Horizon Care (Derby) Limited

Ivy House

Inspection report

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Derbyshire
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Date of inspection visit:
06 June 2019

Date of publication:
12 July 2019

Ratings

Overall rating for this service	Requires Improvement
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Ivy House is a residential care home providing personal for up to 20 people aged 65 and over. At the time of the inspection 15 people were using the service.

People's experience of using this service and what we found
The leadership and the management of the service was ineffective. The service had a registered manager, but they were no longer employed and were in the process of cancelling their registration.

The provider did not fully understand the requirements of Duty of Candour in relation to information about people, staff, complaints, and to comply with the legal requirements.

The was a continued lack of oversight and governance systems to monitor the service. There were no audits, record of visual checks and monitoring records to ensure people were safe and protected from avoidable harm or injury. People's care was not planned, monitored or reviewed. Staff relied on their knowledge about people's needs and information shared at the handover meetings. Records relating to people, staff and the management of the service were not kept up to date or securely. There was no formal opportunity for people and staff to express their views about the service.

The provider had appointed a new manager, not yet registered with the Care Quality Commission and a deputy manager. People told us staff supported them and they knew who the manager was.

Rating at last inspection and update
The last rating for this service was requires improvement (1 May 2019) and there were multiple breaches of regulation. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to the day to day management of the service. As a result, we undertook a focused inspection to review the Key Questions of Well Led only.

We reviewed the information we held about the service. No new areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

At the previous inspection we found breaches of regulations. At this inspection we found the provider still needed to make improvements to meet the regulations therefore we are taking further action. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ivy House on our website at www.cqc.org.uk.

Enforcement:

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our Well-Led findings below.

Ivy House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
This inspection was carried out by one inspector.

Service and service type
Ivy House is a care home.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. However, they were in the process of cancelling their registration.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We did not request that the provider completed a Provider Information Return, as this was an unannounced focused inspection. We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with two people who used the service. We spoke with three members of staff and the deputy manager and the manager. We reviewed two people's care records and other records about the management of the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found. This included the requested staff meeting minutes, staff training information and the home improvement plan.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last inspection in May 2019, the provider had not made sufficient improvements to the systems to ensure good governance of the service. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● There continued to be a lack of leadership in how the service was managed. The service had a registered manager, but they no longer worked at the service and was in the process of cancelling their registration. The provider had appointed a new manager and a deputy manager.
● The provider had not displayed the latest Care Quality Commission (CQC) inspection report, which is a legal requirement. The manager immediately printed the inspection report from the CQC website and had displayed it.
● We found the provider had not made sufficient improvements to meet the breaches of regulations identified at the last two consecutive inspections. Informal checks of the premises and equipment safety were completed; however, no records were kept.
● There was limited improvement made to the premises. For example, the damaged window frames, loose tap fittings, frayed carpets and gaps between the floor trims in the shower room were still outstanding. There was damaged furniture, glass panels and other building material still left lying around to the rear and side of the property. This was not safe for people to use.
● A new morning and night cleaning schedule was put in place. This had clear information about the cleaning tasks to be carried out and the frequency of deep cleaning. This regime started on 27 May 2019 and missing signatures were found in the records. There was no evidence to show visual checks had been carried out to ensure people's bedrooms had been cleaned.
● Staff did not always follow infection control procedures and their practice was not monitored. For example, a used mop and pile of soiled laundry were left in the hand wash basin in the laundry room. A soiled floor sensor mat with exposed cable and a damaged shower chair continued be used. This meant

systems were not robust to protect people from avoidable harm.
● There was continued lack of oversight and systems to monitor and assess the quality of care and safety within the service. Audits, safety checks and the reviewing of people's care plans and medicines had not been completed. The manager was developing new audit documentations.
● People's care plans had not been reviewed. Staff told us they did not refer to people's care plans and relied on the information shared at handover meetings. The manager told us they had begun to review people's medication care plans and protocols to ensure the information about people's prescribed medicines was correct. Thereafter, they planned to re-assess everyone's care needs and develop detailed care plans.
● People's views about how the service was managed had not been sought. The manager told us they planned to hold a residents' meeting and send satisfaction surveys in the summer.
● The systems to ensure staff were recruited safely, trained and supported was not effective. The recruitment file for the manager had been removed from the premises by the director. The staff training information had not been updated and was not available. The manager had identified an external trainer to provide face to face training for more interactive learning, so staff's understanding could be checked. However, training dates had not been confirmed. Staff meetings had taken but the meeting minutes were not available.
● Following our inspection visit the manager sent us the staff meeting minutes. The new management team and improvements planned were discussed. The minutes showed only the management team had attended. We could not be sure staff had attended this meeting or how the information would be shared with them.
● The provider did not understand the duty of candour requirements. There was no record of complaints or records relating to the management of the service.
● Incidents, accidents and safeguarding concerns had been logged in people's care records but there was no record of the action taken.
● The provider had not submitted notifications to the CQC as required. It is a legal requirement for providers to notify CQC of all significant events that occurs and affects people's safety.

The provider failed to have systems or processes in place to assess, monitor and improve the quality and safety of the service. This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. We are taking further action in response to the breach found.

● People knew who the manager was. A person said, "[Manager] seems quite nice, [they've] got a bit about them. [They] came to introduce [them] self to me."
● We found a few improvements had been made. A bedroom had new flooring and the opening of the toilet door next to the lounge had been changed to promote people's dignity. A person said, "They have put some chairs outside so it's nice to sit in the garden. It's a shame there not much to look at."
● Staff spoke positively about the changes being made by the new manager and said, "We have to check the toilet is clean every two hours and sign the log sheet" and "It's better now because we are allocated certain tasks and people to look after."

Working in partnership with others
● Representatives from the local authority quality team had conducted monitoring visit in response to concerns raised about people's care. They found the manager and deputy manager were responsive and had taken action to ensure people were safe, but further improvements were still needed.
● A health and safety inspection by the local authority has been scheduled. They will take account of our findings from this inspection and the previous inspections.