Caring Homes Healthcare Group Limited

Ivy Court

Inspection report

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
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

About the service
Ivy Court is a residential care home providing personal and nursing care to 68 people aged 65 and over at the time of the inspection. The service can support up to 71 people. People who used the service, some of whom were living with dementia, received either residential or nursing care. Some areas of the service, such as the garden and cinema room, were shared spaces to which everyone had access.

People's experience of using this service and what we found
People were placed at risk of harm because safeguarding procedures had not been followed. Risk assessments and care plans did not provide staff with all of the information they required to keep people safe. People had been restrained which was against the providers policies. Staff had not been trained in how to restrain people safely. Management of medicines continued to place people at risk of not receiving the right medicines at the right time. People did not always receive the support they required in a timely manner. Accidents and incidents had not been analysed so that lessons could be learnt and preventative action taken.

Some of the systems and processes in place to monitor the quality and safety of the service remained ineffective in identifying and driving up improvements. This meant that the service was not well led. Where issues had been identified action had not been taken to ensure improvements were made in a timely manner.

Best practice guidance was not followed to ensure people received effective care and support. Staff did not always receive the support and training they required to carry out their roles. People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. Although people were asked their views on the service this was not always acted on.

People's care plan still did not always contain sufficient or accurate information about their needs and risks or the care in a way that reflected their preferences. Complaints had not been recorded, investigated or the appropriate action taken to prevent a reoccurrence. The experience people received of end of life care was variable. Written information about people's preferences and wishes were minimal. Staff had not received training in end of life care.

Thorough recruitment procedures had been followed to ensure staff were suitable to work with vulnerable people. Staff mainly treated people with respect and kindness and upheld their dignity. People had sufficient food and drinks throughout the day. A variety of activities were offered for people to take part in. People were supported to access health professionals and appointments.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvements overall with Safe being rated inadequate. (Report published January 2019.) There were three breaches of the regulations. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had not been made and the provider was in breach of seven regulations.

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to not providing personalised and safe care, not protecting people from risk of harm, unsafe management of medicines, unlawfully restraining people and not following the procedures to make decisions in people's best interests , not acting on complaints and not having a governance system in place which ensures necessary improvements are made in a timely manner at this inspection.

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

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions of registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safw findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Ivy Court

Detailed findings

Background to this inspection

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

Inspection team
Three inspectors and an Expert by Experience carried out 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.

Service and service type
Ivy Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. When a registered manager is in place they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was carried out over two days and both days were unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health professionals who have contact with the service.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and four relatives about their experience of the care provided. We spoke with 11 members of staff including the manager, two regional managers, operation director, senior operations director, care workers, domestic staff and kitchen staff. We observed how staff supported people in the communal areas.

We reviewed a range of records. This included four people's care records and 11 medication records. We looked at three staff files in relation to recruitment and staff files in relation to supervision and appraisals. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification and assurances from the provider that action had been taken to mitigate the immediate risks to people that we identified during the inspection.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to ensure that there was safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- Some of the issues that had been identified with the management of medicines at previous inspections had still not been rectified. For example, medicines prescribed for external application such as creams and emollients were not safely stored to prevent people from accessing them and potentially causing themselves harm.
- Medicines were given by staff and recorded on Medicine Administration Records (MAR charts), however, we noted some gaps in the MAR charts which may have meant people had not received their medicines as intended by prescribers. Observations of staff during the inspection showed that when they gave people their medicines they did not always complete the MAR charts. Medicines were sometimes not given to people because they had not been available and obtained in time to ensure they received their treatments continuously. When people refused their medicines there were often no further attempts by staff to offer them later when appropriate to do so.
- There was guidance to help staff give people their medicines prescribed for when-required use but some written information lacked sufficient detail to enable staff to give them to people consistently and appropriately, for example, when people were prescribed more than one pain-relief medicine on this basis. Additional charts were in place for people prescribed medicated skin patches to ensure they were applied safely and appropriately and removed but these were not always completed by staff. When people were prescribed medicines for external application such as creams and emollients, there was a lack of information for staff to refer to about where on people's bodies they should be applied. When people had known allergies and sensitivities to medicines, records were sometimes inconsistent which could have led to error and medicines being administered inappropriately.
- Advice was not always taken and recorded about each medicine that was administered in food or drink (covertly). There was not always clear information available to staff about how the medicines should be prepared.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate the proper and safe use of medicines. This placed people at risk of harm. This was a

continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately after the inspection. They confirmed that audits of the medicines and records had taken place. They also stated that staff were receiving further training and being reminded of their responsibilities as registered nurses.

Assessing risk, safety monitoring and management
At our last inspection the provider had failed and to ensure that there was systems to robustly assess the risks relating to the health safety and welfare of people This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Risk assessments were not always in place for known risks. For example, one person's care records included a hospital discharge letter stating that they were at risk of aspiration. People at risk of aspiration are at a higher risk of aspiration pneumonia this is because they breath material in to their lungs such as food particles. The records also included an assessment by a health professional who stated the person should have thickened fluids but was refusing to. There was no risk assessment in place regarding the risk the person choking and no care plan about how the risk should be managed.
● Risk assessments included the dates for review. However not all risk assessments had been reviewed as planned to ensure that they were accurate. For example, one person's falls risk assessment was completed in April 2019, identified them as high risk of falls and stated that it should be reviewed on a monthly basis. The risk assessment had not been reviewed since April even though the person had experienced three falls since then.
● No risk assessments were in place for two people who displayed challenging behaviour towards others. This meant that staff did not always have the information they required to reduce risks to people.

Failure to assess the risks to people's health and safety places them at risk from harm. This is a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not always protected from the risk of abuse or improper treatment. Staff had received training about the procedures they should follow if they suspected anyone had suffered any abuse. However not all staff were able to tell us the correct procedures to follow. Allegations of abuse and poor practice had not always been acted on to ensure that people were safe from harm.
● One person had raised concerns about how a staff member had supported them with personal care. Their concern had not been recorded, reported to the local safeguarding team or investigated. This placed them and other people at continued risk of abuse or poor practice.
● We were told on the first day of the inspection that the provider had a no restraint policy. However, during the inspection, we saw evidence that two people had been physically restrained so that personal care could be carried out. No assessments or guidance were in place about restraining people. The staff had not received training in how to restrain people safely. No action had been taken in response to the restraints taking place to investigate the incidents or prevent them from recurring.

Systems were not robust enough to ensure that people were protected from abuse and improper treatment. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●After the inspection the provider confirmed that action had been taken to investigate the incidents of restraint and prevent them from recurring.

Staffing and recruitment

●The manager could not tell us how the staffing levels had been established. The call bell response times had not been monitored to see how long people had to wait when they needed assistance from staff. There were mixed comments received from people and staff about if they received their support when they needed it. One person told us, "I've had to wait 30 minutes in the morning for people to come when I press the buzzer and last week it was after 10.30 before I was hoisted. I spoke to (Clinical Lead) and I said I wanted to be up half an hour earlier today and I was. Another person told us, "I only need one person to help me get up in a morning and there's enough staff for what I need." A relative told us, "The carers work their socks off, but there are 8 people here needing hoists and 4 on palliative care and there just aren't enough to do all of it".

● Staff told us that staffing levels were not always adequate to meet people's needs in a timely manner. They explained that on some occasions they did not have enough time to assist people up before lunch time. They also told us that although they normally had time to provide basic care they did not have time to make tasks enjoyable for example, they rushed through assisting people with personal care rather than taking longer and having time to talk to people and make it a more enjoyable experience for them. One staff member told us that one person liked to have a shower every other day. The staff member stated that there was not always enough time for them to assist the person with a shower.

● Recruitment systems were effective and ensured suitable people of good character were employed to work at the service.

Learning lessons when things go wrong

●Analysis of accidents and incidents was not robust. Although data reports regarding accidents and incidents were available these had not been used to identify trends and action had not been taken to prevent reoccurrence or to share learning with staff.

Preventing and controlling infection

●Staff received training in infection control and safe infection control procedures were followed. One person told us, "It's (the home) is very hygienic."

●Staff were able to explain infection control methods and the use of personal protective equipment. We saw staff put on gloves and aprons before providing personal care to people.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- End of life care planning and the care of dying adults in the last days of life did not adhere to best practice with regards to guidelines outlined by the National Institute for Health and Care Excellence (NICE).
- People's medicines were not managed in accordance with NICE best practice guidelines or guidelines issued by the Royal Pharmaceutical Society of Great Britain.
- The nurses had not always worked in accordance with the nursing and midwifery council (NMC) code of professional standards.
- Poor practice was not always recognised, reported or acted on. For example, when people had been restrained this was not raised with the manager.

Failure to ensure that people's care was always provided in a safe way in accordance with nationally recognised guidance places people at risk of harm. This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- After the inspection the provider stated that they had issued a copy of the NMC code of professional standards to all nurses to remind them of their responsibilities.

Staff support: induction, training, skills and experience
- Staff had received training when they first started working at Ivy Court and this was updated each year. New staff completed the Care Certificate, which identifies a set of standards and introductory skills that health, and social care workers should consistently adhere to and includes assessments of competency.
- Although some people living at Ivy Court displayed behaviour that challenged others none of the staff had received training since working in the home in how they should respond when incidents occurred.
- Staff comments were mixed regarding if they felt supported to carry out their role. The manager stated that it was the providers policy to carry out staff supervisions bi monthly. However, this had not taken place for all staff. We looked at the supervision dates for six members of staff. One had not received any supervisions in 2019 and four had only received one supervision in 2019. The manager stated that he had booked dates in for staff to have supervisions. The manager stated that there was no list available of dates that staff had received their appraisals. Of the six staff files we looked at there was no record of an appraisal for five of them.

Failure to follow best practice guidelines and to ensure that staff have the necessary training and support places people at risk of being cared for staff whom are not competent to carry out their role effectively. This

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

Ensuring consent to care and treatment in line with law and guidance
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.

In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met.

● Capacity assessments and best interest decisions had not always been undertaken when needed. For example, for people who would otherwise refuse their medicines and had them given to them hidden in food or drink (covertly), the service had not always assessed their mental capacity to ensure it was appropriate to give them their medicines in this way. In addition, when assessments had taken place, decisions made in people's best interest did not always show that appropriate consultations had taken place.
● Some people's records showed that they could not consent to personal care and sometimes refused assistance. Although capacity assessments had been completed for activities of daily living there was no record of best interest decisions being made or how care was provided in a least restrictive way.

Failure to carry out capacity assessments and best interest decisions meant that people's rights may not always be upheld. This is a breach of This was a breach of Regulation 11 (Need for consent) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to eat and drink enough to maintain a balanced diet.
● People had choice and access to sufficient food and drink throughout the day. One person told us, "I like the food; there's almost too much food and you have a choice." Another person told us, "The food is good although I would like a little more vegetarian options and fish.
● When needed people received support with eating and drinking at a pace that suited them. Staff were aware of people's dietary needs. Special diets were catered for.
● People had requested an afternoon tea trolley to provide drinks and snacks. The manager stated that this was in the process of being organised.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Staff supported people to attend appointments with health professionals such as GPs, dentists, chiropodist, opticians and hospital consultants.
● Staff told us they ensured people had the support they needed if healthcare was required and we saw

from records that referrals were made as necessary.
● When needed the palliative care team were consulted regarding end of life care. However, their advice had not always been recorded in people's care files.

Adapting service, design, decoration to meet people's needs
● Ivy Court is a purpose-built home. The building is fully accessible and equipped to meet people's physical needs. The premises were decorated to a high standard and each person's room was furnished to their taste, with many personal belongings to support people to feel it is their home.
● There was signage throughout Ivy Court so that people knew which way to go and where to find amenities.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People and relatives' comments about how they were treated were mixed. One resident said, "They're mostly very caring, but of course not all are. It takes time to train them, but they're always very willing; nothing is too much trouble." Another person told us, "Sometimes they are short on staff, but they do their very best and the staff are very good on the whole. I think they do a good job here and I would recommend Ivy Court." One relative stated, "I find the care extremely good here. [Family member] seems to have got back their inner core of happiness." Another relative told us, "The carers can vary."
- We observed that people were treated with kindness. Staff spoke to people in a respectful manner and provided reassurance when needed.
- People's care plans did not always contain enough detail so that their independence could be promoted. There was not always guidance about what people could do for themselves or what they needed support with.
- Staff explained how they promoted people's dignity. For example, always knocking on people's doors before entering and when possible keeping people covered up when assisting them with personal care. However, staff did not always promote people's choices or ensure their dignity was promoted. For example, one person's personal care was completed in a way that did not promote their dignity or respect their choices.

Supporting people to express their views and be involved in making decisions about their care

- People had been asked their views on the service. However, the providers policy had not been followed to ensure that there was an action plan in place to address any areas where the satisfaction score was below 85%.
- There had been a recent "Residents and Relatives" meeting. One person told us that they had made some requests at the meeting and that the manager was making the necessary arrangements.
- We observed that people could spend their time how and where they wanted to. Some care plans showed that people had been involved in the writing and reviewing of them and had agreed with what had been written.
- The manager stated that information about independent advocates was available if people needed it.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Not all care plans included information about people's preferences, life history and goals for the future. In some care plans the information was very task based and focussed on basic support that people required such as assistance with personal care. Some sections of the care plans had not been completed. For example, one person's pre-admission assessment stated that they required support to meet their religious needs. However, their care plan did not provide any information about what support they required or who would provide it.
- Although care plans had been reviewed they had not always been updated to reflect the information agreed in the reviews. For example, the review of one person's care plan stated that they wanted to change how often they had a bath or shower. However, the care plan had not been updated so that staff had the information about the person's preferences.
- The manager stated that he was aware that not all care plans were person centred and needed reviewing and rewriting. He stated that some staff had been made "Care plan champions" and they were responsible for ensuring that the care plans were accurate and they had been given supernumerary time to make the improvements. The manager showed us one care plan that had been rewritten and it was in much more detail and included people's preferences. However, issues with people's care plans not being accurate and complete were first raised during an inspection in 2017.
- For people who were unable to tell staff about their pain levels and who had pain-relief medicines prescribed for when-required use, pain assessment tools were not always used by staff to ensure consistency when judging if people needed them.

Failure to provide accurate person centred information about the support people required meant that people were at risk of not getting their needs met in the way they preferred. This is a breach of regulation 9 (Person Centred Care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

- Although there was a robust complaints procedure in place this had not been followed. Complaints had not always been recorded, investigated or appropriate action taken in a timely manner.
- People told us that they had recently raised concerns with the manager and they thought they were being dealt with. However, there were no records of any complaints received since January 2019. The manager confirmed that complaints had been raised with them but they had failed to record the complaint and any action that had been taken in response.

Failure to record, investigate and take action in relationship to any complaints raised means that necessary

improvements may not be made. This is a breach of regulation 16 (Receiving and acting on complaints) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support

● The manager stated that people at the end of their life were treated with dignity and respect.
Positive comments had been received from family members about the support that they and their relatives had received at the end of their life. However, we also received comments from one family that raised concerns about how some of the staff had treated their family member at the end of their life. They told us they had seen some exceptional care but they had also felt that some of the homes staff had "a layer of compassion and understanding missing". They stated that some nurses had not communicated with their family member when administering medication.

● The palliative and end of life care plan for one person who was in the final days of their life was very basic and did not include important information about their wishes and preferences. It had not been updated to include information from the palliative care team. For example, the person's care plan stated that as they were at high risk of developing pressure ulcers they should be assisted to reposition in bed every four hours. Their repositioning chart did not show that this was being done as expected. The manager stated that staff had told him that the person's family member had requested that they should not be repositioned as this caused the person pain. There was no record of the request. The manager also stated that the palliative care team had agreed that the person should not be repositioned. There was no record of this instruction from the palliative care team. Failure to update people's end of life information could mean that not all staff are following the same procedures.

● Staff had not received training in end of life care.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them.

● Staff supported people to participate in social and daily living activities such as bingo, craft sessions, shopping, musical entertainment, card and board games. People told us they really enjoyed the trips out that were organised by the activity staff. However, there was a notice in the entrance of the home that stated that due to the popularity of the trips out people would have to be restricted to one a month. The operations director stated that she would look into this as the number of trips out should not be restricted. One person told us "There is always something to do if you want. They have singers and entertainment and there's a beautiful library. One relative was seen taking part in craft session with their family member and afterward commented "Taking part in the activities is really good for [family member].The activities are really important to her life. [Family member] enjoyed making cards this morning and they love it when the children come in from the nursery. [Family member] is a mad keen gardener and loves the garden, it's a fantastic bonus for people here."

● People were encouraged to have visitors and could see them in communal areas or in private. Relatives and friends visiting were welcomed and offered food and drink whilst in the home so that they could enjoy time with their family member.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

● The manager stated that information could be provided in different formats such as large print. Signage in the home was designed so that it could be easily seen and contained words and pictures.

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care
At our last inspection the provider had failed to ensure that there were effective systems in place to assess, monitor and improve the quality and safety of the service. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

● Action had not been taken to ensure that where needed improvements to the service were made and sustained. There was a system in place to report incidents and investigate errors relating to medicines, however, this was not often used to record incidents where people had been potentially placed at risk.
● Although the provider had a governance system in place this was not working effectively to ensure that where issues had been identified actions had been taken in a timely manner to make the improvements. We received an action plan from the provider after the previous inspection in January 2019 when Ivy court was rated inadequate in Well-led. The action plan stated that improvements were being made to the management of medicines, care plans, supervisions, appraisals, audits and staff understanding of the MCA. The date for completion of the actions was given as 30 April 2019. However we found further evidence of breaches of regulations in all of these areas. We also identified breaches of regulations in relation to safeguarding people from abuse and receiving and acting on complaints.
●People, relatives and staff feedback was mixed about the management of the home. One person told us, "The new manager seems more responsive and get things done and doesn't get the staff's backs up." Another person told us, "[Name of Manager] hasn't been here long and he's got a lot to sort out, but things seem to be improving." Some staff members said that they didn't feel supported and that they hadn't had regular supervisions. One new member of staff told us they had a supervision in their first few weeks of employment but had not had once since to discuss their progress. Staff told us they had raised concerns with the manager about how a person had been treated by another member of staff. However, they didn't think any action had been taken in response. The manager confirmed during the inspection they had not investigated the concerns or spoken to the person involved. This lack of response to concerns raised did not create an open culture or encourage people or staff to raise further concerns.
●Although monthly regional manager visits and reports were completed for Ivy Court these had not ensured that action had been taken to make improvements where necessary. For example, the monthly reports for April, May and June 2019 all identified the home manager was not completing audits. The report for May

2019 documented a care plan was not in place to support a person with their behaviour that challenged others. The care plan had not been put in place by the time of the inspection.
●Some audits had taken place however action plans were not in place to ensure actions needed were completed.

Failure to follow the governance systems in place has meant the areas for improvement have not always been identified or the action needed to make improvements has not been taken in a timely manner. The above evidence demonstrates a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Good governance).

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
●There was no registered manager in post. The manager had been in post for 11 weeks. They stated that since the home opened in 2015 there had been 12 managers – although only three of them had been registered. The regional manager and operations director had also recently changed. At the time of the inspection there was no deputy manager in post. Two new clinical leads had recently been appointed.
●By law the commission must be notified of certain events in the care home. During the inspection it was identified that the required notifications had not always been made. This had meant that we did not have information so that we could monitor events within the home and take follow up action if needed.

Failure to notify the Commission of certain events is a breach of regulation 18 The Care Quality Commission (Registration) Regulations 2009.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
●The manager stated that when people had suffered serious injuries or incidents they had not discussed this further with the person or if needed (due to lack of capacity) relevant persons.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics ;Working in partnership with others
● People's health and welfare needs were met by a range of local healthcare providers, social work teams and community services.
● Records showed that staff supported people to access healthcare appointments to maintain their wellbeing.