Optimum Care (UK) Ltd

Ivy 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?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 30 November and 1 December 2016 and was unannounced. This meant the staff and registered provider did not know we would be visiting.

Ivy House Care Home provides care and accommodation for up to 28 elderly people or people with a dementia type illness. On the day of our inspection there were 11 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Ivy House Care Home registered with CQC on 24 April 2015. This was the first inspection of the location.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out. However, some maintenance repairs were not carried out in a timely manner.

Accidents and incidents were appropriately recorded and investigated. Staff had been trained in safeguarding vulnerable adults. Medicines were stored safely and securely, and procedures were in place to ensure people received medicines as prescribed.

Staffing levels were adequate to provide safe care. The registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff. Staff were suitably trained and received regular supervisions. The home manager had a training plan in place.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA) and was following the requirements in the Deprivation of Liberty Safeguards (DoLS). However, statutory notifications to CQC had not been submitted for three DoLS applications that had been authorised.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Ivy House Care Home. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person centred way. Care records were regularly reviewed however one person had experienced recent falls and their support plan did not reflect this.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs. However, the activities co-ordinator had recently left the service and people were unable to access external activities until a new activities co-ordinator had been recruited.

People who used the service and family members were aware of how to make a complaint however there had been no formal complaints recorded at the service.

Staff felt supported by the management and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service. Family members told us the management were approachable and understanding.

We found a breach 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 the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe as some maintenance repairs had not been carried out in a timely manner.

Staffing levels were adequate to meet the needs of people who used the service and the registered provider had an effective recruitment and selection procedure in place.

Accidents and incidents were appropriately recorded and monitored.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

People were protected against the risks associated with the unsafe use and management of medicines.

Is the service effective?

Good

The service was effective.

Staff were suitably trained and received regular supervisions.

People were supported by staff in making healthy choices regarding their diet.

People had access to healthcare services and received ongoing healthcare support.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect and independence was promoted.

People were well presented and staff talked with people in a polite and respectful manner.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

Care records were regularly reviewed however one person's support plan did not reflect the person's history of falls.

The home had a programme of activities in place for people who used the service however at the time of the inspection there wasn't an activities co-ordinator in post.

The registered provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led as some statutory notifications had not been submitted to CQC.

The service had a positive culture that was open and inclusive. Staff told us management were approachable and they felt supported in their role.

The registered provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

The service had links with the local community.

Ivy 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 registered 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 30 November and 1 December 2016 and was unannounced. This meant the staff and registered provider did not know we would be visiting. One Adult Social Care inspector, an inspection manager and an expert by experience took part in this inspection. An expert by experience is a person who has personal experience of using, or caring for someone who uses, this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They gave consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with four people who used the service and three family members. We also spoke with the registered manager, home manager, four care staff members and a health and social care professional.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures. We also

carried out observations of staff and their interactions with people who used the service.

Requires Improvement

Is the service safe?

Our findings

Entry to the premises was via a locked door and all visitors were required to sign in. Family members we spoke with told us they thought their relatives were safe at Ivy House Care Home They told us, "I know that the staff are up to the job if there was an emergency. The tumble dryer caught fire recently and they followed procedures" and "Yes, [Name] has alarms if she gets up during the night". A person who used the service told us, "Yes, I do feel safe."

We saw the home had a maintenance system in place. We discussed maintenance with the home manager and looked at the maintenance book. The home manager told us they checked the maintenance book daily and if there were any urgent repairs, they would be reported to the registered provider immediately. However, the registered provider arranged for repairs to be carried out by maintenance staff based in Derbyshire and we saw they were not always actioned in a timely manner. For example, a broken kitchen door lock was reported on 7 October 2016 but was not repaired until 14 October 2016. We saw nine faults that were reported between 22 November and 29 November 2016 had not yet been actioned. These included three faults in an occupied bedroom, which were a damaged fire bar on top of the bedroom door, a cold radiator and a leaking sink. Another example was a fault to the front door, which would not close or lock. This was reported on 2 October 2016 but not repaired until 7 October 2016. This meant the system in the home was not working effectively.

The home manager agreed to chase the outstanding repairs up with the registered provider. The registered manager and home manager told us they had tried to employ maintenance staff locally but had not been successful. The registered manager told us they would be trying again to recruit local maintenance staff. This was a breach of Regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We asked people and their family members whether there were enough staff at the home. They told us, "Yes, perfect", "There is enough but not always", "Sometimes no. There are less staff fairly recently and now have to deal with meals" and "There's less staff now. Two left last week and one this week." Staff raised some concerns about staffing levels, particularly at meal times. They told us, "Hard to tell [if staffing levels were

suitable], everything gets done and all [staff] are managing", "The kitchen duties takes you away from providing care" and "I'm aware it covers the legal requirements but could do with more cover".

We discussed staffing levels with the home manager, looked at staff rotas and observed staffing levels during our visit. There were two care staff members and a domestic member of staff on duty during the day, and two care staff members on duty during the night. We asked the home manager what contingency plans were in place if both members of staff were busy. The home manager told us they were available to assist and we observed the home manager and domestic staff member were available, for example, helping out at meal times and when activities were being carried out. We asked the home manager how staff absences were covered and they told us agency staff were used if they were unable to cover the absence with their own staff. We observed staffing levels were adequate to provide the care and support that people needed however in the long term this may impact on the home manager and domestic staff's ability to carry out their own roles.

The provider had an infection control policy and procedure and a monthly infection control audit was carried out. The infection control audit checked infection control procedures, cleaning and disinfection, laundry, personal protective equipment (PPE), pest control and waste. The home had two infection control champions, who attended monthly meetings with the local infection control team and fed back issues and updates to staff. We saw PPE, hand hygiene signs and liquid soap were in place and available. Cleaning schedules were in place, which included two bedrooms to be deep cleaned per day. The list of tasks to be completed each day were signed by the domestic staff and checked by the home manager. We asked people who used the service and family members about cleanliness at the home. They told us, "Top notch cleaning lady. Room and corridors are clean, it's part of the night staff's job to clean also" and "Yes, very good cleaner and helpful". Staff we spoke with understood their responsibilities with regard to the prevention and control of infection. This meant people were protected from the risk of acquired infections.

One person who used the service had an epilepsy support plan in place. This described the type of seizure the person may have, what action staff were to take for each time of seizure and what to do next if that did not work, for example, ring 999. We saw people's risks were assessed as part of the care planning process and described potential risks and action for staff to take to reduce the risk. This meant the registered provider had taken seriously any risks to people and put in place actions to reduce the risks.

Hot water temperature checks were regularly carried out for bedrooms and bathrooms and were within the 44 degrees maximum recommended in the Health and Safety Executive (HSE) guidance Health and Safety in Care Homes (2014) apart from one room, where the temperature was recorded at 50 degrees. We discussed this with the home manager who was not aware of the high recorded temperature. They told us the room was currently unoccupied but would action it immediately.

Gas servicing and electrical installation servicing records were all up to date and portable appliance testing (PAT) had been carried out. Risks to people's safety in the event of a fire had been identified and managed, for example, the fire certificate of inspection, and the fire alarm and fire extinguisher testing were all up to date. A fire emergency plan was in place to ensure all staff knew what to do in the event of a fire and Personal Emergency Evacuation Plans (PEEPs) were in place for people who used the service. This meant checks were carried out to ensure that people who used the service were in a safe environment.

We saw a copy of the registered provider's safeguarding policy, which set out the registered provider's commitment to safeguarding. We looked at the safeguarding file and saw records of safeguarding incidents and concerns, and saw that CQC had been notified of all relevant incidents. We found the home manager and staff we spoke with understood safeguarding procedures and had followed them. Staff told us they had

received training in how to protect people from harm and could tell us what they did to keep people safe. For example, follow risk assessments, carry out regular checks on people and ensure the building was secure.

We saw a copy of the registered provider's accidents and incidents policy and procedure. Accident and incident forms we looked at had been appropriately completed and included a management report, providing details of any investigation carried out and what actions had taken place. For example, one person had experienced three falls in a short period of time. The home manager had commented that input from the falls team would be appropriate and we saw this had taken place. Records showed that analysis of accidents and incidents regularly took place.

We looked at the management of medicines and saw a copy of the provider's medication policy, which included the procedures for staff training, administration of medicines, obtaining supplies, storage, controlled drugs, covert medication, PRN (as required medicines) and the procedure to follow if medication errors were identified.

The medicines trolley was secured to the wall in a locked medication room. The medicines room also contained a separate, locked controlled drugs cabinet. Controlled drugs (CDs) are drugs that are at risk of misuse. A CD register recorded the administration of controlled drugs, all entries were counter signed and a record was maintained of the balance left in stock.

We observed the senior care staff administering medicines at lunch time. The staff member spoke with people to advise them what they were doing, gave the medicines to the person with a cup of water and observed them being taken before updating the medicine administration record (MAR). A MAR is a document showing the medicines a person has been prescribed and records when they have been administered.

MARs included a photograph of each person, and details of their name, date of birth, room number, GP and whether the person had any allergies. MARs we saw were accurately completed and up to date.

Records showed that one person who used the service was receiving medication covertly. Covert medication is the administration of any medical treatment in disguised form. We saw a copy of a letter from the person's GP and saw that a best interests decision had been made with regard to covert medication for the person.

Daily medication checks were carried out and a monthly audit took place. Daily checks included the supply, storage, administration and recording of medicines. The audit had identified an issue with the controlled drugs stock balance, which the home manager had investigated.

Staff were appropriately trained in the administration of medicines and received regular competency checks. This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People and family members told us, "The staff are beyond reproach", "[Name] is well looked after" and "I can't criticise the staff". Family members told us communication from the home was good. One family member told us, "They ring as soon as anything happens."

A health and social care professional told us they had received positive feedback from family members regarding Ivy House Care Home and told us, "Whenever you ring up they are good at following up on things" and "I've had no issues".

New staff completed an induction to the service before commencing employment. The home manager told us they recruited new members of staff who had previous health and social care experience. Staff files we looked at showed staff had completed a good range of training prior to employment with Ivy House Care Home, including emergency first aid, safeguarding, mental capacity, moving people safely and dementia awareness. The home manager had recently implemented a new training system, using an external distance learning training provider. We saw staff had recently completed training in fire safety, infection control and food hygiene. The training included working through a series of work books and completing knowledge checklists that were sent off to the external training provider to be marked.

The home manager showed us their training matrix, which confirmed the dates staff had completed training prior to employment at Ivy House Care Home and the training completed and planned since employment. Staff we spoke with told us they were sufficiently trained for the role.

Staff received regular supervisions. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. The registered provider's policy stated that staff would receive supervisions four times per year. Records showed staff had received supervisions with the home manager in July, September and November 2016. Topics for discussion at supervisions included safeguarding, health and safety, caring and employment matters. We saw where performance issues or training needs were identified, these were recorded in the supervision records. This meant staff were fully supported in their role.

People and their family members we spoke with told us the food at the home was, "A very good standard" and "Excellent plus". People had access to a choice of food and drink throughout the day and were able to eat in their own rooms if they wished. People appeared to enjoy their food and we saw staff supporting people in the dining rooms at meal times when required. Staff wore appropriate personal protective equipment (PPE) while serving and assisting with meals. People were offered choices of food and drink and staff had a good understanding of people's individual preferences.

Care records included nutrition and hydration support plans. We saw one person was at high risk of malnutrition and had dysphagia. Dysphagia is the medical term for people who have difficulty swallowing. The person had a completed malnutrition universal screening tool (MUST). A MUST is a calculator for

establishing nutritional risk. The person had an action plan in place, which stated the person's food intake was to be documented daily, assistance and encouragement was to be provided at mealtimes, staff were to ensure the person was positioned appropriately, weighed weekly and fork mashable food was provided. We saw appropriate records were in place and the kitchen had details of the person's dietary requirements on the notice board. Records showed that a referral had been made to the speech and language therapist (SALT) and their recommendations were included in the person's support plan. Staff we spoke with were knowledgeable about people's dietary needs. This meant people were appropriately supported with their dietary needs.

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. Mental capacity assessments had been completed for people and best interest decisions made for their care and treatment. Staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. DoLS applications had been appropriately submitted to the supervisory body, which meant the registered provider was following the requirements in the DoLS. However, for those applications that had been authorised, statutory notifications had not been submitted to CQC.

Care records included details of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records were up to date and showed the person who used the service and their family members had been involved in the decision making process.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of visits from external specialists including GPs, podiatrist, speech and language therapist and district nurses. Professional contact sheets were maintained for any contact people had with healthcare professionals.

Some of the people who used the service were living with dementia. We looked at the design of the home for people with dementia. There had been some recent refurbishment work carried out at the home and we saw corridors were clear from obstructions and well lit, which helped to aid people's orientation around the home. Carpets were clean and contrasted clearly with walls. Likewise, hand rails contrasted with the walls and communal spaces and bathrooms were spacious and free from clutter. People and family members we spoke with told us they were able to find their way around the home and it was well laid out. This meant the service incorporated environmental aspects that were dementia friendly.

People and family members we spoke with were complimentary about the home. They told us, "Very good, comfortable and warm", "It's purpose built for the job, better than converting an old place" and "Bit run down but are bettering it all the time, the garden is lovely".

Good

Is the service caring?

Our findings

People who used the service and family members were complimentary about the standard of care at Ivy House Care Home. They told us, "The care is superb", "They [staff] are fantastic" and "The carers make the home".

People we saw were well presented and looked comfortable with staff. We saw staff talking to people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way. We saw and heard how people had a good rapport with staff. Staff knew how to support people and understood people's individual needs. For example, one person had a daily newspaper delivered and staff asked the person if there was anything interesting in it. Another person liked to have a particular drink at lunch time and staff were aware of this.

People were provided with choices. For example, at meal times or by what name they wished to be called, and their preferences were recorded in their care records. People's bedrooms were individualised, some with their own furniture and personal possessions. We saw many photographs of relatives and social occasions in people's bedrooms.

Care records contained evidence that people's privacy and dignity had been considered. For example, "Ensure [Name] is clean and has fresh clothes on daily to maintain their dignity at all times" and "Ensure wearing a clean nightie at all times".

We asked people and family members whether staff respected the privacy and dignity of people who used the service. They told us, "Yes, they do with all the residents. They knock on doors before entering. If I'm using the toilet they don't rush me", "Yes, very much so" and "Yes, but I'm ok to do things myself". Staff we spoke with were able to explain how they protected people's privacy and dignity. For example, "Close curtains, make sure bedroom door is shut, toilet door, leave them alone if they're in the toilet. Knock on the door before entering" and "If being showered would wrap towel around top half then bottom half, would ensure blinds and doors are shut, knock before entering rather than barging in". This meant that staff treated people with dignity and respect.

We saw independence was promoted and people were able to care for themselves where possible. A family member told us, "[Name] is very independent, 90% of the time" and "[Name] sometimes needs to be encouraged to go to the dining room". Staff told us, "We try to get them to do their own personal care, ask if they want to do this, encourage to pick up food themselves, one resident likes to make his own bed", "If they can walk, encourage them to come to the dining room for dinner", "Use the care plan and assessment, ask what they would like to eat, when would they like to go to bed, try to encourage them to do things for themselves" and "Get them to do what they can, even if slow. One lady eats slowly and is behind by 30 minutes usually, would encourage her to continue and give her the odd prompt". This meant that staff supported people to be independent and people were encouraged to care for themselves where possible.

Care records showed that some of the people who used the service had advocates. These were

predominantly family members. Advocates help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities.

End of life support plans were in place for people. These documented people's end of life wishes. For example, whether the person wanted medical assistance should they experience a life threatening condition, where the person wanted to live in the event of a terminal condition, funeral arrangements and advanced decisions. An advanced decision is when a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness. This meant people had been able to be involved in their end of life care.

Good

Is the service responsive?

Our findings

The service was responsive. People's needs were assessed before they moved into Ivy House Care Home, which meant staff were aware of people's care and support needs before they began using the service.

Each person's care record included a personal information sheet, which included important information about the person such as; preferred name, religion, date of birth, known allergies, GP details and next of kin. We saw that this had been written in consultation with the person who used the service and their family members.

Support plans were in place for people and included mobility, personal care, nutrition and hydration, mental health, continence, medication, recreation and activities and last wishes. Support plans described the person's abilities and needs, level of risk, action plan and desired outcomes.

For example, we saw one person was at high risk of developing pressure sores due to lack of mobility and incontinence. The person had a Waterlow risk assessment in place. The Waterlow scale uses a number of questions to give an estimated risk of the development of pressure sores. The person had an action plan in place that staff were to follow to reduce the risk of the person developing pressure sores. This included inspecting the person's skin regularly, review mattress and seating surfaces, introduce a re-positioning schedule and manage moisture contact with the skin. The outcome of this plan was to, "Ensure [Name]'s skin remains healthy and does not develop pressure sores."

Care records were regularly reviewed and up to date. However, one person's care record stated they had no known history of having fallen in the previous 12 months. Accident and incident records showed the person had fallen three times in previous weeks and had been referred to the falls team. The person's support plan had been reviewed since the falls but had not been updated to reflect this. We saw appropriate action had been taken for the person and all of the person's other documentation was accurate and up to date. We discussed this with the home manager who told us they would get the support plan updated straight away.

We looked at what the registered provider did to protect people from social isolation. An activity rota was on the notice board in the foyer and provided a list of activities such as bingo, exercises, word games, music and visits from local school children. We observed activities being carried out in the dining room, including arts and crafts and dominoes. We saw a poster advertising the home's Christmas party, where entertainment was to be provided and family and friends were invited. People had recreation and activities support plans in place, which listed activities that people liked to do and what outcomes were to be achieved from the support plan. For example, to promote the person's independence and encourage them to take part in recreation and activities.

Weekly trips were arranged to a local pub for lunch and afternoon bingo however as the activities co-ordinator had recently left the service, these trips were not available until a new activities co-ordinator was appointed. The home manager told us the vacancy had been advertised and they were hoping to appoint a new activities co-ordinator as soon as possible. The registered manager told us they hoped to fill the

vacancy in December 2016. We asked people and family members if there was much to do at the home. They told us, "Sometimes play whist drive or play cards if I want to", "I have been taken to the local pub for a drink", "I play bingo on a Wednesday" and "The noticeboard informs but I'm not a great mixer". This meant the provider protected people from social isolation however was unable to support any external activities until a new activities co-ordinator had been appointed.

We saw a copy of the registered provider's complaints policy and procedure. This was made available to people who used the service and visitors on the notice board in the foyer and in the registered provider's statement of purpose. This provided information of the procedure to be followed when a complaint was received.

There had not been any complaints recorded at Ivy House Care Home in the previous 12 months. People we spoke with and their family members were aware of how to make a complaint but did not have any complaints to make. This showed the registered provider had an effective complaints policy and procedure in place.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. The home manager had applied to CQC to become the registered manager at Ivy House Care Home and the current registered manager was going to de-register.

The registered manager was not based at Ivy House Care Home. They told us they were in regular contact with the home and the home manager told us the registered manager supported them in their role, for example, with daily telephone calls and support visits.

Registered providers must inform CQC about specific incidents, accidents and changes, in order that CQC can monitor services and plan future inspections. We saw some statutory notifications had been appropriately submitted to CQC. However, three statutory notifications for Deprivation of Liberty Safeguards (DoLS) authorisations, authorised in June 2016, had not been submitted. We discussed this with the home manager and registered manager. The registered manager told us they were aware of the requirement to submit statutory notifications for DoLS authorisations but they were not aware these applications had been authorised. The home manager agreed to submit the notifications without delay.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them ensuring people's personal information could only be viewed by those who were authorised to look at records.

We asked people who used the service and their family members about the management of Ivy House Care Home. They told us, "It's managed very well", "They do a good job", "The manager is very nice but has a different attitude and approach, he is helpful. I can't fault him, just not the same approach" and "I have no experience of any other home but [home manager] is fair enough when needed to see them and they will find out for you if they don't know the answer".

Staff we spoke with felt supported by the home manager and told us they were comfortable raising any concerns. They told us, "Yes, I would just go and tell [home manager] if not happy", "Yes, find [home manager] to be a good manager. They are fair and acts upon things if you bring it to their attention" and "[Home manager] has an open door policy".

Staff were regularly consulted and kept up to date with information about the home and the registered provider. Staff we spoke with confirmed this. We saw records of staff meetings, the most recent had taken place on 11 November 2016 and was attended by eight members of staff.

The service had links with the local community. For example, a local pub held "Golden years" lunch events and afternoon bingo once per week. The local community centre held regular events and was also the emergency back-up location should there be an evacuation from Ivy House Care Home due to fire or other emergency situation.

We looked at what the registered provider did to check the quality of the service, and to seek people's views about it. A six monthly audit of the home was due to be carried out by the registered manager in December 2016 and the home manager had a comprehensive action plan in place for the service. The home manager or senior staff member carried out a monthly management audit. These were up to date and included audits of admission and care planning documentation, moving and handling, pressure care, accidents and incidents and recreational activities.

We saw the audits file, which included a number of daily, weekly and monthly audits carried out by the home manager and senior care staff. These included audits of medicines, fluid balance charts, wheelchairs, pressure relieving equipment and mattresses, mealtimes, health and safety, infection control and maintenance. Audit records we saw included action plans for any identified issues. For example, the health and safety audit identified that new first aid boxes were required, which were purchased.

We looked at the minutes for a recent residents and family meeting that had taken place on 31 October 2016. The agenda included food hygiene, infection control, lounge facilities, maintenance and meal times.

A satisfaction survey had taken place in January 2016 and asked questions regarding the quality of care, food, cleanliness, laundry, privacy, dignity and whether staff provided a prompt response. The majority of the responses we saw rated the service very good or good. We noted that the provider's policy for surveys stated that surveys would be carried out every three months. The home manager confirmed that the survey was annual and the policy required changing.

We saw feedback cards were provided in the foyer for people and visitors to feed back on the quality of the service via the carehome.uk website.

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.

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 15 HSCA RA Regulations 2014 Premises and equipment The premises was not being properly maintained as repairs were not carried out in a timely manner. Regulation 15 (1) (e).