Voyage 1 Limited

Ivydene

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?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 8 and 17 June 2016 and was unannounced. The home provides accommodation and personal care for up to 9 people with a learning disability. There were 9 people living at the home when we visited some of whom also had additional needs relating to a physical disability and living with dementia. Ivydene is based on two floors, connected by a passenger lift. In addition to a basement where the laundry is located there was a lounge and dining room where people were able to socialise; kitchen, bathrooms and everyone had their own bedroom either on the ground or first floor.

A registered manager was not in place at the time of the inspection, although one of the managers had applied to be registered with CQC and their application was being processed. We were informed shortly after the inspection that the manager was no longer working at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. There was a lack of consistency in the management of the home and although staff felt the managers were supportive they did not feel the home was well- led.

We found fundamental standards were not being met and people's safety was compromised in some areas.

People told us they did not feel safe and were scared of two other people who lived at Ivydene. They were not protected from the risk of physical or emotional harm due to the actions of other people. Individual risks were assessed and managed although these did not include examples of positive risk taking such as domestic tasks or the risks of physical abuse from other people.

There were inadequate numbers of permanent staff and the home was reliant on agency staff who had often not previously worked at the home. People were not always cared for with kindness and compassion.

People's privacy was protected and they were involved in some decisions about their day to day care and meals but were not involved in other decisions about the service. Staff sought verbal consent from people on a day to day basis however, they did follow legislation designed to protect people's freedom.

People were supported to access healthcare services when needed however it was not always clear from records what people's longer term healthcare needs were or why they had been prescribed some medicines.

Some areas of the home were not suitable or accessible to people.

People were cared for by staff who had completed most essential training and were supported in their work although staff felt they did not have the necessary skills to support people who could become violent.

There were suitable systems in place to ensure the safe storage and administration of medicines. Healthcare

professionals such as GPs, chiropodists, opticians and dentists were involved in people's care where necessary.

Weekly meetings with people were held to seek their views about some aspects of the service. People and relatives knew how to make complaints although one complaint had not been properly responded to.

Quality assurance arrangements had identified many but not all of the above concerns and the provider's management team including the general manager and the area manager were visiting the home on a regular basis. We were not told about significant incidents which had occurred in the home as required.

In other ways, the home had an open culture. People and staff said the managers were approachable and they had contacted external professionals for support and guidance. Visitors were always welcomed.

People said they enjoyed their meals and received a choice of home cooked meals based on their needs and preferences. People were supported to engage in a planned and ad hoc individual activities of their choosing.

We identified six breaches of the HSCA regulations and one breach of the registration regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

You can see what action we have taken in the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not protected from the risk of physical or emotional harm due to the actions of other people. Individual risks were assessed and managed although these did not include examples of positive risk taking such as domestic tasks.

There were inadequate numbers of permanent staff and the home was reliant on agency staff who had often not previously worked at the home.

Appropriate recruitment practices were followed and medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff sought verbal consent from people on a day to day basis however, they did not follow legislation designed to protect people's freedom. People were supported to access healthcare services when needed however it was not always clear from records what people's longer term healthcare needs were or why they had been prescribed some medicines.

Some areas of the home were not suitable or accessible to people.

People were cared for by staff who had completed most essential training and were supported in their work.

People received suitable meals and a choice of drinks to suit their individual preferences.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not always cared for with kindness and compassion.

People's privacy was protected at all times and they were involved in some decisions about their day to day care and meals but were not involved in other decisions about the service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were comprehensive and reviewed regularly but did not contain all relevant information.

Staff responded to people's needs on a day to day basis. Weekly meetings with people were held to seek their views about some aspects of the service.

People, relatives and staff knew how to make complaints but these were not always responded to as per the provider's policy.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The provider did not notify CQC of all significant events, as required.

There was a lack of consistency in the management of the home and although staff felt the managers were supportive they did not feel the home was well- led.

Ivydene

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 17 June 2016 and was unannounced. The inspection was undertaken by one inspector and a specialist advisor in the care of people with a learning disability.

Before the inspection, the provider 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 the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with four people living at the home and with two relatives. Following our inspection, we received feedback from a health professional and two care professionals. We observed people being supported in the communal areas. We spoke with three members of care staff and staff managing the service.

We looked at care plans and associated records for four people, and records related to the running of the home including staff duty records, staff recruitment and training files, records of accidents and incidents, policies and procedures and quality assurance records.

The home was registered with the Care Quality Commission in April 2014 and has not previously been inspected.

Requires Improvement

Is the service safe?

Our findings

Two of the people living at Ivydene had incidents when they became upset and could be violent towards staff and other people living at the home. Although staff tried to prevent these incidents and were consulting with external professionals there was an increasing impact on the other people living at the home. Permanent care staff had received basic training to meet the needs of people who may present a risk to themselves or others as per the provider's training procedure. Additional guidance specific to one person had also been provided to staff via an external specialist. However, staff continued to feel that they did not have enough skills or experience to support one person. One care staff member said "it's [training] not enough to know what to do with [names of people] when they are being violent".

The home's managers told us they were working with social services care managers and learning disability specialists to ensure people were safe. Managers told us they were seeking additional funding to provide more individual support for people but this had not yet been agreed by the care managers. The service was funding some additional individual support pending the funding agreement by care managers however incidents of physical assault were still occurring and in the case of one person the frequency of incidents was increasing. The manager had identified that for one person there were no indicators that could be used to predict when incidents may occur. We had received notifications of incidents of physical assault by two people on other people living at the home. These notifications had been increasing since December 2015. In the first week of June 2016 there were incidents most days. The service therefore could not assure people they would be safe and people were sometimes not safe.

Staff told us about their concerns for their safety and that of people living at Ivydene. One staff member told us "I don't want anything to happen to someone when I am here". They added that "[name] is now targeting staff as well". Staff described how they moved people to the kitchen "out of the way". One staff member described an incident when they had been unable to get help. They said "I called for help when I was in the bathroom. No one came. I was helping [name person] to bath. I had the door locked as [name second person] was banging and kicking the door. No one came as the alarm was broken. I ran out and screamed for help when [name second person] went to their room". Senior staff described some actions that had been taken to make people safer. We saw walkie talkies had recently been provided for staff so they could summon assistance in an emergency. Staff also told us how one person had been putting things in the electric sockets in their bedroom which now had guards on them. The home's managers were working with staff and providing direct interventions when required. For example, we read in reports that following one incident the two managers had supported the person to go out for a walk to help them relax. This also allowed the staff and people in the home to relax following the incident.

People told us they did not feel safe and gave us examples of when they had been harmed or abused. One person told us they wanted to move to live somewhere else. They explained this was because they were "always frightened – scared – everyone is, especially [name of another person who lives at the home]. [Name] keeps shouting and swearing and tries to move my wheelchair. I could get hurt". Another person expressed similar views and told us about their fears. They told us "I don't like [same name]. They punch my wheelchair tray and knock my chair about." The person added "I'm not up to it any more – I stay in my room

when [name] is in [the home] or go in the kitchen if the staff are there". The person said they had told their relative who "went to the office". They added that their relative had said to them "'Don't take any notice', but I do, it frightens me". A family member also expressed concerns about safety. One family member said, "[name] says they want to move but they don't really want to leave here, but they are scared". As well as experiencing physical abuse people were witnessing staff being physically assaulted and people shouting and swearing at staff. This meant people were at risk of emotional/psychological abuse and would contribute to their fear that they may also be physically abused by the person.

The failure to ensure people were kept safe at all times is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safeguarding services from abuse and improper treatment.

Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse, and how to contact external organisations for support if needed. Incidents of physical assault by two people were being correctly reported to the local safeguarding team with whom the manager was in contact. The manager described the action they would take should a safeguarding concern be brought to their attention.

There were six permanent staff employed at the home. We were told one was due to commence maternity leave and the another was due to leave soon after the inspection. One staff member said "There is not enough staff here. It's always agency. When I go there will be just four permanent staff." They added "with [name person] getting worse and worse it's just too much." Another staff member told us they were thinking of leaving but they had not yet handed in their resignation. They said that "We have to do all the shopping, cleaning, cooking. It's too much." The provider was aware of the shortage of permanent staff and had taken action by using on line shopping and to move a member of staff who usually worked in another home to Ivydene on a short term basis. They told us they had been moved to work temporarily at the home and added "I'm here to help because there are not enough staff". The provider was also using agency staff however, there was little consistency in agency staff. During the week of the inspection eight different agency staff were rostered, some working one shift. This meant people were not receiving care from staff who they knew and who understood their individual needs and wishes.

One person told us there were not enough staff and they could not often go out. Staff also described how the shortage of permanent staff was affecting people. They said "there are no drivers; the residents are not getting out at all". They added "We used to get out more". Another staff member told us "We have to allocate one staff member to support [name person] meaning we have less for other people". We saw one person was paying thirty pounds for a taxi to take them to and from a regular physiotherapy appointment. Staff told us a taxi was used as there were no staff able to drive the two house cars. The provider's area manager told us they were providing some additional funding for taxis. On both days of the inspection we saw people were able to attend planned day services, health appointments and some adhoc community activities.

The failure to have adequate numbers of suitably skilled and experienced staff is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing.

All care plan folders viewed had individualised risks identified and included descriptions of the type of risk and action to alleviate or minimise the risk. Risk assessments were personalised and relevant to the care needs of the person. For example, risks to people related to moving, community activities and nutrition. Risk assessments and guidelines for staff were also seen in relation to people who were assaulting other people and staff. However, these were not effective as they were not reducing or preventing the incidents.

The provider produced a range of environmental risk assessments which the manager stated they were able

to individualise to the home. Records showed essential checks on the environment such as fire detection, gas, water and electric supplies and equipment, were regularly serviced and safe for use. However, not all actions were being taken to ensure the environment was safe. A steep set of stairs led from a ground floor corridor to the laundry area. The laundry room had a lock but this was not in use when we asked to see the laundry room. The home had a shaft lift and the area where the lift equipment was housed was also not secure as it had an unlocked door and stated 'high voltage'. This area had a range of potentially flammable items stored close to the 'high voltage' electric supply posing a fire risk. The manager arranged to clear this area during the inspection.

People received their medicines safely. Staff had received appropriate training to administer medicines. Medicines administration records (MAR) were completed correctly. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. People told us they could request and receive as needed medicines such as paracetamol for a headache. There were suitable systems in place to ensure the safe storage and disposal of medicines. A refrigerator was available for the storage of medicines which required storing at a cold temperature in accordance with the manufacturer's instructions. Systems were also in place to manage prescribed topical creams and records showed these were being applied.

The provider had a safe and effective recruitment process in place to help ensure that staff they recruited were suitable to work with the people they supported. All of the appropriate checks, such as references and Disclosure and Barring Service (DBS) checks were completed for all of the staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. The provider ensured they received information about agency staff prior to their working at Ivydene confirming that the agency had completed similar checks on staff they supplied to the home.

Personal evacuation and escape plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Permanent staff were aware of the fire safety procedures and the action they would take if an evacuation was necessary, agency staff were less clear about emergency procedures. Evacuation Ski sheets, which are an aid to assist staff to evacuate people with limited mobility in an emergency, were also available for each person who may require them.

Requires Improvement

Is the service effective?

Our findings

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 Mental Capacity Act, 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. DoLS applications had been made to the supervisory body with the relevant authority for all of the people using the service. We were told one had been assessed and a DoLS authorisation was in place. We asked for confirmation that the individual conditions which were specified within the authorisation were being complied with. We told the manager what the conditions were as listed in the DoLs approval. The manager said they were unaware of the conditions and that they were not being complied with. One condition specified that the person should be supported to attend church weekly. The manager told us this was not occurring and the person had not attended church since at least December 2015. They said that volunteers from the church had been supporting the person to attend but they no longer did this. Following the inspection we identified during a local authority professionals meeting that a second person also had had a DoLS approved. However, the managers were unaware of this and there was no information about this in the person's care records.

The failure to ensure people's legal rights are protected was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014Regulation 13 Safeguarding services from abuse and improper treatment.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. We saw staff followed consulting with relatives and professionals and documenting decisions taken, including why they were in the person's best interests. Staff sought people's consent before providing care or support, such as offering to provide support to help them mobilise. One member of staff told us, "I always tell the residents what I am about to do and ask them if it is okay. It they say no, that is their choice. I might wait a while and ask again". Daily records of care showed that where people declined care this was respected.

People may not have all their healthcare needs met as these were not always known to staff or managers. Information about two people's medical history of epilepsy or why they were prescribed specific medicines for epilepsy was not available. The manager did not know this information and there was nothing with the people's care plans to explain why they were receiving anti-epileptic medication. For one person their records stated they had not had seizures since childhood in excess of forty years previously. Another person had been receiving a daily dose of Diazepam since 2012 in addition to two anti-epileptic medicines. There was no epilepsy management plan or reference to any reason in the records regarding the use of these medicines for this person. One longer term staff member was able to describe how the person had shown minor and very infrequent seizure activity causing tremors in one leg on two occasions in the preceding five

years. This information was not recorded in their care file and there was no information about any medical reviews of their epilepsy such as neurology appointments.

The failure to ensure people's health care needs are known and met was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12 Safe care and treatment

People saw doctors, dentists, opticians and chiropodists when they needed to. Staff told us people's medical needs were met. One care staff member said "They [managers] are actually good at that, as soon as someone is ill they call the GP". We saw staff were encouraging one person to keep their legs raised because the person's feet "get swollen". Prior to the inspection we received information from the home informing us that a person had developed a pressure injury. The information showed that staff had identified an initial concern and consulted with the district nurse who had not felt there was a problem, however, when there was no improvement staff also consulted the person's GP and eventually a diagnosis was received and appropriate action was taken. This showed staff did request medical advice when they were aware that there may be a medical need.

Other than moving and handling training there was no information about the training agency staff had completed to show that they had the skills and knowledge to meet the needs of people living at Ivydene. The manager requested this information from the agency during the inspection which confirmed that agency staff had undertaken most relevant training. The provider had a form for agency staff inductions. This included specific information relevant to the home including action that should be taken in an emergency. However, this form had not been completed for any of the agency staff working at the home.

New staff received induction training, which followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. They worked alongside a more experienced member of staff until they had been assessed as competent to work unsupervised. The provider had a system to record the training that staff had completed and to identify when training needed to be repeated. This included essential training, such as medicine administration, safeguarding adults, mental capacity act and first aid. Care staff confirmed they had attended training and were supported to achieve qualification in care. Staff felt they had the skills to meet people's needs other than in respect of when people were being physically aggressive. Staff had access to other training focused on the specific needs of people using the service however they had not undertaken epilepsy training which several people living at the home were receiving medicines for.

The provider had a procedure to provide support and supervision for permanent staff however, the manager told us that prior to January 2016 staff had not been receiving regular formal supervision. The manager had initiated a supervision programme and we saw that this was now being completed for all permanent staff. The manager planned to undertake appraisals but these had not yet occurred.

People told us they liked their bedrooms which we saw had been personalised by their occupants. Adaptations had been made to make Ivydene suitable for the people living there. These included overhead hoists and a shaft lift which accessed the ground and first floor. There was a lounge, and separate dining room which were decorated and furnished in a homely style. People could access the patio areas from a conservatory or the office although those in wheelchairs would require support to do so due to a raised lip at the doorways. The manager said people did not tend to use the conservatory as this was quite narrow and therefore not suitable for many activities. During the inspection nobody was seen to access or was seen supported to access the patio area. This area was not welcoming and there was little to encourage people to go outside even though the weather was pleasant. The remainder of the garden and laundry room could not be accessed by most people as there were steep steps to these areas.

People told us they could make choices about their meals and daily records demonstrated that people were being provided with a range of main meals, drinks and snacks. Staff told us that "things had got better" with food shopping and said the cupboards "are not so bare". They told us the home now did on line shopping whereas previously they had been walking to the shops daily to purchase food. We observed people being given choices about meals and supported to eat and drink at regular intervals during the day.

Requires Improvement

Is the service caring?

Our findings

People were not always treated in a caring or respectful way. We observed two people sat at a table in the dining room. There was a book on the table. One person was endeavouring to look at the book. Another person kept pulling the book back. This was repeated several times. One person said "Wanna look at the book", the other person said "It's my book". There were no staff present. We returned shortly after and the exchange was continuing with loud voices. We looked for a staff member and found one sat in the adjacent lounge who must have been able to hear the altercation in the dining room as there was a door leading directly between the rooms. We asked the staff member if there was another book as the two people were in loud disagreement over one book. The staff member got up and came into the dining room; they looked at the situation, said nothing to either person and took the book. One person said it was her book. The staff member opened the book and saw the person's name written on the front. The staff member left taking the book with them. The staff member did not speak with the people or with us. On another occasion we heard staff respond inappropriately to a person. The person was waiting to go to day services and had their lunch box with them. They looked in the box and noted that their banana had been eaten (leaving behind the banana skin). The person showed this to a staff member who said to them "that's very naughty". The person had not eaten the banana but noted that someone else had done this but was spoken to as if they were a child being 'told off' and looked upset. These observed interactions did not show respect or caring for the people concerned.

The failure to ensure people were treated with dignity and respect was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 10 Dignity and respect.

At other times we observed positive caring interactions between staff and people. For example, at lunch time we saw a care staff member explaining to two people that they had burnt the lunch and offering them alternatives. The two people evidently liked the staff member and engaged in an exchange of jokes with the care staff member and laughed at the error.

People said they were asked their opinions and could make choices but some of these choices were limited. For example, one person told us they chose their own clothes each morning; however they also told us they did not go out with staff to purchase their own clothes. This was confirmed by staff although they did not explain why this was the case. The person did not know why they did not go to the shops. Two people told us they got up early. We were unable to identify if this was their choice. When we asked one person if they liked getting up early they replied "I have to have two staff". When we asked the other person why they got up so early they said "because the night nurse has to help me". We tried rephrasing the question and the person repeated they got up early because the "night nurse had to help them". It was not clear that these two people had been supported to understand that they had a choice. Care records did not indicate why people were getting up early every day. We were shown picture cards of meals and activities however, staff told us they did not use these and therefore people may have been unable to fully express their views.

We were told people who were able to respond were asked about the weekly menu plan and saw that people were receiving a range of meals. However, there were no records of people's choices or that any

specific work had been undertaken to enable people to think about what options they had. The manager showed us picture cards of meal options however staff said they did not use these and said "People always choose the same things". The same situation was occurring for activities. We saw people were asked if they would like to go for a walk but they were they were not shown option cards or offered choices via other communication methods about other activities or where they may wish to walk or what they may like to do whilst out.

People were not actively involved in decisions about the service. For example, people and a newer staff member told us that people were not involved in the recruitment and selection of new staff. One person said "we are not asked what we think [of new staff]". The provider's recruitment policy made no reference as to how people could be involved in the selection of new staff. The manager said they were looking at how people could be more involved in the running of the home including staff recruitment. Each week a meeting was held with people. The minutes of these showed topics such as menus and activities were discussed. Care plans and other information such as meeting minutes were not in an accessible format, such as pictures or similar, to aid people's understanding.

Care plans did not include information about how people were supported to develop independence skills or assist with routine domestic tasks. People and staff told us people could access the kitchen but that people were not involved in cooking or meal preparation. Staff told us they did the cleaning and people said they were not involved in cleaning, personal laundry or gardening.

The failure to ensure the care people received reflected their preferences was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 9 Person-centred care.

People's personal records were not stored securely and confidential information could have been accessed by people not authorised to view this. All service user records were on open shelves in the staff office. At the start of the inspection we found one person was sitting in the office on their own. The office door was not locked meaning confidential information about people was not stored securely. On the lower ground floor we found records waiting to be archived stored in a walk in cupboard which was not fitted with a lock.

The failure to ensure records were maintained securely is a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

People were supported to maintain links with family members. Family members told us they were able to visit whenever they wished. The manager described how they were supporting one person to visit their family in Europe. People also told us their privacy was respected and staff always ensured bedroom or bathroom doors were shut when they were receiving personal care.

Requires Improvement

Is the service responsive?

Our findings

The manager had sought guidance from external health professionals about incidents of a violent nature against staff and people by two people using the service. These incidents were continuing and for one person the aggressive incidents were increasing in frequency. Care plans for these two people included some guidance for staff about the way they should respond to these incidents. However, should a situation arise which placed staff and people at significant risk there was no crisis or emergency response plan. This would mean that in an emergency staff would not know what they should do or who they should contact to provide immediate support. A structured crisis response plan would mean the person would receive the most appropriate care and support should an urgent situation occur. An oncall system for management support was available when a manager was not in the home.

People were involved in their care planning where possible. Where this was not possible, family members were involved, if this was appropriate. People had signed their care plans, where they could. The provider's care planning process was comprehensive and detailed. However, for two people all information about health care and medicines was not included. As part of the care plan there was a detailed 'day in my life' document. This gave specific individual information about how each person liked to receive support with their routine care needs. This included detail about what people could do themselves and what they required assistance with.

Some people attended a local day service several days each week. People who did not go to the day service were offered some in house activities such as use of ipads and some craft activities. We also saw one staff member and a staff member go out for a walk and another person who attended a physio gym session. A visiting musician was at the home on one day of the inspection and people were enjoying joining in with the singing. However, people were not supported to develop independence skills or be involved in routine daily activities. For example, we were told that people could go into the kitchen but that no one actually helped with the cooking. The home's laundry room was located in a basement down a steep flight of stairs and was therefore not suitable for people to assist staff or be involved in their own laundry. Some people said they were not involved in cleaning their own bedrooms. They had also not been given the opportunity to become involved in gardening although the patio area of the garden contained a raised area where people could have assisted staff to grow flowers or vegetables.

Some requests from people were responded to. For example, we saw a person ask staff if they could have a lie down on their bed in the afternoon and staff responded promptly to this request.

People's views were sought about some aspects of the service. People told us about a weekly meeting when they were asked about meals and plans for the next week. We saw people were asked about what had been good about the previous week and what had not been so good. They were also asked about meal preferences for the coming week. However, for two weeks shortly before the inspection it was noted in the minutes that people had said that what was not good was the shouting and swearing that had been occurring. The minutes did not show what action was being taken to address this or inform people about

what staff were doing about this. The minutes were in a typed word format which was not suitable for everyone living at Ivydene.

A staff member said "I have complained [to the manager] but no one does anything. I think the relatives know how to complain, I'm not sure but nothing happens". One relative told us they had recently complained as they did not think their family member was safe. They said they had not received a response from the manager either to acknowledge the complaint or inform them what was being done. During the inspection one of the managers spoke with the relative saying they were trying to resolve the situation which had led to the complaint. We discussed the complaint with the manager who described the action they were taking to respond to the complaint. The manger was unable to find the complaints record book. The action plan following the home's quality audit undertaken in May 2016 identified that a complaints book was 'not available, organised or corresponds to all entries on the [provider's computerised monitoring system]. We were therefore unable to view records of this complaint.

Requires Improvement

Is the service well-led?

Our findings

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. We identified incidents in daily records and behaviour recording charts where people had physical altercations with other people living at the home which we had not been notified about. We also identified that we had not been notified when a Deprivation of Liberties Safeguards application had been approved. We raised this with the managers who acknowledged that these notifications should have been made, but could not explain why they had not been.

The failure to notify CQC of incidents of suspected abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

There had been several changes in the home's management. In December 2015 the home's registered manager left and in January 2016 the provider had allocated a temporary manager to the home. In March 2016 they had appointed a new manager. The temporary manager had continued to work with the new manager to identify and resolve the issues and stated that they were supporting the manager to make the necessary improvements. Shortly after the inspection we were told the new manager was no longer working at Ivydene and they would be recruiting for another manager.

Staff did not feel the home was well run and described a lack of team work. When asked about how the home was managed one care staff member said "No teamwork. No one helps each other. If someone finishes their work they do not help out those who haven't". Another staff member said "the managers keep saying it will get better but it's not". Other staff were more positive and said "It is better now with the new managers. They will help if they think you need help. I do feel supported by them. They are trying to do activities. It's smoother running". They added "[Name manager] has cleaned things up there is a rota (for cleaning) it's much cleaner now". All the staff stated the managers were very nice and that they would support the staff if needed. The small number of permanent staff told us they felt under pressure because they were "always working with agency". The provider's managing director had attended a staff meeting in January 2016. The minutes of this and other staff meetings were seen and showed the managing director and operations manager were aware of many of the issues we identified and were supporting the temporary manager to rectify these.

The provider had a formal quality monitoring and assurance system. The first formal audit was completed in January 2016 by the provider's quality monitoring team at the request of the temporary manager. The audit had identified significant improvements were required. Subsequently a further audit had been completed in May 2016 which had showed a significant improvement but that further improvements were still required. We were provided with the home's current action plan which detailed what action was required and who would be undertaking this. The actions identified covered issues such as choice, meeting healthcare needs, person centred care planning. This showed the provider was seeking to improve the service. The temporary manager described how they had invited the local authority contracts monitoring and infection control team to visit the home. They also described how they had requested involvement from external health

professionals for advice in respect of people who were placing themselves and others at risk. This demonstrated an openness to the service.

The provider had other quality monitoring systems in place such as monitoring incidents and accidents and complaints. However, they had not identified that CQC was not being notified of all incidents and a relative said they had not been formally responded to following making a complaint. The provider had not ensured that people were at the heart of the service such as involving them in key decisions about the appointment of new staff.

The failure to assess, monitor and improve the quality and safety of the service provided was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 17 Good Governance.

The temporary manager described their goal as being to "move past the current issues facing the service, such as recruitment, and develop a high quality consistent staff team to provide a safe home for people living there". They identified the key need to ensure people had "adequate activities, recruit more drivers and offer choices". Between the two days of the inspection visits the managers took action to address some of the issues we identified to them on the first day. When we identified safety concerns about the environment the manager arranged for these to be rectified immediately, however they had not identified the concerns themselves. The temporary manager described improvements they had made such as introducing cleaning schedules and audits. They told us they had also recently introduced keyworkers and this would be further developed when the staff team was at full strength.

The home's managers were supported by an area manager who stated they visited the home several times per month and had telephone contact with the managers at other times. They attended the home on both days of the inspection and clearly knew the people who lived there and the provider's recording systems. They stated a commitment to improving the service and ensuring people's safety.

The home had links within the local community. People attended the local church for coffee mornings and accessed local day services for people with learning disabilities. The home was within a short walking distance of a local high street and we were told people would go to the local shops or get local takeaway meals.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not notify us of allegations of abuse involving the people who used the service. Regulation 18 (1) and 18 (2) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person has failed to ensure the care people received reflected their preferences and choices. Regulation 9 (1)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The registered person has failed to ensure people are treated with dignity and respect. Regulation 10 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person has failed to ensure people's health care needs are known and met. Regulation 12 (a), (b) (i).

Regulated activity	Regulation
Accommodation for persons who require nursing or	Regulation 13 HSCA RA Regulations 2014

personal care	Safeguarding service users from abuse and improper treatment The registered person has failed to ensure people are kept safe and protected from abuse and that their legal rights are protected. Regulation 13 (1)(2)(5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person has failed to assess, monitor and improve the quality and safety of the service provided and ensure that records are kept securely. Regulation 17(1)(2)(a)(d).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person has failed to have sufficient numbers of suitably skilled and experienced staff. Regulation 18 (1).