Caring Homes Healthcare Group Limited

Ivy Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 4 and 5 May 2017 and was unannounced.

Ivy Court is registered to provide residential and nursing care for up to 71 people. At the time of the inspection 61 people were living at the home. The home supports older people, some of whom are living with different forms of dementia and some people who have nursing needs. The accommodation is purpose built and was completed in 2015. The building is over two floors, and is set in a large garden.

There was not a 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently left. The home was being managed by a regional manager who represented the provider and the deputy manager. The provider confirmed to us that a new manager will be starting at the end of the summer. For the purposes of this report we will refer to the acting manager and deputy manager as the management team. There were also clinical leads who led the nursing and care staff on shift.

At this inspection we found four breaches of the Health and Social Care Act 2008. You can see what action we asked the provider to take at the end of this report.

Risks to people's safety had not always been managed well. Cleaning products, thickening agents used to thicken people's drinks and people's medicines were not always secure. The provider had not assessed whether it was safe for these to be left out. The home supported some people who were living with dementia. Therefore, these people could have been at risk of accidently ingesting these products.

Safe recruitment checks for new staff were not always completed as is required to ensure they were safe to work within a care environment. A recent safeguarding concern had not been managed in a robust way, in order to protect the people who were living at the home.

The administration of people's medicines had been audited and checked. The deputy manager and clinical leads were proactive in responding to a change in people's health needs. The deputy manager and clinical leads had completed risk assessments for people living at the home. Certain risks which people faced were being managed well for example pressure care and when people were at risk of being an unhealthy weight. The management team and provider also ensured that the equipment used was safe.

Care staff and nursing staff received training in a number of different topics relevant to their work. However they lacked supervision and their competency to perform their role safely and effectively had not been regularly assessed. This led to some care staff providing people with poor quality care.

There was not enough care staff working in the home to meet people's needs or provide them with adequate stimulation to enhance their wellbeing. People, their relatives, and staff all raised concerns about the staffing levels of the home. The management team and provider had not responded to these concerns. They had not investigated and taken action.

The management team and the provider did not always have robust quality monitoring systems in place. They had not actively involved people, their relatives, and staff in the development of the home. The management team and provider had also not created an open and listening culture at the home.

People spoke positively about the food and drinks they had. The chef had a good knowledge of people's likes and dislikes and people's specialist dietary needs. People also had good access to drinks.

There were planned activities and outings. However, people did not feel there was enough daily social activities taking place. The management team and provider had not considered ways to encourage social stimulation within the home. People were not being asked if their social needs were being fulfilled at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines and certain products were not always stored securely which posed a risk to some people's safety.

There were not always enough staff to meet people's needs.

Safe recruitment checks were not robust to ensure staff were appropriate to work in the home.

The safety of the premises and equipment people used was reviewed on a regular basis.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff competency was not checked on a regular basis to ensure the care they provided to people was effective.

People spoke positively about their meals and drinks.

People had timely access to services to support them in maintaining their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Some situations were not managed in a way which promoted people's dignity.

People's confidential information was not always stored securely.

People and their relatives spoke positively about the nurses and care staff.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs.

Staff did not spend time with people and engage with them.

There were limited day to day social opportunities for people.

People's care needs were assessed and reviewed.

Is the service well-led?

Inadequate

The service was not well led.

The provider and leadership of the home had not sustained the Good which was found at the last inspection.

The provider had not responded to the concerns raised about staffing levels.

There had been inconsistent leadership of the home.

The leadership had not involved people, staff, and relatives in the development of the home.

There was a lack of quality monitoring of the service and audits were not always robust.

Ivy Court

Detailed findings

Background to this inspection

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

The inspection took place on 4 and 5 May 2017 and was unannounced. This inspection was completed by one inspector, one inspection manager, and an expert by experience. 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 the inspection we viewed all of the information we had about the service. The previous manager had completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications the manager had sent us over the last year. Notifications are about important events the manager or provider must send us by law. We also contacted the local authority quality assurance team and local authority safeguarding team to ask for their views on the service.

During the inspection we spoke with six people who used the service and nine relatives. We spoke with the acting manager, deputy manager, regional director, chef, and six members of the care and nursing staff.

We looked at the care records of six people who used the service and the medicines administration records of seven people. We also viewed records relating to the management of the service. These included risk assessments, seven staff recruitment files, training records and audits. We looked at records relating to the safety of the building and equipment used in the home. During the inspection we also completed general observations.

Requires Improvement

Is the service safe?

Our findings

We visited Ivy Court in March 2016 and rated the home as Good in Safe. However, at this inspection we have rated Safe as Requires Improvement.

When we visited Ivy Court we found that some domestic cleaning products, medicines and prescribed thickeners for drinks were not always stored securely. The management team told us that some people living in the home may lack the capacity to understand the correct use of these items. Therefore, this posed a risk to some people's safety.

In all three public kitchenettes within the home, we found opened dishwasher liquid detergents next to the sinks. In one kitchenette on the first floor, where people who were living with dementia resided, this detergent was placed directly next to a jug of juice. We spoke with a nurse about this, who then placed the detergent in an unsecure cupboard in the kitchenette. They therefore, did not take sufficient action to secure this cleaning product.

During our visit we also noted a prescribed tin of thickening agent, which is used to prevent a person from choking when they drank fluids, next to this detergent. The prescribed label had been taken off the container. When we asked a nurse who this belonged to we were told it belonged to a named individual. They could not explain why the label had been taken off the tin. This is important because this is a prescribed product and the amount of thickener to fluid can vary for individuals. We looked in the cupboard above and found another person's prescribed thickener in this unsecure cupboard, next to the tea bags. If ingested with the incorrect amount of fluids, prescribed thickeners can block a person's airway.

We visited one person's room who lived on the nursing and residential floor. We found their topical prescribed cream on the floor of their bathroom. This should have also been stored securely to prevent it from being accidently ingested. We also found an out of date opened medical cream in this person's bathroom. This should have been removed as it was possibly no longer effective. On the second day we visited Ivy Court we found the medication trolley left open, unsecured, and unattended for a short period of time. We spoke with the management team about these issues, who told us they would immediately take action to address them.

We looked at a sample of seven people's medicines to see if they had received them appropriately. We found one person had not received one of their prescribed medicines. We raised this with the nurse who spoke with the deputy manager. They made plans to give this person this medicine. However, we noted it had not been given to the person on the intended day. We also noted that this medicine had not been identified by the nurse as having not been given to the person correctly, when they gave the person their other medicines the following morning.

The above concerns constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our audit of people's medicines, we found all other medicines were accounted for and people's Medication Administration Records (MARs) were completed correctly. There was guidance for the nurses when administering people their 'as required' medicines. We saw one nurse putting this guidance into practice with one person. We also saw that medicines were stored at the correct temperatures and this was monitored on a daily basis.

We were shown a training programme which showed that staff had received training in how to protect people from the potential risk of harm and abuse. We spoke with staff about how they reduced the risk of people experiencing harm and abuse. We received a mixed understanding and knowledge from some staff about what would constitute harm. Some staff did not know of outside agencies they could also report concerns to. Others said they had numbers on their phones and they would contact the provider's safeguarding telephone number.

We received a notification from the previous manager about a potential recent safeguarding concern before we visited the home. It had been referred to the local authority which is the appropriate practice. However, the plans the management team had made about how this situation would be managed were not robust or completed in a timely way. The management team had raised concerns about the practice of a member of staff but this member of staff continued to work with the people at the home. The deputy manager explained to us that this member of staff was always working with another colleague during their shift, but we noted this was not always the case.

The management team showed us a record of safeguarding incidents which involved people who lived at the home harming each other. We cross referenced these to our own records and found that the manager or provider had not notified the CQC about these. The manager or provider must notify the CQC about these events by law. We spoke with the deputy manager who told us that these events had been shared with the local authority safeguarding team.

Safe recruitment checks were not fully in place. Staff identities had been verified and the Disclosure and Barring Service (DBS) checks, about staff's backgrounds, had been carried out. However, out of seven staff files two members of staff had only one reference each. We were told by the regional director that this was not the policy of the provider. Three of these staff files we looked at had unexplained gaps in each of their employment histories. We looked at one member of staff's file and found they had disclosed they had been dismissed from their previous employer. There was no investigation at the time this person was appointed to check it was safe to employ this person. We raised this with the management team who were unaware of this issue. The purpose of all of these employment checks are to ensure that new staff are suitable to work within a care environment.

The above concerns constituted a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with five people about the staffing levels and two people told us that call bells took a long time to be answered. One person said, "The bells are not always answered quickly enough."

We spoke with nine relatives; seven of these told us that they did not think there was enough staff on each shift to meet their family member's needs. One relative told us, "One thing that could be improved is staffing. [Relative] had once waited half an hour for the toilet. I prompted staff two or three times and [relative] was in danger of having an accident (incontinence episode)." Another relative told us, "I would say staffing is an issue. They usually 'double up' with a 'floater'. Occasionally that just isn't enough, especially (when supporting people with) toileting. When illness hits in the winter there are definitely days when

staffing is not sufficient."

During our visit staff and relatives told us about a recent day when due to staffing levels being low, it was decided that people would be safer staying in bed. A member of staff told us that people were supported with their personal care but they were not supported to transfer out of bed into a chair or supported into the communal lounges. We spoke with the management team about this. The senior managers said they were not aware of this issue but the deputy manager said they were. No investigation had taken place to look at why this situation happened. The management team were not in a position to prevent it from happening again because no investigation had taken place.

Some relatives told us that they stayed until their relative was ready for bed and in bed until they left the home. This was in case their relative needed support and staff were not available to provide this in a timely way. One of these relatives told us, "I have some reservations. I make sure my [relative] is laid down and comfortable before I leave. If I don't I'm not sure what will happen, because they are short staffed."

The care staff we spoke with felt there were just enough staff on shift to meet people's care needs. However, staff told us that it was challenging to support people who required two members of staff to assist them. Two members of staff told us, that if two people who required two members of staff to support them needed assistance at the same time, "They have to wait." Care staff also told us that they found the staffing levels were challenging when staff called a few hours before their shift, to say they were not able to work. Often they told us, these members of staff were not always replaced by agency staff.

During our two day inspection we observed interactions between staff and people. However, these were limited interactions as most conversations and engagement with people were task focused. We raised this with the management team. They told us about the dependency tool they used to calculate if there was enough staff to meet people's needs. However, they had not investigated further when staff had raised their concerns about staffing numbers. Practices for replacing staff at short notice were also not reviewed. They were also not aware of relatives and people's concerns about staffing levels. We concluded that there were times when there was insufficient numbers of staff.

The above concerns constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe living at Ivy Court. One person said, "Oh yes, I feel extremely safe and secure. I don't feel I will come to harm." Another person told us, "I'm really safe here. It's the way I'm looked after that counts."

People had risk assessments which explored the risks which they faced. These assessments were reviewed if people experienced any changes to their needs. We could see that actions were taken to minimise these risks. However, we found an issue with one person's risk assessment. It identified the risk, but there was no clear and robust plan of action for staff to follow, in order to manage this risk.

We looked at the care records for one person who had a breakdown in their skin. There was a repositioning chart and specialist equipment in place as a measure to reduce this risk. This demonstrated that the management team were aware of this individual risk and they had put systems in place to monitor and manage it. However, when we looked at this person's repositioning charts we found there were gaps in these recordings. On some occasions some hours had passed after the recommended repositioning periods. These were put in place by a senior nurse at the home to aid the recovery of this person's pressures sores and prevent them from developing a further breakdown in their skin.

This person also had a daily chart for assisting staff to apply a particular skin cream to their skin, to try and prevent the skin from breaking down. However, we also noted that there were recent gaps in this chart as well.

We spoke with the deputy manager who showed us this person's pressure care plan which demonstrated this person's pressure ulcer had improved, due to the intervention of the care staff and nurses. We therefore concluded that this was a records issue. However, this record is important to demonstrate that the staff were responding to this risk.

The management team monitored incidents and accidents. When a person had a fall this was logged and recorded. After this an analysis of why it happened took place, and what action was needed to prevent it from happening again. This fall would then be added to a spread sheet and those who were experiencing a high number of falls were discussed in a meeting held by nurses. They would then consider if they could do anything else to reduce these people's risk of falls.

There were various safety checks in place to ensure the building and equipment used in the home was safe. There was a regular fire alarm test and the fire associated equipment was also tested to ensure it was working correctly. Specialist equipment used to support people to mobilise was also regularly tested. Water temperatures were checked to prevent people from scolding themselves. The bacterium Legionella was also tested for. This can grow in water supplies and cause people to become unwell.

Requires Improvement

Is the service effective?

Our findings

We visited Ivy Court in March 2016 and rated the home as Good in Effective. However, at this inspection we have rated Effective as Requires Improvement.

Care staff did not always have effective and robust support to enable them to perform well in their work.

Care staff did not have regular supervisions to discuss their work and they were not having their care practice regularly checked. The purposes of these checks are to monitor staff practice and identify any training needs.

Some members of the care staff told us that they had not had a one to one conversation or had their practice observed, to see if they were competent in their work. This also included when they had finished their induction period. When we looked at a sample of staff files there was no record that new staff had had competency checks. We spoke with the deputy manager who confirmed care staff did not receive competency checks as a routine, but if nurses discovered issues this would be addressed. However, we found that the issues with daily notes were not being addressed. We also found some practice issues around choice, and dignity. When we observed any practice issues with the care staff, there were no nurses present to observe these events.

The management team told us about the training staff received. However, the management team did not have a system which checked whether staff had retained and understood this training sometime after they had completed the training courses.

We spoke with the deputy manager who told us about the clinical training nurses completed and how this was monitored to check the training was up to date. The deputy manager told us that nurses were assessed to see if they were competent in these areas. We looked at three nurses' files who worked at the home. One of these nurse's records showed that their competency had not been checked. We spoke with the deputy manager who said that individual nurses kept these documents and they did not have a copy of these to evidence the nurse's clinical competency. They told us that they would revise this system and ensure a copy of nurse's competency checks would be included in their staff files.

Staff had completed training in a number of different subjects however, some care staff and nurses said that they found the amount of on line training they were asked to complete in a certain period difficult. Three care staff and nurses out of the six we spoke with told us that they were not confident they had retained the training.

The care staff we spoke with said they did not attend staff meetings. They told us they were invited to attend on days they did not work, and they were not able to attend. When staff meetings were held we were told by staff, that if they were working on shift they were not allowed to attend as there would not be enough staff on shift to meet people's needs. We looked at a sample of staff minutes and found very few care staff

attended these meetings.

Both the nurses and the care staff we spoke with told us their induction was a positive experience and said it had prepared them for their new role. We were shown a training programme which showed that all staff had had training in a range of relevant subjects. This included areas such as first aid, infection control, and 'living in my world' which is a specialist dementia course. We also observed safe moving and handling techniques when people were supported with their mobility.

We concluded that improvements were required to ensure care staff received regular and robust support to carry out their work.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

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

When we looked at people's care records we could see that people had capacity assessments to see if they could make certain decisions. These people's next of kin's were identified to consult with if a best interest decision was required. The staff and nurses we spoke with told us that they encouraged people to make their own decisions. Care staff said they always sought people's consent before supporting them with their personal care tasks. One person who had capacity left the home when they wanted to. The care staff, nurses, and management team supported this person to make their own decisions about their life. We concluded that the staff, nurses, and management team worked within the principles of the MCA.

The deputy manager told us that all the people who were living with dementia on the first floor had a DoLS application in place. We were told that this was because the service was restricting their movement to go outside. Care staff and nurses told us how they would support a person who lacked capacity and requested to go outside. We also concluded that the care staff and the management team were not restricting people's freedom of movement unlawfully.

People spoke positively about the food and drink provided at Ivy Court. One person said, "The food is very good and if I don't like what they are offering, I can choose something else." Another person told us that, "The food is good. I like it." A person's relative said, "The food is fabulous, I've eaten here. There's a good variety and it's fresh. The Christmas dinner was amazing."

We spoke with the head chef when we visited the home. They showed us a record of what people's dietary needs were. Some people were on specialist diets to prevent them from choking and some had certain food allergies, which the chef and kitchen staff were aware of. Some people were on a pureed diet to help reduce the risk of them choking. The chef showed us how they made these people's meals appetising and appealing. Individual foods had been pureed and placed separately on a plate. These individual foods were of a bright colour to maximise the appeal of these foods.

The deputy manager told us and we saw records which confirmed, people had access to specialist health professionals, to support people with their dietary needs.

During our visit we saw two members of the hospitality staff asking people what they wanted to eat for the next day and going through the choices available with them. The chef also told us that they obtained people's food likes and dislikes. The chef explained to us how they tried to give people certain foods which they knew they especially liked. They said, "I know [name of person] particularly likes smoked salmon so I put some in their scrambled eggs, and I know [name of different person] likes steak so I try and get this for them sometimes." The chef said they were starting to review people's foods likes and dislikes. They also told us about their plans to produce pictorial menus.

We observed that meal times were evenly spaced and that people were given drinks and encouraged to drink. Some people were supported to eat and we could see these people were supported to eat at their own pace. Staff spoke with people during this process but this was limited. One member of staff supporting one person to eat. This member of staff was looking around the room and not engaging with the person they were supporting to eat. At one point they were holding a spoon with food on it in front of the person, but they did not see that this person was indicating that they wanted to eat the spoonful of food. The person made attempts to move themselves closer to the spoon, but for a time, they could not reach the food.

The dining experience was not consistently positive across all the dining rooms. In one dining room there was limited interaction between people and staff. There was no real effort made to make the lunch time a social, pleasant occasion for people. A member of the kitchen staff was standing by a serving area. Staff were in a long line in front of people eating, ready to take people's meals to their rooms, either to support them to eat or to deliver their meal to them. Care staff and a member of the kitchen staff were talking amongst themselves and checking they had the right meals for the right individuals. Sometimes these members of staff were talking very loudly. Often people were being referred to as room numbers or by the meals they had chosen. We concluded that this was not conducive to a friendly and social dining experience.

The people we spoke with were positive about the support they received to maintain good health. People told us how their health needs had improved as a direct result of the nurses and care staff. One person said, "When I came here I was in a poor state of health and frankly I felt I was coming here to die. People here have given me confidence and the will to live. That nurse [name of nurse] has been incredibly supportive; [name of nurse] is outstanding." Another person told us, "I was put here for palliative care, but they have looked after me so well that I'm still here."

When we looked at people's care records we could see that the GP and other health professionals had been contacted when a person's health needs had changed. The deputy manager told us about one person who required specialist involvement relating to their health. The deputy manager told us the action they took to secure this input. A relative told us that, "They [staff] are on the ball. If there's a medical concern they'll explain it to me. They decided to get the speech and language therapist for [relative] which I appreciated."

Requires Improvement

Is the service caring?

Our findings

We visited Ivy Court in March 2016 and rated the home as Good in Caring. However, at this inspection we have rated Caring as Requires Improvement.

We spoke with people and their relatives about whether they were treated with kindness in their day to day lives at the home. From all of the nine relatives we spoke with and three of the six people we spoke with they made positive comments about the care and nursing staff. However, three people expressed some negative comments about how they are treated by some members of staff.

We spoke with one person who told us, "All the nurses are marvellous. They always smile and are so friendly. They certainly give the impression they like you. Nothing is too much trouble." Another person said, I talk to people [staff] and they chat to me. I like that. I am happy with things." A relative told us, "They [staff] have compassion. They'll [staff] make us a cup of tea and make us all feel we matter. Here respect and dignity shine through." A further relative said, "The [staff] are so good, they clearly care."

However, one person told us, "Most nurses and carers are nice. It's like anywhere, some are not so caring." Another person told us, "The nurses are mostly lovely, I can't fault them. The poor ones soon leave." A relative told us, "The majority of staff are nice. To some it's just a job. Most fully respect [relative]."

During our visit we observed some caring interactions between care staff, nurses and people at the home. We saw a nurse stop what they were doing and sit beside a person who had limited communication and hold their hand and make soothing sounds to them. We also saw staff laughing and engaging in conversation with a group of people who were completing an activity.

Over our two day inspection we saw that interactions with people were caring. However, our observations showed that staff did not have much time to engage with people unless they were completing a task. Relatives spoke positively of the care and nursing staff. Most felt that the staffing levels prevented staff from regularly demonstrating their thoughtful and kind caring abilities.

We asked people and their relatives about how the care and nursing staff enabled them to maintain or increase their independence. We also had mixed views on this subject.

Two people told us how the care staff and nurses spent time with them to regain their independence and motivation with life. One person said, "I asked for help with walking and they agreed. Bit by bit I got there." Another person said, "People here have given me the confidence and the will to live." A relative also told us, "They encourage my [relative] to use [relative's] frame rather than a wheelchair."

However, one relative said, "[Relative] would be more independent if there were activities to stimulate [relative] mentally and physically. [Relative] would be stronger and more able to do things for [themselves]. Another relative said, "No I don't think they encourage independence. Once [relative] is in [relative's] chair in

the lounge they will happily leave [relative] there. [Relative] can walk a little but it needs two of them, so a wheelchair is their answer, as that needs one [member of staff]."

We concluded that the staffing levels of the home were impacting on staff's ability to fully build meaningful relationships with people and support their independence.

People told us that they were involved in the planning of their care. One person told us, "My daughters are involved in it." A relative also told us that, "We [staff and relative] discuss [relative's] needs and when changes are made to [relative's] care plan it is agreed."

During our visit to the home we saw staff treated people in a way which promoted their dignity. We saw a person being supported to be transferred using specialist equipment. This was carried out in a way which protected this person's dignity. We also saw staff supporting people in a discreet way to access the bathroom.

However, we also observed an occasion when a person was pushed in their wheelchair into a lounge by a member of staff. Two members of staff referred to this person as "Her." They didn't speak with the person or ask where they wanted to go. We later saw the same members of staff support this person to be transferred to an armchair. During this process they did not speak with the person. One of these members of staff repositioned this person's skirt without explaining what they were doing or seeking consent. They said to the other member of staff, "I'll just pull the skirt down." We also saw a person lying in their bed with their door open. Directly opposite was a communal lounge with large glass windows and doors. This person had pulled their bed sheets up which had exposed the incontinence product they were wearing. This was on full view of the people in the lounge. Staff were present in this room, but action was not taken.

People's confidential information was not always stored in a secure place. People's care records and their historical notes were stored in locked rooms within the home. However, we noted that some people's daily notes which included information such as their fluid and food intake, their repositioning charts, and continence needs were sometimes placed outside their rooms. We spoke with the deputy manager about this. They said that staff did this as some people did not like having a folder in their rooms. In order to protect this private information and promote these people's dignity, we suggested an alternative place to keep these records were discussed with these individuals.

Requires Improvement

Is the service responsive?

Our findings

We visited Ivy Court in March 2016 and rated the home as Good in Responsive. However, at this inspection we have rated Responsive as Requires Improvement.

The support and care which people received at Ivy Court was not always responsive to their individual needs.

We spoke with one person who told us, "There's nothing for me to do. Some days there'll be something on, but that will be when someone comes in like the Church Minister or dancers. I'm a reader so I can cope, but we all need more to do. It's not a surprise I get fed up. It affects us all and I can tell you it's not a nice feeling. People might say we don't want to do things, but with encouragement many of us would." Another person said, "What are they doing offering me a jigsaw? Is that all they can think of? Everyone sits around; maybe they think we are too old." A further person told us, "I spend a lot of time in my room. I would like some more things to do so I could get out of my room."

During our visit we spoke with people's relatives. Most spoke positively about the care staff but felt there were not enough activities for their relatives to engage with. One relative told us that, "There are some decent trips out, like to the Roman Catholic Cathedral and today it's Eaton Park. You should see the pleasure in [relative's] face when they go on these trips. [Relative] talks to people and has such a good time. Other than that there are not enough daily activities, especially exercise. The last home [relative] was in really got [relative] going, but I don't sense that here. So [relative] just sleeps a lot."

When we visited the home we could see there was an activity co-ordinator working. There was an activity plan detailing an activity daily. There were also some planned trips over the next two months. The first day we visited people were going out to a local park. However, relatives told us that trips out could only accommodate a small amount of people and this was rotated. Some relatives told us that there were more social opportunities in the 'dementia part of the home' rather than in the residential and nursing part of the home.

On the floor of the home that supported people living with dementia, we observed a group activity involving three people and an activity co-ordinator engaging with these people in a game. Music was playing . At one point we saw two members of staff dancing with pompoms.

When we were on the ground floor we saw one planned activity downstairs involving four people on the second day we visited. During the rest of our time at the home there were no other activities taking place.

The staff we spoke with said they did not have time to sit and chat to people. The care staff and nursing staff told us that a lot of people spent all their time in their rooms. Some members of staff expressed concern for these people; they did not feel they had enough social stimulation. One member of staff said, "Sometimes people press their buzzers because they are lonely, but we don't have time to have a 30 minute chat with

them."

Some people and their relatives said that staff did occasionally chat and engage with people but this was not the norm. One relative said, "They [staff] laugh and joke with [relative] which is lovely and you can see what it means to [relative]. Of course they are so busy, these are not regular occurrences."

During our visit we observed people being positioned in front of some patio doors. These people were not asked if they were happy to sit there. One of these people asked a member of staff if they could go outside. This member of staff said they would get someone to take them. We sat in the same room from 10:58 am to 11:40 am and no one came to take this person out. We saw another person sit on their own for most of the day, eventually a nurse placed a tactile object in their hands. They began to touch this and move their feet. We later saw a person being moved to a lounge; the member of the care staff put the TV on and left them, without checking what they wanted to watch. This member of staff then turned the music off in the room without asking people who were facing the windows if they were okay with this. During our visit we heard music was playing in the communal areas. This was generally 1980's pop music on a loop. We saw that people were not asked what music they wanted to listen to and were not engaged with this music.

We looked at people's care assessments and we could see that information personal to people had been obtained to try and get to know people and make the care they received personal. People's likes and dislikes had been obtained, their background and the people who are important to them. However, this information was sometimes limited and it was not utilised. For example one person's assessment said they liked music, but it did not say what type of music. We looked at one person's record who was unable to communicate. There was information about their past interests and passions, but this information had not been used to try and engage with this person.

People's care plans did not always have a record of their preferences about their day to day care. Some people's care plans identified the times people liked to get up, others did not. Some specified if people wanted male or female carers, and some did not.

When we looked at a sample of care assessments and reviews we could see that people's care needs were assessed and reviewed on a regular basis. However, these reviews did not take into account people's social needs and if these needs were being fulfilled. People also told us that they were not being involved in their reviews or asked about their views of the care they received.

We concluded that although there were some activities and trips taking place, people's individual social needs had not been appropriately planned for and were not being delivered to enhance people's sense of wellbeing.

People's relatives told us that they were not given the opportunity to give their views and feedback about the support their relatives received. One person's relative said, "They [management] never ask me if things [with relative] are all right. That would be nice to have a chat about things." Another relative said, "Staff do not ask me how things are going with [relative]. I'd like that." Most relatives told us that they could not attend 'the relatives meetings' because they had historically taken place during the week on an afternoon. During our visit we spoke with many relatives who were very motivated to speak with the management team but had not been given the opportunity to do so. One relative told us, "If I'm honest they [manager] spends all their time in the office."

Inadequate

Is the service well-led?

Our findings

At the last inspection in March 2016 the service was rated as Good in all domains. However, the provider and the management of the home have not been able to sustain this rating of Good. We have rated Well Led as Inadequate.

When we visited Ivy Court we found that the home was not being well led. The registered manager had recently left and the regional manager and deputy manager were running the home when we visited. We had positive feedback from other professionals about how the previous manager had led the service. However, we had received negative feedback about how the provider had supported the home during this time.

The home has been opened since July 2015 and since this time has had two registered managers. Some staff expressed their concerns about this. When the home first opened the local authority quality assurance team and safeguarding team were involved due to concerns raised about the quality of the care people received. There had been historical concerns raised about the staffing levels being too low. One of the registered managers felt they were not being supported by the provider. The local authority had a meeting with the provider about this issue. When the service was rated as Good they were supporting a total of 23 people, they were supporting 61 people at this inspection. As the management of the service had increased the numbers of people living at the home, they had not ensured the way the home was staffed was robust.

The management team had not responded when staff raised concerns about the staffing levels, care staff told us that they raised their concerns about the staffing levels to the management team but these were ignored. One member of the care staff said, "They [management] brush it to one side." Another member of the care staff said, "They [management] don't pass the time of day with us or people here."

When on one occasion the staffing levels were so low it was decided people were not safe if they left their beds, this was not investigated. When we raised the concerns about staffing levels and staff not having time to interact and chat with people, we were told that staff did have this time, and the management team defended the tool they used to calculate staffing levels. They did not suggest they would investigate this important issue. The way staffing levels were being monitored and managed was not effective.

The culture of the home was not open. Care staff, relatives, and people who lived at the home were not being involved in the development of the service. We were told that the management team and provider were not making opportunities for staff to share their views about the home. Meetings were poorly attended and care and nursing staff had limited supervisions. Their competency to ensure their care practice was safe and effective had not been assessed for some staff and was periodic for others. There was no plan in place to address and resolve these issues.

Relatives said they were not given the opportunity to express their views about the home. One relative told us that they had raised concerns recently to the management team; they told us that they got a response via

e-mail. They told us that they were in most days visiting their relative, but the current management team did not come and speak with them.

There was no auditing or monitoring of the culture of the home. We asked the management team if this was taking place, they confirmed it was not. The previous manager had left. Care staff and the nurses did not know who the new manager was, but one had been appointed recently.

We found basic safety issues with the storage of domestic detergents, and prescribed thickeners. These had not been identified by the management team or by previous quality audits.

There were issues with the recruitment safety checks for new staff. There was a lack of robust competency checks completed to check if staff had the skills and knowledge to perform well in their work. These records and induction systems were not being checked or audited.

The quality monitoring checks which were carried out did not consider if people received care which was centred on their needs. If people were treated with dignity and respect or if people's views were being considered. We were told by staff, people, and their relatives that a lot of people stayed in their rooms. There had been no engagement with people to check why this is. We asked the management team about this, but they had not asked people, or considered if this was an issue which needed exploring.

The audits were not always robust. The provider was completing quality monitoring audits on a regular basis, which included a clinical audit. When we looked at a sample of the quality monitoring audits, no issues had been identified. The audit looked at a range of areas, but the audit record did not always demonstrate that these areas had been tested and checked.

We saw that the management team and provider had a system of monitoring falls and accidents. Some months these figures were very high, for example 53 falls in March and 51 falls in April. We were told about the nurse's processes around managing these falls. We were also told that the provider analysed these statistics and drew possible conclusions from these. We spoke with the quality auditor. They told us what action they had taken to check if appropriate and timely action had been taken to manage people's risks of falls. However, there was no audit record of these actions in their audit report to evidence this.

Previous analysis of falls had not identified a weakness in how falls were being monitored. Before February 2017 when a person had a fall, their falls would only be monitored after the second fall. This was not assessed on an individual basis. Also, if people had a history of falls and their health needs deteriorated, their risk of falls and their general health needs were not re-assessed.

We found that people's daily notes were not being consistently completed. There were gaps in these recordings and this had not been identified by the nurses checking these or by the recent quality monitoring visits. According to the home's action plan the issue of gaps in daily records had been 'signed off' and was no longer an issue; however we still found recent gaps in people's daily notes. These records were also not always being stored securely and this was not identified at the quality monitoring visits.

A survey had been completed about people's views on the food at the home and their dining experiences. However, there was no plan to revisit this subject to investigate the negative results the survey had identified. A dining experience had been observed but people were not asked about their views about their dining experience. This audit had not identified the issues which we found when we observed lunch.

The management team had started to monitor people's call bells. However, they were only taking one

person's call bell reading for a 24 hour period. Only one person's call bell was being looked at per week. This was not a robust way to monitor if people were waiting a long time for their call bells to be answered. People were not being asked if they felt they were waiting a long time for their bells to be answered.

The registered manager and provider had notified the CQC about some of the important events that they must notify the CQC about by law. However, they had not informed the CQC about safeguarding incidents which involved people in the home harming one another.

We were shown a complaints and compliments folder and we sought further clarification about the conclusion of a sample of complaints. We could see one complaint had been addressed and investigated. We looked at another complaint; there was a recorded conversation with the person advising them what action the then manager would take to address their complaint. However, this was not followed up to check the person was satisfied with the action taken and outcome of the complaint. The recorded information about the complaints did not state that the complainants were advised about what actions they could take, if they were not happy with the outcome or how the complaint had been handled. We concluded that the management team needed to improve this element of their complaints processes.

The above concerns constituted a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care staff and the nurses spoke positively about the deputy manager and the clinical leads. The nurses and the care staff we spoke with said they felt confident going to these senior staff to seek advice or raise an issue.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provided had failed to ensure that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. People's medicines were not always managed safely. Regulation 12 (1) and (2) (a) (b) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Good Governance The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided and to maintain securely an accurate, complete and contemporaneous record in respect of each service user. The management of the service and persons employed. Regulation 17 (1) and (2) (a) (b) (c) (d) (ii) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 19 HSCA RA Regulations 2014 Fit and

personal care Treatment of disease, disorder or injury	proper persons employed Regulation 19 HSCA 2008 (RA) Regulations 2014: Fit and proper persons employed. The management of the service had failed to have effective systems in place to ensure suitable staff were employed. Regulation 19 (1) (a) (b) and (2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The management of the service had failed to have sufficient numbers of staff. Staffing. Regulation 18 (1) and (2) (a).