionals. We also spoke with the provider, a representative of the provider, four nurses, a cook, an activity co-ordinator, three senior carers, one care staff and the new manager.

We reviewed care plans and associated records for twenty-four people who used the service. We reviewed staff rotas and management records relating to incidents and accidents, training and staff recruitment information. We reviewed policies and procedures and quality assurance information held at the service.

Inadequate

Is the service safe?

Our findings

As many of the people who lived at the service were living with dementia and complex needs they were not all able to tell us about their experience. People who were able to tell us, told us they felt safe at the service. Relatives we spoke with during the inspection confirmed this. However, our findings did not support the feedback we received. We found people were not always protected from the risks of harm and neglect.

We were aware the provider was working with and being supported by health and social care professionals from the local authority and clinical commissioning group (CCG). There had been on-going concerns, including a large number of safeguarding referrals since our previous inspection. Derbyshire County Council Adult Care had made in excess of 20 safeguarding referrals over a four-month period. The referrals were investigated by the local authority; the local authority introduced safe and well checks to the service as well as increased professional advice and support. The systems at the service for identifying and reporting concerns were inadequate. The safeguarding investigations identified people at the service were not being protected from the potential risk of harm.

The systems for identifying and reporting concerns were ineffective. Staff told us they knew how to report safeguarding concerns, although we found staff had not recognised or reported concerns to the local safeguarding team. People were not protected from abuse and received improper treatment as the provider did not have robust systems in place to ensure they were protected. The provider failed to inform the Care Quality Commission (CQC) of the high level of safeguarding concerns, as they are required to do. The local authority and clinical commissioning group had suspended placements of new people at the service along with the regular safe and well checks. A visiting health professional told us they had increased their visits to the service as they were concerned for the safety of people.

People were not protected from abuse. We found incidents forms which stated one person had hit another person living at the service. We found that another person sustained an injury as staff had failed to protect them appropriately. These incidents had not been recognised by any staff members as possible safeguarding concerns and not investigated in any way. No plans had been put in place to mitigate future risk, nor had they been discussed with the people they involved. These incidents had not been reported appropriately by the service or investigated immediately upon becoming of aware of them by the provider. There had been no discussion with the local safeguarding team to check whether a safeguarding alert was required and staff were unable to confirm this. In addition, the Care Quality Commission were not made aware of these occurrences.

We identified a safeguarding concern in relation to a person's emergency rescue medicine during our inspection. This was reported through to the local safeguarding authority who are investigating the safeguarding concern.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure people using the service were protected from abuse.

Medicine records showed the management of medicines was not being carried out safely. We reviewed people's medicines administration record (MAR) charts and found the correct systems and processes were not followed to ensure medicines were administered as prescribed. MAR charts should have been completed by staff after each person had taken their medicines. We saw there were unexplained gaps in people's MAR charts. We also saw medicine's had been signed as given but were on occasion left in the blister packs, without any recorded reason. We found that another person's medicine for a specific health condition was signed as being administered on the MAR chart but was still in the monitored dosage system (MDS). MDS is a medicine storage device designed to simplify the administration of solid oral medicines. This meant the provider was unable to assure themselves that people had received their medication as prescribed.

We saw medicines with special storage instructions were left overnight in the medicines trolley, when they should have been stored in the medicines fridge. Medicines had not been stored in line with the manufacturers guidelines, so the provider could not be assured that they were still safe to use.

Some people had patches prescribed for pain relief. We saw one person was prescribed patches for pain relief and it was not recorded on the body chart where the patch had been applied on three occasions. It is recommended the patches are not applied to the same place each time they are applied as it could have an impact on the person's skin. However, as the records did not identify where the patch had been applied, it was not possible to avoid repeated application to the same area. This meant people were at risk from skin becoming irritated or sore.

We saw procedures had not always been followed with regards to specific medicines administration. Creams for skin conditions had been prescribed for people and records for administration were kept in their rooms. These creams were to be applied by care staff and we found records had not been completed. We saw there were three occasions within the past month where the nurse had failed to monitor blood sugar levels effectively for two people with diabetes. We saw the taking and recording of people's pulse prior to administering of a specific medicine had not always been carried out. This meant risks to people's health and welfare were increased due to clinical procedures not being correctly followed.

On the first day of our inspection we saw the morning (8am) medicines were still being administered at 11:30am. There was a risk that people may not have had an adequate gap between each dose of their medicines, which would mean an increased risk of the effects, and side effects of the medicines We observed the nurse administering medicines, and noted they were frequently distracted by answering the telephone and talking to colleagues. This meant there was an increased risk of mistakes being made.

Some people were prescribed 'as required' (prn) medicines and records to confirm the quantity of the medicines administered were not always clear. We were told by health and social care professionals they had previously made the clinical lead aware of this so they could ensure the records were improved, however we saw no evidence of this. We asked the clinical lead about one person's emergency rescue medicine which was prescribed for epilepsy. The clinical lead was unaware initially that the person had this medicine and then of where the medicine was stored. They then took an hour to locate it. If the person required this medicine it would be needed within a matter of minutes. This showed a lack of understanding in relation to medicines management. We were not assured the clinical nurse recognised the importance locating the medicine and it was not documented within the persons care plan that this medicine was available and should be administered in an emergency situation.
There was a wooden sideboard in the upstairs dining room. The sideboard was not locked and contained a large quantity of prescribed food supplement drinks and desserts that had been prescribed for people. There was a risk that people that used the service would be able to access these prescribed supplements.

The service did not follow current and relevant professional guidance about the safe management and review of people's medicines. Medicines were not stored, administered and disposed of in a safe manner and in line with current and relevant regulations and guidance. This demonstrated medicines were not managed safely and people were not protected from the risks of inappropriate administration of medicine.

Risks relating to people's care were not always identified and assessed. Where they had been identified there was a lack of detailed guidance for staff to follow. Appropriate actions had not been taken to mitigate identified risks. For example where a person was at high risk of falls their risk assessment did not contain sufficient information on how to reduce the risk and support the person in a safe manner. We found that one person who was high risk of falls experienced a further fall at the service through which they sustained a serious injury.

We looked at accident and incident records and we found three incidences of people falling between 21 May 2016 and 11 June 2016. The care plans related to these people all identified they required assistance with mobilising and were at high risk of falls, and yet they were all 'found' on the floor. There was nothing in the accident and incident records which identified there was a member of staff supporting them when they fell. Control measures identified to reduce the risks of people falling and ensure their safety, had not been followed.

People's waterlow assessments were not fully completed, updated or reviewed. The primary aim of the waterlow assessment tool is to assist staff to assess the risk of a service user developing a pressure ulcer. We saw waterlow assessments for four people that had not been fully completed and for two people where relevant areas on the assessment had not been highlighted. This showed that the assessments and level of risk were not accurate and staff were not able to identify the individual areas of risk.

We saw there was a wooden sideboard in the upstairs dining room. The sideboard was not locked and contained a large quantity of food supplement drinks and desserts that had been prescribed for people. There was a risk that people that used the service would be able to access these prescribed supplements.

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

When asked if there was enough staff a relative told us, "Probably not all the time, but most of the time." They went on to say, "Some staff may go off sick or let them (provider) down at the last minute." One member of staff told us on some occasions there were insufficient staff to meet people's needs in a timely manner. They told us when this happened, it meant some people remained in bed until lunch time as there were insufficient staff to assist them with personal care. The member of staff told us this happened about twice a month. We saw staff rota's showed there were sufficient numbers of staff on duty; the provider had ensured the service was over-staffed. However due to the lack of leadership and direction, staff were not deployed effectively to meet the needs of the people.

The provider told us they were continually trying to recruit suitable staff. Although we found there were sufficient numbers of staff on duty, we identified some lacked the skills needed to care for people who were living with complex health conditions. For example, we asked a senior carer to tell us what they would do if someone suffered an epileptic type seizure. The senior carer acknowledged their understanding and knowledge in this area was limited. The senior carer found it difficult to tell us how they would respond in this example of a medical emergency. We asked the senior carer if they had participated in any specific training related to epilepsy and they confirmed they had not. This meant there was a lack of consistent, safe and appropriate care for people who lived at the service.

We looked at the recruitment records of eight staff employed by the service. We found one staff member had started work prior to the provider completing relevant pre-employment checks on them. Another person had only one character reference and two senior members of the staff team had given references to each another. One member of the staff had some restrictions in place around their practice however it was not always clear that these were being followed.

We received conflicting information from registered nurses at the service about the amount of people with pressure sores. For example, the clinical lead told us there were no people requiring treatment for pressure wounds, however a bank nurse told us there were three people. We looked at people's care plans and established there were three people receiving treatment for pressure sores. This was a concern as we could not be assured that people were receiving appropriate pressure area care. Where people had pressure sores there were no clear guidance or plans in place to ensure people received appropriate treatment for them. We found on one occasion a person had an inappropriate dressing applied to a wound. For another person, information on how frequently their dressings should be changed was not available.

We looked at pressure area risks for three people who required assistance to move and change position in order to relieve their pressure areas. Though there were record charts in the daily files indicating people had been assisted to move to relieve pressure area care, it was not always indicated who had undertaken this or what time it had happened. This meant it could not be verified this had taken place.

There was a 'stand-alone' air conditioning unit in the nursing treatment room which was leaking water onto the floor, this was due to the bucket which contained the condensed water overflowing. When we brought this to the attention of staff they emptied the bucket and mopped the floor. However, this was a risk to people due to slipping (though only staff used this room) but also a possible of infection from dirty water. This was a concern as it increased the risk of the legionella bacteria coming into the home. Legionella bacteria are commonly found in water. People were not sufficiently protected from the risks of developing Legionnaires disease of which the older people are at a higher risk.

People's care plans were not effectively updated and evaluated. We saw in one person's care plan their needs and assessments had not been updated since 6 January 2016. On further review we saw the same person was at risk of weight loss and their eating and drinking plan had not been updated since the same date.

We reviewed another person's care plan and their dependency assessment had been completed seventeen times between 17 September 2014 and 29 March 2016, but all entries were identical. This indicated this was not a true record, as we would expect people's dependency to fluctuate and change over time. We saw in another person's care plan there was a pain assessment chart but this had not been completed. This meant that the service were unable to establish whether the person had any pain or not and assure themselves that the person was comfortable.

One person told us they felt safe and they received their medicines when needed. They went on to tell us, "My pain patch is changed every Saturday." They also told us they received pain relief quickly and when they need it. Another person told us, "I only have to ask and it is there; we can have whatever we want." A relative told us, "On the whole it is very good; when I visit everyone seems fine." The relative went on to tell us they thought their family member was, "Very safe; we're quite satisfied."

Personal protective equipment, for example, gloves and aprons were easily accessible by staff and were present in corridors. This helped to ensure staff were wearing appropriate clothing cover before they assisted a person with personal care.

Inadequate

Is the service effective?

Our findings

People were not always supported to maintain good health. We saw one person had been reviewed by the dietician and the service had been advised to continue to monitor their weight weekly. The aim of this was for the person to maintain their current weight. The service had not been weighing this person weekly and they had only been weighed twice since the beginning of April. This person had lost 5.5 per cent of their body weight between 3 April 2016 and 22 May 2016 and the service had failed to take any further action. We found another person who had been prescribed nutritional supplements to enhance their diet and ensure they received appropriate nutrients had not been receiving them. The service had failed to any action in relation to this. This put both of these people at risk.

Some people living at the service were at risk from lack of nutrition and weight loss. One person's weight was recorded five times between 6 January and 26 May 2016 which showed they had lost almost 10kgs in six months; this meant a total of 15 per cent loss in body weight. The advice in their care plan stated they required nutritional supplements and yet when we checked records, we saw they were not receiving these. This meant this person was at risk from weight loss due to not receiving the correct nutritional support.

Another person was weighed when they moved to the service and their care plan indicated they were at risk of malnutrition, we could find no record of their subsequent monthly weights being recorded in the weight book. A third person lost weight 5.5 per cent of their body weight over a seven week period however, there was no information about whether this weight loss was significant or what action the staff were going to take. When we spoke with senior staff about what action was being taken with regard to these people, they were unable to provide an answer. This meant people were at risk of weight loss and their nutritional needs were not being safely managed.

One person had been visited by the community matron and it was recorded in their care plan they were not drinking enough. We saw they had been in hospital previously with dehydration. The care plan was updated by the community matron, to advise staff the person required hourly drinks due to their risk of dehydration. We saw it documented, if the person had not drunk at least one litre a day then the GP was to be contacted. On three occasions 8, 9 and 10 June 2016, daily records indicated the person had insufficient to drink, however we found no evidence to suggest the GP had been contacted. The person was admitted to hospital mid-way through our inspection, due to dehydration. We received the information relating to this person from the local authority rather than receiving the information from the service.

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

Due to the complex needs of people's health needs and conditions, people were not always able to tell us their views about the skills and knowledge of the staff. Of those we spoke with, one person said, "Some of the staff are okay". Another person told us, "Good staff are hard to keep." A relative told us, "People's needs must come first; staff have different abilities and having consistent nurses is a must." The relative went on to

say, "Most staff seem to be trained okay, but some nurses are not as consistent."

When we asked one person if they thought staff had the skills and knowledge to care for them they said, "Some do and some don't", they went on to say, "Young ones are very helpful but I'm not sure they're up to it." Health and social care professionals told us they were not confident all the staff had the skills and knowledge to meet people's needs.

Staff we spoke with explained they had shadowed a more experienced member of staff before they commenced working alone. They said they had been supported until they felt safe to work independently. They also explained how they had received training to support them in the work they did. For example, health and safety, diet and nutritional needs and safeguarding. However, we spoke with one member of staff who told us their induction had lasted only one day and they began to work with people to support them with their care needs before they had an opportunity to look at the care plans or get to know people well. This showed that not all staff members were provided with an appropriate induction to prepare staff for their role and have the relevant skills and information to enable them to meet people's needs.

A lack of skilled staff was evident in our discussions. For example, we asked a senior carer to explain what actions they would take if a person had epilepsy and required emergency rescue medicine. They told us, "I would contact the district nurses and ask for a visit to give the medicine." We further explored this with the staff member as we were concerned for the welfare of the person should they require emergency treatment for seizures. The senior carer recognised their knowledge and understanding of epilepsy was limited. They went on to tell us they had not had any training specifically around epilepsy. Staff had not received appropriate training to enable them to fully understand and meet people's needs. There was a risk that people would not receive the care they needed as staff did not have the relevant knowledge to meet people's needs.

We looked at staff's training records and found much of the training the provider considered mandatory for their staff was out of date or had not been completed. We saw there was no record of any training specific to working with people with epilepsy. We saw only two staff members had received training in falls prevention and only one staff member had attended training in diabetes. This meant staff did not have the understanding, skills or knowledge, to effectively support people's complex health needs. This put people at the service at risk.

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

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 to 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, and whether any conditions on authorisations to deprive a person of their liberty were being met. People were not always assessed in relation to their capacity to make decisions about their care. Consent to care and treatment was not always sought. However, when we discussed the Mental Capacity Act and Deprivation of Liberty Safeguards with

staff they had a basic understanding of what these meant for people they cared for.

People's care plans did not clearly record whether people were able to make their own decisions. Where people lacked capacity to make certain decisions, the provider did not follow the principles of the MCA and best interest meetings did not take place. For example, we saw there was a signed letter from a GP regarding disguising one person's medicine if they refuse to take it. When we looked at the letter and found it had expired six weeks previously. We asked the nurse to contact the GP and discuss this with them. The nurse contacted the GP as we requested and another letter was issued. However, there was no evidence of the person, or an appropriate representative being involved, in a best interest meeting relating to the use of covert medicines.

Care plans we looked at were not signed to show whether people or (where appropriate) their representatives had agreed with or consented to the plan of care. This approach to caring for people did not protect their rights to make decisions about their own lives and about how the care was offered to them.

The MCA DoLS require providers to submit applications to a 'supervisory body' for authority to restrict people's liberty. We saw applications had been made to the relevant supervisory body for people who were assessed as being at risk of being deprived of their liberty. Adult social care professionals from the local authority told us the applications had been made at their request. We saw people with a DoLS authorisation were supported by a relevant person's representative. One relative told us, "[Person's name] has a DoL in place; he asks to go home but it's not safe." They went on to tell us, "I'm [person's name] representative for DoLS; it would not be safe for [person's name] to be at home." This meant people's rights were being upheld, and restrictions in people's care were lawful, but only because the local authority requested the applications were made.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had enough to eat and drink. Menu choices were available and we could see other options were available if people did not like the main choices on offer. The kitchen staff told us they were happy to prepare different food and to cook what people wanted. When we spoke with people, they confirmed this was the case. We saw drinks were readily available throughout the day and one person said "Oh yes, there is always a drink there," indicating to the side of their chair.

When we visited the kitchen we could see there was fresh fruit and vegetables available and plenty of food in the store cupboard. The cook was aware of people who required a special diet and what to prepare if a vegetarian was resident in the service. For example, one person living in the service required a gluten free diet; the kitchen staff were aware of who this was and how to prepare food which was safe for them to eat.

We could see the kitchen staff were aware of which people required a higher calorie diet; one person who required a weight reducing diet. However, kitchen staff told us all people living in the home had nutritional supplements added to their food. When we asked about the person who was on a weight reducing diet the kitchen staff told us they cooked the person's food separately, although we were unable to confirm this.

Homemade cakes were available; however, when we checked the storage date for these we saw some of the home-made cakes were seven days old. This meant people were not always provided with a freshly made diet.

A health professional told us due to the growing number of concerns, they had felt the need to increase their

visits to the service. The health professional had also arranged for people's annual health check to be brought forward as they concerned about the services ability to assess and identify people's health needs effectively. They felt this was necessary to ensure people's health needs had been assessed correctly. However, we spoke with another health care professional and they were very positive about the service. They advised us they had done two training sessions at the service and had been pleased with the services and staffs' response. The health professional told us the staff always phoned them for guidance if they are unsure. They also told the recording of information had improved. They went on to tell us they have revised the guidance they were leaving at the home. They told us this was in the form of summary sheets, which we saw were available and on display on people's bedroom walls.

Requires Improvement

Is the service caring?

Our findings

We looked at people's care plans and saw no evidence of people or their relatives in the compilation and evaluation of these. This meant care was delivered in a way which may be contrary to people's wishes and without their agreement. People had not been supported to have involvement with the delivery of their care. None of the people we spoke with could confirm they had been involved with the formulation of their care plans.

People's personal and confidential information was not always kept safe and secure. At the start of our inspection we found the nurses office door was left open without a staff member being in the room. There was a key pad to the office door for security, however the door was held open. People's care plans were on display on open shelves. This meant there was a risk of people's confidentiality being compromised. A prescription was pinned to the notice board which was at risk of theft.
People told us they were treated with respect by the staff. One person told us "Staff are always kind". We asked one person if they felt there was a nice atmosphere in the home they said, "Yes, I think so", they went on to tell us they had made a few friends in the home and they believed they received good quality care. A relative told us, "They've [staff] always treated me with respect." Of the people and relatives we spoke with, everyone told us they liked the service due to the family feel. One relative told us, "It is so friendly and may be that is due to it being family run." Another relative told us, "We like it because it is family run."

However, staff did not always talk with people in a respectful and age appropriate manner. During our inspection visit we heard a staff member say, "Good girl and good lad," to two older people living at the service. We perceived these terms as lacking in compassion, respect and dignity. We heard one person ask a staff member who was supporting them if they could have breakfast, the staff member responded by saying, "Say please." This response does not show dignity and understanding of the person they are supporting. We spoke with the provider about this and they assured us they would take action to address this with all the staff.

We saw interactions between people, visitors and care staff were warm, caring and good natured. People's relatives said they felt welcomed when they visited the service. One relative told us they visited their family member twice a day to support at mealtimes. The relative told us they visited at these times because they wanted to. They went on to tell us the provider, "Insisted I have my meal with [relative]." Another relative told us they also visited at lunchtime, they said, "I visit every day at lunchtime; I have lunch with [person's name]." They went on to say, "The food is good; there's a good variation." One member of staff told us "I love my job". Another member of staff told us, "Things have been difficult recently; things are picking up, but it takes time."

However, people were not always supported in a caring way. One person who was not feeling well was left seated in a recliner chair in their bedroom with no means of summoning assistance. This person was able to use a call bell but staff had failed to ensure it was within reach. We took action to rectify this and reported this to the staff. We found another person who spent most of their time in bed had been left without their call bell within reach. We spoke with staff who confirmed this person was able to use their call bell and it

should have been left within their reach. This meant the some people would not have been able to alert staff or call for assistance should they require.

At 11.20 in the morning we saw one person playing dominoes with a member of staff but the person was still wearing a used apron from breakfast. The staff member had failed to notice the person was still wearing a soiled apron. This showed a lack of empathy and responsiveness towards the person.

We saw at lunch times people were treated with dignity and respect. People were supported in a way that maintained their dignity. For example, we saw staff sat at eye level with the person they were assisting with their meal and explained to them what they were eating. When we spoke with one staff member about how they maintained people's dignity at meal times, they said, "It's important not to rush people". We spoke with one relative they told us they had never seen any uncaring or undignified exchanges between staff and the people who lived in the home.

Staff explained how they maintained people's dignity when they were providing personal care by ensuring doors and curtains were closed and only the part of the body they were providing care for at any one time was not covered. Staff told us they were aware of the importance of people choice about their daily living activities. For example, a staff member explained to us how they helped people to make choices about what clothes to wear by holding up two different outfits and encouraging them to choose. Another member of staff told us how important it was when they were providing personal care to be flexible. The staff member explained this they were flexible so people's individual needs and wants were met in a way that responded to their preferences.

Inadequate

Is the service responsive?

Our findings

Staff were required to complete individual daily records for each person. The records were stored in people's bedrooms and should have detailed important information about people's health and welfare. However, we saw, although information was recorded, it was not always accurate and had little positive impact on people's experience of care. Records were completed inconsistently and in a manner which was not easy to understand. For example, we saw staff documented a person had eaten, "25% toast," rather than the actual quantity.

We found care plans did not provide detailed information about each person. Care plans had gone through a number of format changes and were not easy and useful working documents. Most of the staff we spoke with were unaware of the detail in people's care plans as they had not read them. One staff member said, "We don't have time to read care plans". This meant the staff relied on handover meetings for details about how to care for people. For example, when we asked one staff member if they knew whether anyone had epilepsy, they told us, "I think [person's name], but I'm not sure if there's anyone else." Although the handover notes were available, they did not always contain the level of detail and information we would have expected to ensure people's needs were met. This meant there was a risk of information passed on was inconsistent. This increased the risk of people receiving poor or inappropriate care.

People who required assistance to get out of bed were not assisted when they requested. For example, we saw one person request to be assisted to get out of bed. A staff member acknowledged the request for assistance and they assured the person they would return to support their request. However, the person had not been supported to fulfil their wishes over two hours and forty minutes later following their request. This meant people's needs and requests for assistance were not met in a timely manner. People did not receive care to meet their needs.

When we talked to one member of staff about people's hobbies and interests and how they were supported to follow these, they told us people were happy just sitting in the lounge and, "Most just snooze after lunch". When we asked staff to describe or explain what hobbies people were interested in, they were unable to tell us. This showed a lack of understanding by staff of what constitutes personalised care and a how important it is people are supported to follow their interests.

One person told us they were never asked by staff how they would like to spend their time and they mostly sat and watched television. Another person told us, "There is nothing much to do." When we asked them what different things they would like to do they said, "They don't seem to have games like bingo". When we asked a third person if they enjoyed living at Ivonbrook they told us they were bored. During our inspection, we did not see anyone being supported to visit the sensory garden, even though it was frequently sunny and warm. On the activity boards, upstairs and downstairs, there was information to staff to ask people if they wanted to go outside if the weather was nice. People told us they could not remember being asked if they wanted to sit outside. At our inspection visits, we only saw the sensory garden used when relatives visited and took their family members outside. This showed that staff did not provide support in line with people's preferences as they were unaware of what they were.

There was a sensory room available for people to use at Ivonbrook, however, it only contained one broken piece of equipment and a picture of a cat. This meant it was neither appealing nor used by people at the service. The room was generally used as a meeting area.

Within people's care plans, we saw a document titled 'This is my Life'. In one person's care plan we saw 'This is my Life' stated the person enjoyed listening to classical music. This person spent a large amount of their day in bed. As the person was living with dementia, they may have benefited from being able to enjoy the music they loved. We discussed this with staff and they were not aware this person enjoyed classical music and were not aware when this had last been played for them. This person had not received person centred care that reflected their preferences.

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

We did see some evidence of activities being carried out; on the first day of our inspection, a local ice-cream vendor visited and people were supported to choose and eat their ice-creams. One on occasion we saw a member of staff carry out a session of chair-based exercises with a small group of people. The staff member understood the needs of the people who participated in the exercise class. The staff member showed empathy and enthusiasm and the session was gratefully received by the people.

When we asked people if they knew how to make a complaint people told us they did. One person said "If there's something I don't like I would see (staff member)." One member of staff told us information from complaints was shared with staff to learn from. They said, "It's good for us to know (about complaints) so we know what we can improve on; what we can change". The provider had a complaints procedure in place, although we were unable to review any complaints as the provider was unable to locate the folder. This meant the provider was unable to show us an effective means of collecting and responding to complaints.

Inadequate

Is the service well-led?

Our findings

Ivonbrook Care Home is required to have a registered manager and one was not in place at the time of our inspection as they had resigned. A new manager had been appointed three days prior to our inspection. The new manager was at the service on the first two days of our inspection. During our inspection there were a number of changes made to the day to day management of the service. This was due to decisions that were made by the provider partnership. The changes were made as there was no effective, clear or visible leadership at the service.

It is a condition of the provider's registration to have a registered manager in post to manage the service. As the registered manager had left their position, the service had no clear leadership or vision. We found the Care Quality Commission (CQC) had not been informed of a number of incidents that had occurred at the service. The provider failed to send written notifications to the CQC to tell us about any important changes, events or incidents at the service, as we would have expected. For example, prior to our inspection we received information from Derbyshire County Council relating to safeguarding concerns about a number of people at the service. However, we had not been notified of any of these by the service.

This meant the provider had breached Regulation 18 of the Care Quality Commission (registration) Regulations 2009 (part 4).

We found there to be a lack of training, support and supervision of the staff and this had not been recognised by the provider. Systems to assess the need for staff training, to keep staff knowledge current and up to date, or to monitor the impact it had on practice, were not effective. We saw from records, most staff had received training in medicines management, however, we had found many failed to do this safely. The provider was unable to show how they monitored the effectiveness of training or how they identified where further training was needed.

As there was no consistent management oversight, we saw no evidence to suggest any analysis had been undertaken to improve the service or to protect people from potential hazards or risks. This meant there was a potential increased risk of accidental injury due to the lack of thorough evaluation and analysis.

There was a system in place for staff to record accidents and incidents; however, we saw the records were not analysed for frequency or potential trends or used as part of an on-going risk assessment in relation to people's needs. We found there were no consistent systems in place to reduce risks in relation to the health, safety and welfare of people. For example, there was no analysis of accidents such as falls to identify any patterns and potential causes, in order to reduce the risk of similar incidents from occurring again. This meant there was no system or procedure in place for staff to learn from the incidents and to improve the care provided to people.

We spoke with the provider about how they assessed, monitored, evaluated and improved the service they provided. We saw systems and processes designed to assess, evaluate and improve the quality of services

and reduce potential risks to people had not always been effective. For example, systems to ensure the safe management of medicines had not been correctly followed.

We found the quality monitoring systems in place to assess the quality of the service were not effective. The provider was unable to demonstrate to us how they audited their service and how they identified where or if any improvements were required. The lack of quality auditing and monitoring meant there was no way of ensuring the service was fit for purpose. As a result, the provider had failed to identify poor practice in the service or the impact it had on the people who lived there. People were therefore at risk of potentially unsafe care due to the lack of thorough monitoring and evaluation of care and services provided.

Audits on people's health care included wound care, medicines, nutrition and hydration were not effective at identifying potential risks to people. During our inspection visits, health and social care professionals made us aware of safeguarding concerns relating to people's physical health and welfare. For example, one person required bed rails to be in place when they were in bed. However, staff failed to ensure the rails were in place and the person fell out and sustained an injury. This showed staff failed to ensure people's health and safety was maintained.

We looked at care plan audits and could see these had been completed in March, April and May 2016. However, the action points identified had not been followed through. For example, the action points identified Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms needed to be discussed with families, consent to care and treatment needed to be discussed with individuals, life histories required completing and restraint plans required updating. We found these action points had not been carried out. This meant up to date information was not available to ensure staff supported people in a way they wished to be supported.

Kitchen audits had been undertaken five times between 7 October 2015 and 18 May 2016; the months of November 2015, February, and April 2016 were missing. The audits were a simple tick box and contained no details or action points. The environmental audits had been completed four times between 20 September 2015 and 23 May 2016. This meant audits of the kitchen and environment were not completed consistently and effectively.

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

People and relatives we spoke with clearly knew who the provider was. People told us they felt confident if they raised a concern or complaint the provider would take prompt action to rectify it. One person told us, "Some people will never be satisfied." All the relatives we spoke with were very supportive of the provider. One relative told us they had been visiting for over a year and gave the service, "Top marks." Another relative told us, "We attended a meeting recently and really can't see what the problem is." The meeting was at the request of the local authority and was to make people and relatives aware of the concerns that had been raised.

Maintenance and servicing records were kept up to date for the premises. Health and safety records indicated equipment, such as fire extinguishers and emergency lighting were checked and serviced when required. We saw an external contractor had checked equipment used for moving and transferring of people. We saw weekly fire checks were recorded as taking place.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider failed to send written notifications to the CQC to tell us about any important changes, events or incidents at the service, as we would have expected. External professionals hade made multiple safeguarding referrals, however the provider failed to alert us.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care was not provided in a person-centred manner. We found care plans did not provide detailed information about each person. Information about people was not always accurate and had little positive impact on people's experience of care. Records were completed inconsistently and in a manner which was not easy to understand.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to obtain consent to care and treatment.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Effective systems were not in place to ensure risks to people's safety and welfare were consistently assessed, monitored and managed. The service did not follow current and relevant professional guidance about the safe management and review of people's medicines. Medicines were not managed safely.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment There have been a high number of safeguarding concerns referred to the local authority by visiting professionals. The staff had not recognised the need to make referrals in these instances.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not in place to ensure the quality of care was consistently assessed, monitored and managed to improve the quality of care for people at the service.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient staff with the right training, knowledge and understanding of people living at the service.

The enforcement action we took:

We took action to stop the provider from admitting or re-admitting people.