The Regard Partnership Limited

Ivers

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Ivers is a care home for up to 25 people who are autistic or have a learning disability and/or a physical disability. The service had previously been a college for people with a learning disability but no longer operated as such. It is a large service with several properties on one site. 'The House' can accommodate nine people; there were also four bungalows, Tyneham, Crantock, Kenley and Trafalgar, that could each accommodate four people. There were 21 people living at Ivers when we visited.

People's experience of using this service and what we found
People had been hurt by a person living at the home; staff had not been able to take action to prevent it. Staff said they lacked training and said they and other people who lived in the home were not always safe.

There was no effective oversight or management of incidents which had occurred. As a result, staff were placing themselves and others at risk. Incidents recurred and people were harmed.

People's care needs, risks and behaviours were not always properly assessed or planned for. Care plans and risk assessments were not being followed consistently. There were generally enough staff to support people, but staff had not always been trained to ensure people's safety or meet their needs.

People were not consistently supported to express their views and be actively involved in making decisions about their care and support. People's privacy, dignity and independence was not consistently respected and promoted.

People's concerns and complaints were not always listened to, responded to or used to improve the quality of care.

The provider and the management team had failed to ensure a positive culture that was person-centred, open, inclusive and empowering. The service did not consistently achieve good outcomes for people.

There was poor oversight and governance of the service. The provider failed to complete effective audits of the service; they had not identified all of the significant concerns we found during our inspection.

The registered manager and provider failed to meet their regulatory requirement to notify us of safeguarding incidents and in being honest and open when things went wrong.

Following the inspection we met with the local authority safeguarding team to discuss our concerns. They took immediate action to ensure people and staff were safe. We also wrote to the provider's 'nominated individual' (the person responsible for supervising the management of the service) to make them aware of our concerns and to ensure they would take immediate action to improve the service. An experienced interim manager began working at the home on 16 July 2021.

People were treated with kindness and compassion. Staff were dedicated and caring. People told us they liked the staff and they were kind to them.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right Support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

This service was not able to demonstrate how they were meeting some of the underpinning principles of Right Support, Right Care, Right Culture.

Right support:
• The model of care used at Ivers did not fully maximise choice, control and independence for autistic people or those with with a learning disability. The National Institute for Health and Care Excellence (NICE) recommends residential care 'should usually be provided in small, local community-based units (of no more than six people)'. The environment, with 21 people with different needs and abilities living on one large site, was not ideally suited to the needs of people with learning disabilities or autism. We had registered this service under the new provider's registration despite it not being in accordance with the NICE guidance. People were not able to have maximum choice or control over their lives.

Right care:
The care and support provided did not always meet the needs of people with learning disabilities. Staff did not receive the training needed on how to meet the needs of people with learning disabilities and autism, so they did not have the skills they needed to provide appropriate support. This was made worse because of heavy reliance on agency staff which meant people did not always receive care from staff they knew and trusted. Where staff were inexperienced or unfamiliar with people's needs, this had a negative impact on the quality of care.

People's care wasn't person centred, or planned with people having choice and control over how their health and care needs were met. Care plans were not consistently followed. People were not always cared for in a safe and consistent way.

Right culture:
• The ethos, values, attitudes and behaviours of leaders and care staff did not always ensure people with learning disabilities led confident, inclusive and empowered lives. This was because there was a lack of leadership and oversight. The service was not person centred, open and inclusive nor did it always achieve good outcomes for people. People's human rights were not always respected; people had been harmed and others put at risk.

Rating at last inspection
The last rating for the service under the previous provider was Requires Improvement, published on 7 September 2020.

Why we inspected
This service was registered with us by this provider on 25 September 2020 and this is the first inspection.

We looked at infection prevention and control measures under the 'Safe' key question. We look at this in all

care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection.

We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, safeguarding service users from abuse and improper treatment, premises and equipment, good governance, staffing, duty of candour and notification of other events 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.

Special Measures
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 their 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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service effective? The service was not effective. Details are in our effective findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Ivers

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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of care service. The inspectors visited the home on 13 and 15 July 2021. The Expert by Experience made phone calls to relatives of people who lived there. They spoke with eight relatives.

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

Notice of inspection
This inspection was unannounced.

What we did before the inspection
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 reviewed all information we had received about the service since the last inspection and took this into account when we inspected the service and made judgements in this report. We also used this information to plan our inspection.

During the inspection
We met 12 people who lived at the home and had conversations with eight of them about their care and support. We spoke with 13 members of staff including the regional manager, the registered manager, one deputy manager and care staff.

We reviewed six care records, six medicine records and seven staff files in relation to recruitment, induction training and staff supervision.

After the inspection
We asked the provider to send us additional information. This included three people's care records and risk assessments, quality assurance audits, a compatibility assessment, copies of staff rotas, staff training records, staff meeting minutes and incident reports. We met with the local authority safeguarding team to discuss our concerns. We also wrote to the provider's 'nominated individual' (the person responsible for supervising the management of the service) to make them aware of our concerns and to ensure they would take immediate action to improve the service. An experienced interim manager began working at the home on 16 July 2021.

Inadequate

Is the service safe?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse

- People were not safeguarded from the risk of harm; people and staff had been harmed.
- One person at the service had hurt other people. They had physically assaulted, hit and bitten staff, destroyed property and had attempted to gain entry to another person's room which frightened this person; incident forms confirmed this. Incidents had happened both in the home and whilst out in the community.
- Staff told us people who lived at the home and staff were "terrified" of this person. This was a term we heard repeatedly during our visits. None of the staff directly employed were prepared to support this person. They did not feel safe in doing so.
- Relatives did not feel people were always safe. One relative said there had been, "A number of safeguarding incidents" and "[name's] and the other's best interests had not been considered."
- Incidents between people were not always reported to the local authority safeguarding team or to the Care Quality Commission (CQC). We read incident reports which were kept in the home. Some of these incidents should have been reported to safeguarding and to the CQC but had not been.
- When people made allegations about staff this was not always reported. One person raised a safeguarding issue with us about one member of staff on the first day of our inspection. We reported this immediately to the registered manager and the local authority safeguarding team. This person told us they had made complaints about this staff member before but felt nothing had changed.
- The registered manager was unclear whether any restraint on one person had occurred. They had failed to follow up incident reports properly to establish exactly how staff had responded to an incident. The regional manager told us, "This raises a number of questions of which I am following up on through an internal investigation process." The provider's investigation found that no restraint had taken place.

The provider had failed to protect people from abuse and improper treatment. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Learning lessons when things go wrong. Assessing risk, safety monitoring and management

- Systems to monitor incidents which occurred in the home were not effective. We read records where serious incidents had occurred. The registered manager had not looked in detail at what had happened and how staff had responded. This meant managers at the home were not able to ensure staff were keeping people safe or that they were following people's risk management plans. Therefore, the provider could not learn lessons and improve the quality or safety of the service.
- Records described recent incidents where a person had assaulted staff and other people who lived in the home. A staff member had recorded they had tried to "hold" the person to stop their behaviour. This was not in the person's care plan and the staff member had no training to do this.

● In another report a staff member "Left [name of the person assaulting them and others] and went to the office for their own safety" during an incident where they and another person living at the home were assaulted.
● The registered manager signed off incident reports but did not always follow up any issues with the staff involved. When we discussed the lack of follow up when one serious incident occurred the registered manager told us "I must have missed that on the forms. I didn't take any action about that." Consequently, there was no information about how to avoid this happening again in the future which left people and staff at significant risk.
● The provider advised us on 21 July 2021 that this incident had been followed up and the staff member now said they had not held the person. They said they had guided them instead. However, this had taken approximately two months to follow up and the person was left at risk during this time.
● Relatives were concerned about lessons not being learnt and felt they were not listened to when things went wrong. One relative told us, "I feel there's a culture of blame. The management blame the care staff, not supportive of the care staff. I don't know who to trust." Another said, "I don't think they are interested in what parents have to say [when things go wrong]."

We found evidence people had been harmed. The provider had failed to adequately assess and monitor 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.

Preventing and controlling infection
● The provider had not ensured that COVID-19 government guidance for protecting people from infection was implemented and followed consistently. Infection prevention and control audits had not taken place and records in relation to cleaning schedules were not completed to ensure good infection control practice.
● Guidance during the COVID-19 pandemic states areas regularly touched should be regularly cleaned to prevent cross infection. Staff were required to undertake cleaning tasks, including 2-hour frequent touch point checks, such as light-switches and door handles. We reviewed the cleaning records in 'The House' and found they had not been completed since 6 June 2021. Night cleaning checks had not been completed since 6 May 2021. A staff member informed us, "We have to do the cleaning, touch areas should be done every two hours; this is not happening. We have raised our concerns, but nothing gets done."
● We discussed our concerns with the registered manager in regards to infection control at the service. They were unable to identify when any audits had been completed in regards to cleaning schedules.
●We were not assured staff were using Personal Protective Equipment [PPE] correctly to reduce the transmission of infection. In the main house there was only one bin to dispose of used PPE, which was located by the front door. Staff informed us they had to carry used PPE through the home to dispose of it. We were informed by the provider, following the inspection, that in the event of any suspected or confirmed cases of COVID-19, there would be separate waste disposal procedures put in place to reduce the likelihood of any cross-contamination.
● PPE was not always worn in line with guidance. We saw some staff were not wearing their masks properly; these were pulled down below their chin. One member of staff told us, "I feel anxious and a little bit at risk to be honest. The staff normally wear their mask under their chins." The provider's own audit completed on 9 June 2021 stated: "Not all team members wore their masks properly. Five team members seen not wearing their PPE appropriately." This had to be improved within four weeks; this had not been improved when we visited five weeks later.

The provider had failed to mitigate the risk of infection transmission and had not implemented guidance to manage COVID-19. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social

Care Act 2008 (Regulated Activities) Regulations 2014.

● A visiting procedure was in place in regards infection control. The signing in book showed visitors were asked to follow infection control processes on arrival at the service, including taking a lateral flow test. Relatives confirmed they completed checks when arriving at the service, but this was not consistent. One relative said, "We don't really know what the rules are, they tell us one thing but when we arrived to visit it was completely different."

Using medicines safely

● Risks in regards passing medicines to staff not employed by the provider had not been assessed. Staff informed us they gave one person's medicines to workplace staff when this person went to work. The provider's staff often did not know who they were passing the medicines to. We discussed with the regional manager who took action to mitigate this risk.

● Medicines were otherwise safely managed. Staff who supported people with their medicines had been trained to do this in a safe way. One person explained to us they took some responsibility for their medicines and showed us how they kept them in a safe place. Staff gave them their medicines which they were then responsible for taking. They knew exactly what medicines they took and what they were for. They told us they always received their medicines when they needed them.

● Relatives spoken with said that the medicine protocols and safeguards in place were complied with and they had no concerns with the safe handling and administration of medicines.

● People had their medicines stored in their bedrooms. Staff made sure medicines were stored safely. Daily checks were taken to make sure medicines were kept at a safe temperature. We reviewed four people's medicine administration records (MAR) and found there were no gaps in the records.

Staffing and recruitment

●There was a high level of staff sickness at the service and a reliance on agency staff. Comments from staff included, "Staffing levels are really short at the moment and we rely on agency staff" and "We plan trips out, but we also have to take people to work, so the trips don't often get started in time."

● Several relatives told us they were concerned about the high use of agency staff, and their family members not receiving the support they needed. One relative said, "I found [name] sat in the home at the weekend, the hottest day of the year, with one carer. [Name] is funded for two to one support and they had used one of his carers to accompany the other residents [on a trip out of the home]. I'm just so upset about this."

●New staff were recruited in a safe way. Staff recruitment records showed pre-employment checks were carried out before staff joined the service, including checks to ensure people were suitable to support vulnerable people. Gaps in employment were explored and documented.

Inadequate

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.

This is the first inspection for this newly registered service. This key question has been rated inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The management team should complete a thorough assessment before each person moved to the home. This was to ensure they were able to meet their care and support needs, manage known risks and to ensure the person would be compatible with the people they would share their home with.
- A thorough assessment had not been completed for the person who had moved in recently. This was despite them having very complex needs, and behaviours which could place people already living at Ivers at risk and pose significant risks to staff. Although the registered manager initially told us an assessment had been carried out, they later informed us it had not. This meant the diverse needs for one person moving to Ivers had not been effectively met. This had placed the person and others at risk.
- Staff told us they had been hurt and felt they had not received effective information or training to keep themselves and others safe. One staff member said, "There was a lot of information that we were not given in regards how to support him safely." Another staff member told us, "Was there even an assessment done? If they thought about how he might affect people already living here, he would never had been allowed to move in. Everyone is terrified of him."
- The outcome for this person was they now had to move to another home as the placement was inappropriate due to the risk to other people in the shared environment. One staff member said, "He should never have been here. We saw immediately this is not the right place for him. Now he has to move home again. It's heart breaking for him."

The provider had failed to carry out thorough assessments of care needs or to assess the impact of new people moving into the home on others to prevent poor outcomes. This was a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support; induction, training, skills and experience

- Staff were not adequately trained and did not have the skills and knowledge and competence that was required to support people effectively.
- People were at risk as they were being supported by staff whose training was either not up to date or had not been undertaken.
- We reviewed staff training records and identified gaps in training for all staff. Staff informed us their training was out of date and that agency staff were supporting people without the correct training to do so.
- Staff were supporting people who had epilepsy, one person who was Percutaneous Endoscopic Gastrostomy (PEG) fed and others with complex care needs. Staff were not supported to maintain their professional skills or encouraged to keep up to date with best practice. One member of staff said, "Not

everyone has had had training in epilepsy or PEG feeding (PEG is a procedure in which a flexible feeding tube was placed through the abdominal wall and into the stomach). It makes staff worried; we have been asking for months for our training to be updated."

● Relatives did not feel staff always had the training they needed. They felt that training in learning disabilities, managing behaviour and sensory issues "was lacking." One relative said, "I would like them to go back to having really good, experienced learning disability carers that really kept the resident's interests at heart." Another relative told us, "There are some carers there who aren't great. They're not experienced."

● One person's care plan identified all staff supporting them needed a wide range of specific training to ensure they had the correct knowledge and skills to keep people and themselves safe. This person's 'transition plan' (a plan to ensure a safe move into the home) stated all staff at Ivers must have this training before this person moved in. We found some key staff had received training; most staff had not. The agency staff who currently supported this person had not completed this training. A senior member of staff who was required to lead and support care staff had not completed this training.

● We discussed our concerns with the regional manager and registered manager who agreed that they had not ensured staff had the correct level of training to prevent them and others being harmed. There was a plan in place to try to catch up with out of date training.

● Staff told us they had supervision meetings with their line manager. Staff told us they did not feel supported and felt supervision was not effective; areas for improvement they suggested or concerns they raised in their supervisions were not acted upon.

The provider had failed to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.

Following our inspection, we shared our concerns with the local authority safeguarding team about the risks to people and staff due to the lack of staff training in how to support one particular person. They took immediate action to keep people safe.

Supporting people to eat and drink enough with choice in a balanced diet.

● People told us they enjoyed the meals provided and they chose what they had to eat and drink from what was available in the home. People chose to purchase their own additional food and drinks as the provider told us following the inspection, "There is not an unlimited budget provided by the funding authorities."

● Some relatives told us they were concerned their family members had gained weight during lockdown. Whilst they understood people were likely to have been less active, they felt not enough consideration was given to healthy meal choices and portion sizes. They felt this had been an issue before the pandemic. One relative said, "If you put food in front of [name], they will just keep eating. Needs someone to help manage how much [name] has." They did not feel this was being done.

● Records showed some people had gained weight. One person's plan was to lose weight by staff encouraging healthier food and smaller portions. One staff member told us, "[Name] is severely overweight. A dietician is involved but there is no consistency here with staff. I work with them everyday and I am not sure what the dietician has even said because the keyworker is not on top of it." This area for improvement was shared with the management team for Ivers, who advised us they have included monitoring this in their improvement plans for the service.

● Staff also told us about one person's weight loss which occurred in 2020; this had been the subject of a safeguarding investigation. Although this process had been completed, we found risks remained as action had not been taken to ensure lessons were learned and staff practice improved and was monitored.

● Staff informed us people used to be involved in cooking and planning their meals, however they no longer

did this. Staff told us the shopping was now completed online by staff and they were unhappy about this. One staff member said, "Some people here loved going food shopping, it was a good activity for them."
●Following the inspection the provider told us, "There had been some changes in the way the shopping was completed at the service, due to the impact of COVID-19. Instead of group visits to the supermarket, the shopping was done online as an interim measure."

The provider had failed to provide people with adequate and suitable nutrition and hydration to ensure good health and reduce the risks of malnutrition. This was a breach of Regulation 14 (Meeting Nutritional and Hydration Needs) 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.

● Some people were clearly aware of their rights and explained to us how they made their own decisions, which were respected. One person said, "I have full control and tell the staff how I wish to be supported." Another person told us, "I make my own choices. Staff do listen to me."
● People were able to personalise their own bedrooms and knew this was their personal space. One person told staff did not enter their room without their consent.
● Staff had an understanding of the MCA and the principles of making decisions in people's best interests.
● When people were not able to make their own decisions, others involved in their care such as family members, made decisions on their behalf. Records of how best interest decisions had been made were in place and kept in people's care plans. Some records had been completed retrospectively, which is not good practice nor in line with the MCA.
● Conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Relatives had mixed views about how people's health care needs were met. They felt support could be inconsistent and plans put in place by other professionals were not always followed or were allowed to stop.
● Staff routinely made referrals to other services and were familiar with health professionals and their scope of support. This included the dietician, speech and language therapy, GPs and epilepsy nurses.

Adapting service, design, decoration to meet people's needs
● People had a wide range of needs. People's individual needs were not consistently met by the adaptation,

design and decoration of the premises.

● People, relatives and staff said people's own rooms were well decorated and personalised. Two people were keen for us to see their rooms and told us they decided how they were decorated and furnished. One relative said staff had, "Really made an effort to make it homely."

● Staff told us the environment worked well for some people, but not for others. Some further adaptations were needed and staff felt they needed to be better at responding to people's needs, for example when people had issues with mobility.

● A number of relatives did not feel their concerns were listened to with regards the environment when it did not meet their family member's needs.

● One relative said, "They are running a home for people with physical as well as learning disabilities. They need to think about safety and access when they are doing any work to the houses."

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.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- One person was very keen to show us how independent they were and how they decided upon the lifestyle they led. They shared a video they had made which explained why they were happy living at Ivers. Another person "loved playing the drums" and showed us their drum kit. They explained how staff had helped them to do this and had helped them learn to play. They also showed us a garden project they had been heavily involved in. They were proud of how nice this part of the garden now looked.
- Relatives had mixed views about how people's independence was promoted. One relative said, "[Name's] achieved so much since they have been there. [Name] has work placements and is more independent." Another relative told us, "[Name] used to help around the house, I think they have become deskilled. [Name] used to help clean and sweep; enjoyed that but doesn't do anything now."
- We saw many positive interactions between people and the staff supporting them. There was lots of laughter, 'banter' and smiling. People were seen laughing and enjoying staff's company. When we spoke with staff, they knew those people's needs well.
- Some people were able to tell us about their interactions with staff. Our observations were completed over a two-day period. Whilst we observed positive interactions, there was a difference in the experiences for people living at Ivers. For example, those more able were able to share how their individualised interest and needs were being met. Others appeared to only have group interactions, even when receiving one to one support.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff were observed to treat people with kindness and respect. People told us they liked the staff and they were kind to them. One person told us, "The staff know me well and know how to support me if I am anxious".
- Relatives spoken with said most staff did their best and were caring and respectful. One relative said, "Some of the care staff are excellent. [Name's] current keyworker is fantastic; she's kind and respectful and like an extended member of our family." Other comments included, "The staff that care for [name] are lovely, they're always very welcoming" and "The care staff do the best job they can, but they're always running on low staff and many of them are agency."
- There were some very relaxed, friendly and kind interactions between staff and people living at the service. However, there were times at the service when people did not feel supported or treated with respect. For example, one person told us they sometimes felt scared and worried by another person living at the service.

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

● Staff encouraged people to make decisions about their care when they could such as what they had to eat and how they spent their time.

● People who could communicate verbally and those who could advocate for themselves were listened to. However, it was not clear how people who used adapted communication were involved in decisions about their care. For example, most staff were not able to use sign language so were unable to communicate effectively with people if signing aided communication.

● Relatives told us they did not feel involved in care planning discussion to help make decisions about how staff should provide person-centred care to their family member.

Requires Improvement

Is the service responsive?

Our findings

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

This is the first inspection for this newly registered service. This key question has been rated 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; 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

● People's care records contained sufficient detail about them, including how they were to be cared for and any risks associated with their care. One person told us they had developed their care plan and told staff how they wished to be supported.
● Relatives told us although their family member had a care plan in place, they had not been involved in updating them. Staff spoken with, including agency staff, told us they read people's care plans.
● Relatives remained concerned about their family members not going out or becoming bored. Several relatives told us activities had been cancelled in the past on a regular basis due to staff shortages, even when people had one to one support. Comments included: "Often [name's] activities were cancelled with no good reason why. I think it was due to lack of staff although they have one to one funding."
● Some people had developed friendships with their peers. We saw that some people were happy spending time together and some went out together. Some people did not get on with others, including some people who currently lived together. This issue had been highlighted in the provider's recent 'compatibility report'. The provider was planning to act on this report's findings.
● Relatives said there was confusion around the role of the keyworker in keeping them up to date and informed. Some said they continued to receive regular contact; others told us care staff had been told they were no longer permitted to contact the families directly or use their personal equipment. This meant that some relatives did not have any contact with their family member for several weeks during lockdown when they were unable to visit. One relative said, "Communication has been really weak throughout the pandemic."

Improving care quality in response to complaints or concerns
● The provider had processes to investigate and respond to complaints and any concerns raised, even if they were raised informally. Records showed that no formal complaints had been made.
● People living at the home had mixed views about how their concerns were handled. Some were happy and felt they were listened to; others felt no action was taken or they had to raise issues several times.
● All staff spoken with (other than the registered manager) said their concerns were not listened to and no action was taken to improve things.
● Relatives said they approached care staff to raise any minor issues because it was difficult to raise an issue with the registered manager due to "lack of accessibility, responding to their call or taking any action or implementing change."

● Some relatives told us they were reluctant to raise concerns or complain. One relative explained they worried about escalating any complaints in case it impacted on the carers. They said, "I did worry about saying anything in case it got the carers in trouble."

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.

● Some people were able to communicate using speech. One person was able to show us how they are involved in making decisions about their care, they informed us they had completed their own communication book and written their own support plan.

● Care records contained information about people's communication needs. Although staff knew people well, we did not see any evidence of them using communication methods such as Makaton (a form of sign language) to help people communicate their needs and choices.

● The provider's compatibility assessment completed in June 2021 confirmed 10 people living at the home were either able to use sign language to communicate or had shown an interest in using it. Other methods people would benefit from included picture exchange and social stories (a tool to help people better understand the nuances of interpersonal communication).

● Staff told us people's communication needs were not being met as they did not have the training to meet these needs. One member of staff told us, "Most people here need staff to be able to sign, we have only had the basic sign training which is not nearly enough for us to be able to communicate with people. We rely on (person's name) to tell us what others are signing".

● Staff told us they would welcome and would benefit from additional training in communicating with people who have a learning disability. The provider had provided communication training in the past but most staff who had been trained no longer worked at the home.

We recommend the provider reviews the Accessible Information Standard and all relevant good practice guidance in respect of supporting people who use adapted communication.

End of life care and support

● A memorial garden had been installed at the service to support people in their grief following the passing of a person who lived at the service in 2020.

● No one was receiving end of life care when we visited.

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.

This is the first inspection for this newly registered service. This key question has been rated 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- There had been a significant lack of effective management over a considerable period of time. This had adversely impacted on the care people received, their safety and the safety of staff.
- During the inspection, we found multiple breaches of regulations. These failings demonstrated there were widespread and significant shortfalls in the way the service was led.
- There was no effective system for analysing, investigating and learning from incidents. This failure meant opportunities had been missed to identify ways of preventing future incidents, and exposed people to the risk of continued distress or harm.
- Some incidents which should have been reported to the CQC and to other agencies, such as the local safeguarding authority, had not been reported. This meant that we had been unable to check that action had been taken to keep people safe.
- Relatives were extremely critical of the management of the service. Comments included: "There's poor leadership, apathy and at times malaise", and "The current manager is weak, there's a lack of vision and imagination from the top."
- Staff spoken with had lost confidence in the management of the home. They said there was a lack of care and consistency and communication was very poor. The service was not well managed and was disorganised.
- The little confidence which remained was in the assistant managers. Staff did offer praise for the support and guidance they had received from the assistants and hoped this could be built on. One staff member said, "[Name of assistant mangers] will come around and check you are ok. If they are not here though, no one comes." One relative told us, "I rate the new house manager [an assistant manager] quite well; she's trying her hardest."

Continuous learning and improving care

- There had been a complete lack of oversight and governance from the registered manager and the provider.
- The registered manager failed to identify risks or act upon risks reported to them by staff. This included known risks relating to people's behaviour, health and wellbeing.
- The registered manager and provider failed to monitor and improve the quality and safety of the service. The registered manager and provider failed to identify and act on the issues within the service.

The provider had failed to consistently assess, monitor and mitigate risks to people's health, safety and welfare. The provider had failed to improve the quality of the service. This was a breach of Regulation 17 of the Health & Social care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to notify the CQC of safeguarding incidents. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Following our inspection, we alerted the local authority safeguarding team to raise our concerns about people's safety and the safety of staff. They took immediate action to safeguard people. We also wrote to the provider's 'nominated individual' (the person responsible for supervising the management of the service) to make them aware of our concerns and to ensure they would take immediate action to improve the service. An experienced interim manager began working at the home on 16 July 2021.

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 registered manager was not completely honest and open with us during the inspection. For example, instead of telling us immediately no assessment had been carried out for a person who recently moved in, they promised to send us the assessment for three consecutive days after we requested it. It was only after we chased this several times, they admitted no assessment had been done.

● Staff told us they had raise concerns in both staff meetings and supervision meetings when things had gone wrong or where they had other concerns about people's safety and their own safety. Staff told us these were not acted upon. Records showed staff had reported their concerns. When we discussed these concerns with the registered manager during the inspection, they were not aware of any of these concerns and had therefore taken no action to address them. The provider's own audit completed on 16 June 2021 concluded "There have been issues raised by staff that need evidence of follow up."

● Relatives did not feel there was always honesty and openness when things went wrong. One relative said, "I don't feel the management are ever open or transparent." Another relative shared several safeguarding incidents with us. They concluded, "[Name] had been attacked by another resident. I felt the management played down these incidents. I felt I was being fobbed off."

● The provider acknowledged the serious shortfalls identified at this inspection and were eager to put processes in place to ensure people receiving care and support were safe and protected from harm.

The provider had failed in their legal responsibility to be open and honest with people when something goes wrong. This was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Care was not always person centred and people were not always cared for in a safe and consistent way.

● Managers in the home could not always intervene or guide staff to ensure people received care that met their personal needs.

● Relatives did not feel the service was person centred, open and inclusive nor did it always achieve good outcomes for people. One relative said, "The manager often says things are going to happen, but they never do. They never follow anything up, you know nothing will be done." Another told us, "It [the service] was amazing when [name] first moved in but went downhill rapidly when Regard [the new provider] took over. I think [name's] still happy there. It's hard to tell, but I know [name] used to be happier."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics. Working in partnership with others.

● There was a lack of consistent, collaborative working with stakeholders. The registered manager appeared insular, and this placed people at risk of harm.

● The registered manager was not always open and honest with other healthcare professionals. For example, information provided to the local safeguarding authority about the staff supporting one person omitted that these staff had not been trained to support this person in a safe and effective way.

● Some more independent people living at the home told us they felt in control of their service and were very proud in showing us how they had help design their care and support. For people with more complex care needs, it was not clear how they had been involved in planning and reviewing their care.

● Relatives did not feel involved or listened to. One family member felt they had been labelled as a 'difficult' parent. They told us, "Whenever I pick up the phone you get a sense of 'oh no, what have we got to deal with now'." Another relative said, "If I had to, I would contact the manager but actually feel it's a waste of time."

● Three family members told us they had approached the home's management with an interest in starting a 'parent's group' for the parents and carers of people living at Ivers. They said this idea had never been taken forward.

● None of the staff spoken with felt involved in decision making; they said their views were ignored. One staff member said, "We keep saying things, but nothing ever happens. Staff have completely lost confidence in it all now." Another staff member told us, "We as staff try to do things, but we are not supported. They don't want to hear what we have to say."

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 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to carry out thorough assessments of care needs or to assess the impact of new people moving into the home on others to prevent poor outcomes. This was a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to provide people with adequate and suitable nutrition and hydration to ensure good health and reduce the risks of malnutrition. This was a breach of Regulation 14 (Meeting Nutritional and Hydration Needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour The provider had failed in their legal responsibility to be open and honest with people when something goes wrong. This was a breach of Regulation 20 (Duty of Candour) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to give staff appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulation.