Four Seasons Homes No.4 Limited

Ivyhouse Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

This unannounced inspection was undertaken on 25 and 26 January and 03 February 2016. Our last inspection in September 2015 found that the care and support people living at Ivyhouse experienced was inadequate. Following the inspection we met with the registered provider and commenced using our enforcement powers. The registered provider sent us an action plan detailing how they would improve to ensure they met the needs of the people they were supporting and their legal requirements. This inspection identified that while some improvements had been made, these had not been adequate to ensure people consistently received good, safe care. We identified some serious concerns for the welfare of people whose care we looked at in detail.

The overall rating for this service is 'Inadequate' and the service was placed in 'Special measures' following our last inspection. The service remains in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the

Summary of findings

provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms 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.

Ivyhouse provides both nursing and residential care with accommodation for up 76 people in four separate units. People living at Ivyhouse all had needs relating to their older age, and some people were also living with dementia. At the time of our inspection there were 65 people living at the home.

When we visited the home there wasn't a registered manager in post. 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. In the absence of a registered manager Four Seasons (the registered provider) had arranged for other managers from within the organisation to take day to day control of the home. The registered provider was in the process of recruiting to the role of home manager with the intention of the successful applicant also applying to become the registered manager.

People had not consistently received safe care and support. Some elements of clinical monitoring and nursing care had been omitted for all of the people whose care we looked at in detail.

We observed and received feedback that the number of staff on duty were not adequate or being used effectively to ensure people's safety and well being or that their care and support needs were met promptly.

An audit of medicines management showed that people had not always had their prescribed medicines in the way the Doctor had prescribed. People could not always be certain the medicines they required to manage or relieve their symptoms would be available for staff to administer.

People did not benefit from a home that had been effectively cleaned and maintained to a good standard.

The Mental Capacity Act 2005 applied to some people living at the home. Although staff had received training about the act, they were not all able to apply the learning to their practice. The human rights of some people who were deprived of their liberty were not always protected as applications had not always been made to the relevant supervisory body.

A range of meals and snacks were provided throughout the day. Some people told us they enjoyed the food and other people told us they didn't. People did not always receive the support they required to have an enjoyable dining experience, and people who required a special diet to meet their medical or cultural needs did not always have the necessary food or snacks provided.

We received positive feedback about the compassionate care and kindness shown by certain members of staff. We observed warm and supportive staff interactions that were well received and which brought comfort and happiness to people. However we also observed some staff practice that failed to maintain people's dignity or respect people's right to confidentiality and privacy.

We looked at the action taken in response to complaints. There was evidence that concerns raised had been investigated and complainants had received detailed feedback. People we spoke with had mixed experiences of how effective their complaints had been. Some people told us changes had occurred and they were satisfied, and other people were frustrated that the matter they had raised had not been resolved.

We received consistent feedback that the opportunities for people to partake in activities that would provide

Summary of findings

stimulation and the chance to mix with other people were unacceptably poor. We observed one, isolated recreational opportunity in the three days we were in the home.

Leadership at Ivyhouse had been inconsistent and in some areas ineffective. There had been numerous changes of registered manager in recent years. At the time of our inspection there were a significant number of leadership posts vacant within the home, including the position of registered manager. The registered provider had taken action to provide temporary management cover in all areas affected, and had moved people with relevant skills and experiences from other homes within the organisation.

The governance and leadership of the home had been ineffective. Audits and checks had failed to find and fix issues, which had resulted in people receiving care that had failed to fully meet their needs or had failed to protect them from the risk of harm. The providers action plan had not driven change and improvement at the required pace, and while changes had occurred the home these had not improved the home sufficiently for it to be removed from 'Special Measures.'

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

People had not consistently received nursing care that kept them safe from the risk of harm.

There were not enough staff in the right place at the right time, to meet people's support needs.

Medicines were not managed safely or always given as prescribed.

Inadequate

Is the service effective?
The service was not effective.

People were not consistently supported with their nursing and care needs to ensure the best possible health outcomes.

People were not protected by staff who effectively and consistently applied the Mental Capacity Act 2005.

People were not always supported to have a pleasant meal time experience. Food options and the availability of food for people who required a special diet to meet their cultural, religious or medical needs were limited.

Requires improvement

Is the service caring?
The service was not consistently caring.

Individual staff were observed supporting people with kindness and compassion.

People could not be certain their dignity or right to confidentiality would always be upheld.

Requires improvement

Is the service responsive?
The service was not consistently responsive.

People were not provided with the opportunity to undertake activities that they liked, provided stimulation and reduced the likelihood of them becoming socially isolated.

There was a complaints procedure and although complaints were investigated and responded to, people reported variable experiences of how effective this process had been.

Requires improvement

Is the service well-led?
The service was not well led.

The service had not benefited from consistent or effective leadership.

Inadequate

Summary of findings

Audits and action plans had not been effective at identifying areas for development or driving forward improvements at the pace required.	

Ivyhouse Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the 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 unannounced inspection took place on 25 and 26 January and 3 February 2016. During the first two days the inspection was undertaken by two inspectors. One inspector returned on the third day to complete the inspection and provide feedback.

In preparation for our inspection we looked at the information we already had about this provider. We also spoke with service commissioners (people who purchase care and support from this service on behalf of people who live in this home) to obtain their views.

Providers are required to notify the Care Quality Commission about specific events and incidents that occur including serious injuries to people receiving care and any safeguarding matters. Appropriate notifications about such events had been sent by the registered provider. However we had not been informed of changes in the management of the home as is required.

During the inspection we spent time on all four of the units within the home. We used the Short Observational Framework for Inspection(SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk to us.

During our inspection we met all of the people using the service. We spoke at length with some people, and other people we just met to assure ourselves they were comfortable. We spoke with eight relatives of people living at the home and spoke at length with six members of staff and four members of the interim management team. During and after the inspection we spoke with six healthcare professionals.

We spent time observing day to day life and the support people were offered. We looked at records including some parts of five people's care plans and medication administration records to see if people were receiving the care they needed. We sampled staff files including the recruitment process. We sampled records about training and the provider's quality assurance and audit records to see how the quality and safety of the service was being managed.

Inadequate

Is the service safe?

Our findings

We last inspected this service in September 2015. At that inspection the registered provider was not complying with the requirements of the law or ensuring people were consistently receiving safe care. The registered provider submitted a plan telling us the actions they would take to address these issues.

At our latest inspection we identified that while improvements and changes had occurred these had not been adequate to achieve compliance with the regulations or to ensure people's needs were consistently met. We are now considering what further action to take and will report on this when the action is complete.

People did not always receive nursing care that kept them safe from the risk of harm. On the first day of our inspection we met all of the people living at Ivyhouse and sought assurance that people were comfortable, safe and had received the care they required. These checks identified that some people had sustained injuries that staff had failed to notice or act upon. The injuries had not all been reported or recorded. We found that people who had known risks including developing sore skin had not all received the care and support they required to prevent a breakdown of their skin occurring. Some people had risks associated with not going to the toilet regularly. Staff had made detailed recordings as was required but action had not been taken when the person had started to show signs of constipation. Some people required help to move safely. We observed staff planning and delivering care that was not consistent with a detailed assessment undertaken by professionals with specialist skills and knowledge about moving people safely. Nursing staff had not always accurately assessed, planned or nursed people in the way their health conditions required. Essential clinical monitoring and nursing care had been omitted which had placed people at risk of harm. This is a breach of the Health and Social Care Act. Regulation 12.

We spent time observing the running of the home, and noted that staff were very busy in all four units. We observed people were often unable to attract the attention of staff as they had no means of calling for assistance when staff were working outside the area they were in; people waited long periods of time for assistance to use the toilet and staff did not have time to offer any engagement or activities. We observed two staff explain that they were about to move a person to their room as requested. They then walked away and didn't return to the person for the duration of our observation. The person was left confused and upset as they had not been supported in the way they requested and had expected. The majority of people we spoke with raised concerns about staffing. Comments from people using the service included, "I need to go the toilet. No one has come so I will try to hold it", "Today there are only two on[referring to the number of staff.] I don't have many care needs so I can wait but some of the others suffer", and "I take tablets that make me go to the toilet a lot. The girls don't always have time to take me, so they put me in pads." People visiting the home told us, "They are a nice group of girls [referring to the staff team] but people are regularly asked to wait for the toilet and their personal care" and "It usually takes a long time to find a member of staff that knows about my relative's needs."

We spoke with the staff managing the home about these comments and our observations. They were able to demonstrate that a formula had been used, which calculated the numbers of staff required depending on the needs of the people in the home. This had been kept under review and changed when the needs of people increased. While this document provided written evidence that the number of staff on duty were adequate to meet people's needs our observations and feedback from people failed to show that the correct numbers of staff were available to provide people with the support they required. Failing to supply adequate numbers of staff to meet people's needs is a breach of the Health and Social Care Act. Regulation 18.

We looked in detail at the management of medicines on Cornflower Unit. We looked to see if people were getting the medicines they had been prescribed at the correct time and in the correct dose. Our audit identified numerous errors when people had received too much or too little of their prescribed medicines. We observed that staff had not always signed to confirm they had given a medication. Staff who had given medicines in subsequent medicine administration rounds had failed to identify these errors or to seek confirmation that medicines had been given. We were unable to confirm that people always had access to the medicines that had been prescribed for them. One person whose care we looked at in detail had been prescribed medicines to relieve the symptoms of their illness. We were unable to confirm that these medicines

Inadequate

Is the service safe?

had always been available within the home. Failing to have these medicines could have resulted in the person experiencing an increased number of distressing symptoms.

Some people needed medicines on an, 'As and when' basis, [PRN], but there were not always guidelines in place to direct staff on how and when to use these medicines correctly. This could result in inconsistency or medicines being used differently to the way the prescriber had intended. People who were able to manage or administer their own medicines had not been assessed to ensure they could do this safely.

We found evidence that two people required their medicines to be administered covertly. [Hidden in food or drinks]. This had not been planned or undertaken in line with good practice guidance to show this was in the person's best interest, or that all other options had been considered and discounted. Failing to properly and safely manage medicines is a breach of Regulation 12 of the Health and Social Care Act 2008.

We observed staff administering medicines. Staff wore a tabard that made people aware they were administering medicines and were to be left alone to concentrate on the task. This was respected by staff, and was a way of decreasing the risk of a medicine error occurring. We heard some nurses explain to people what the medicine they had was for and gave people reassurance and drinks to help them take their medicines. The process was unrushed and we saw the nurses often used this as an opportunity to enquire about the person's day or wellbeing.

At our last two inspections we had raised concerns about the standard of cleanliness within the home. This inspection identified that some progress had been made and the general standards of cleanliness and the management of unpleasant smells had improved. At our last inspection we identified that some people's bedrooms had not been adequately cleaned and we found food and drink residue on people's bedroom floors and furniture. At this inspection we re-visited the same bedrooms, and found that effective cleaning had still not taken place. In Daffodil unit we observed that some specialist chair cushions were visibly dirty. When we looked closely at them, we found they had been soiled with urine. This soiling had not been identified by staff or in audits of infection control and the cushions had been placed on chairs ready for people to sit on. All these issues had been brought to the attention of the provider at previous inspections. Failing to maintain the premises and equipment in a clean and hygienic condition is a breach of the Health and Social Care Act 2008. Regulation 15.

We asked people and their relatives if they felt safe. Feedback was varied. Some people using the service told us they, "Felt happy", and that they liked the staff who supported them. However these people also described their frustrations with their care. Relatives we spoke with told us they didn't feel that any individual staff would harm their loved one, but did describe risks to people's safety associated with a lack of staff, and a lack of staff who specifically knew their relative. Professionals we spoke with echoed this. They confirmed they had no concerns about abusive practices but they described risks to people's safety associated with a lack of staff continuity, staff supervision and staff that knew how to meet people's more complex care needs.

Requires improvement

Is the service effective?

Our findings

We last inspected this service in September 2015. At that inspection the registered provider was not complying with the requirements of the law or ensuring people were consistently receiving effective care.

The registered provider submitted a plan telling us the actions they would take to address these issues. At our latest inspection we identified that while improvements and changes had occurred these had not been adequate to achieve compliance with the regulations or to ensure people's needs were consistently met. We are now considering what further action to take and will report on this when the action is complete.

Some of the people we met at Ivyhouse had needs that required staff to apply the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). We looked at the support given to people living on Daffodil unit relating to this area of their care. The staff we spoke with were unable to tell us about DoLS and were unable to tell us who in the unit was having their liberty restricted. The unit manager was aware of the need to make applications for people but at the time of inspection was unsure how many applications had been made and who these were for. No record of the applications made could be found within the unit, and the unit manager had to locate a copy of applications made that was stored in the boot of their car. The combination of these findings did not provide evidence that people would receive person centred care, that would protect their human rights or that was appropriate to their needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008.

For another person whose care we looked at in detail, we found that a potential deprivation of the person's liberty had been identified and an application made promptly. Staff we spoke with were aware of this, and we observed staff providing appropriate support to the person.

Some people living at Ivyhouse were at risk of not having enough to eat or drink. We looked in detail at the food and drinks offered to and consumed by people who had been assessed to be at risk. Records showed that regular drinks, meals and snacks had been provided. People had been weighed as another way of ensuring they were having enough to eat and drink. These records showed people's weight had mainly been stable. In Rose unit records showed a person had dropped a significant amount of weight in a short period of time. It was of concern that staff had not confirmed this, sought professional advice or reviewed the care plan. We brought this to the attention of the interim management team who later discovered that this was a recording error. This did not provide evidence that people's nutritional needs were being continually reviewed and that changes would be identified and responded to in good time.

We observed the serving of mid-morning snacks, as well as lunch time and tea time meals during our inspection. People were not consistently supported on all of the units to have a pleasant meal time experience. We observed that people were not always supported to sit comfortably, not always provided with condiments, and specialist diets were not always catered for. People we spoke with provided mixed feedback about the food they were offered. Some people told us, "The food is lovely," and others were less satisfied. Their comments included, "It's food of a kind. Nothing you could exactly give a name to." We observed another person receive a drink from the mid-morning trolley round, but was not offered a snack. When we asked them about this they told us, "It's news to me that snacks are available." We observed that there was not always a snack on the trolley suitable for people who needed the texture of their diet altering.

People had a variety of healthcare needs. We looked in detail at the specific nursing needs of some of the people we met. For each person we found significant shortfalls in the planning and delivery of their care. In some cases this had resulted in harm that could possibly have been avoided. Examples of this included expert guidance for one person to reduce the chance of skin damage occurring not being followed by staff. The person went on to develop sore skin.

Professional good practice guidelines state that taking photographs of wounds is a good way to record and monitor changes in a wound. However this practice had not always occurred and nursing staff said a camera was not always available or ready for use. One nurse said, "We simply couldn't find the camera." Health professionals we spoke with gave examples of nursing staff not being able to find or have in stock the correct dressings for people's wounds. They also gave examples of how the lack of

Requires improvement

Is the service effective?

consistency within the nursing staff team had resulted in people not always having care that met their needs. Failing to provide safe and effective nursing care is a breach of the Health and Social Care Act 2008. Regulation 12.

People and their relatives told us that healthcare needs were generally well met, and their comments included, "My relative has diabetes, and I'm happy they know how to provide good diabetic care," and "Mum has been ill the past two weeks. They have taken good care of her."

We looked at the systems in place to ensure staff on duty had the training and experience they required. We found that training was provided which would ensure staff had knowledge about basic care principles and information about safe working practices. It was of concern that our inspection found that both registered nurses and care staff had not been provided with the specific skills and knowledge they required to meet the complex, varied and changing needs of the people living at Ivyhouse. This had contributed to people's needs being unmet, not being met well and not in accordance to good practice guidelines.

Requires improvement

Is the service caring?

Our findings

We last inspected this service in September 2015. At that inspection the registered provider was not complying with the requirements of the law or ensuring people were consistently receiving compassionate care.

The registered provider submitted a plan telling us the actions they would take to address these issues. At our latest inspection we identified that while improvements and changes had occurred these had not been adequate to achieve compliance with the regulations or to ensure people's needs were consistently met. We are now considering what further action to take and will report on this when the action is complete.

We looked at the arrangements made to help people and their relatives plan and receive the care and support they wished for at the end of their life. Some people's physical health conditions were such that they were already in the end stages of their life. One person whose care we looked at in detail had not been supported to ensure they had all the medicines prescribed to relieve and manage their symptoms. Other people at Ivyhouse were living with dementia. Good practice guidelines for people living with dementia identifies the need to undertake advanced end of life planning to ensure the support at a person's end of life meets with their wishes, spiritual views culture and life history. Staff we spoke with and the care and records we observed did not provide evidence that staff had the specialist skills and experience to recognise when the 'end of life' stage begins. Because of this they had failed to support people and their families to make good plans. Professional guidance states this can lead to 'suboptimal' end of life care for people living in nursing homes. Failing to make these plans and record them may result in the person not receiving the care at the end of their life that has been determined as medically best for them, or was their expressed wish. This is a breach of the Health and Social Care Act 2008. Regulation 12.

People we spoke with gave positive, specific feedback about the care individual staff had given them. Comments from people living at Ivyhouse included, "I can't speak for anyone else, but I'm really well cared for here," and "I'm really happy with how I have been supported at Ivyhouse."

A relative went on to tell us, "I have no qualms about the care at all. I couldn't recommend it here highly enough. Sometimes I come when they aren't expecting me. It's heart warming to see them chatting to Dad and giving him a hug." Other people were not satisfied and their comments included, "I'm not certain Mum does get good care." The person went on to tell us about concerns they had with their relatives personal care, healthcare, lack of activities and staffing.

Our observations identified some compassionate and individual care where staff provided people with reassurance and comfort. We saw that this often brought people happiness and relief from their confusion or distress. However we also observed staff share confidential and private information about people within ear shot of other people living at and visiting the home, we observed some people's dress was not protecting their dignity and we observed a nurse undertake some observations of a person's blood pressure and temperature while they were eating a meal. These interactions were not caring or respectful of people's dignity.

We observed that some staff had effective communication skills and were able to use different ways of enhancing communication by using touch, ensuring they were at eye level with people who were seated and altering the tone of their voice appropriately. However we also observed some interactions where staff did not have these communication skills. We heard and observed some staff seek consent to interventions when people required support with personal care but this was not consistent throughout our inspection, or in all units of the home.

We looked at how people's cultural and religious needs were being met. During our inspection a person was admitted to the home. Records that had been received by the home one week prior to the person's admission identified that the person actively practised a faith and had some specific dietary requirements relating to this. Despite the information being known to staff at the home, plans had not been made to ensure the person's needs were planned for and that suitably prepared food would be available for them. We observed the person being offered food that was not consistent with their requirements and which caused the person offence.

Requires improvement

Is the service responsive?

Our findings

We last inspected this service in September 2015. At that inspection the registered provider was not complying with the requirements of the law or ensuring people were consistently receiving good, responsive care.

The registered provider submitted a plan telling us the actions they would take to address these issues. At our latest inspection we identified that while improvements and changes had occurred these had not been adequate to achieve compliance with the regulations or to ensure people's needs were consistently met. We are now considering what further action to take and will report on this when the action is complete.

We spoke with people and their relatives about the opportunities people had to partake in activities that were of interest to them. People consistently told us there wasn't enough to do and their comments included, " It gets really boring, there is nothing to do." Relatives we spoke with supported this and told us," I was told there would be entertainment, but I come three days a week and I have never seen any." We observed there were people being cared for in bed who were lonely and socially isolated. Some people required special moulded chairs to enable them to sit out of bed, these chairs were either not available or specialist seating assessments had not been requested. One person told us, "I did have a special chair but it disappeared." Other people told us, "I'm lonely in my room. Staff are nice but they don't have time to spend with me" and "I'm a bit fed up. I'd like to sit out more, but they don't have the time to get me up." During our time in the home we only observed one short structured activity, when a member of staff played a board game with one person. We saw posters on display around the home advertising activities such as beauty and pampering sessions, which we were informed no longer went ahead.

During our observations we identified some people who displayed their feelings by showing unsettled behaviour or by shouting out. These people spent long periods alone in their room. On some occasions we observed staff standing in communal areas of the home, supervising people sitting in the room. Staff missed these opportunities to spend time engaging with people. Our observations, feedback from people, care plans and daily records we looked at failed to provide evidence that people had opportunities to participate in activities that they would enjoy, provide stimulation and protect them from the risk of social isolation. This is a breach of the Health and Social Care Act 2008. Regulation 9.

The registered provider had developed a written policy to ensure complaints and concerns would be heard and investigated thoroughly. Records we viewed showed that written complaints received at the home had been logged, investigated and responded to. The response was usually compassionate and detailed the actions that had been and would be taken in response to the issues raised. The relatives we spoke with gave mixed feedback about the effectiveness of raising concerns. One family told us, "If I have a problem I speak right away with the person in charge. It always gets the matter sorted. I rarely have to do this." Other people told us, "I've raised concerns but nothing seems to get done. I didn't feel they were taken seriously" and "I have raised the same issue several times. Nothing has been done, I have just raised it again today, and they are sorting it out now." We had been made aware by relatives that clothes sometimes had gone missing during laundering. One relative we spoke with told us their frustration about the laundry and said, "Clothes still go missing. It's just something I expect to happen now." There was no evidence that complaints and other feedback provided were used as a way of continually evaluating and improving the service. People who made a complaint were not confident that changes would be made to improve aspects of the service so that the issue of concern would occur again.This is a breach of the Health and Social Care Act 2008. Regulation 17.

Inadequate

Is the service well-led?

Our findings

We last inspected this service in September 2015. At that inspection the registered provider was not complying with the requirements of the law or ensuring people were benefitting from a well led service. The registered provider submitted a plan telling us the actions they would take to address these issues. At our latest inspection we identified that while improvements and changes had occurred these had not been at the level or pace required to achieve compliance with the regulations or to ensure people's needs were consistently met. The action taken by the provider had not been enough to remove the service from special measures. We are now considering what further action to take and will report on this when the action is complete.

Leadership at Ivyhouse had been inconsistent and ineffective. There had been numerous changes of registered manager in recent years. At the time of our inspection there were a significant number of leadership posts vacant within the home, including the position of registered manager. The registered provider had taken action to improve this situation. In the absence of a registered manager the organisation had provided temporary management support to the home, which included staff who had recent experience of supporting other services to improve. The provider had also developed an action plan based on their own concerns as well as those identified in our last inspection. However these actions had not been sufficient to ensure the management and leadership of the home was effective.

The inspection identified that leadership on individual shifts and units had not always been effective. Information about people's needs had not always been communicated fully and systems that would enable new staff coming into the home to effectively care for people were not consistently in place. We observed this have a negative impact on people who required their wounds redressing. Staff were unable to locate the required dressing for people either at all, or with ease. Professionals we spoke with described how staff often worked in isolation or in "silo's." Our own evidence about staff failing to communicate effectively, or to re-order medicines and dressings when stock was low, supported this view. Other professionals told us that staff seemed to lack leadership and direction. The findings of our inspection supported that this was the case.

The registered provider and senior staff had undertaken a number of audits and checks to ensure care that met their expectations regarding safety and quality was being delivered. Although we found that audits had often identified issues, actions had not been taken which effectively addressed these shortfalls.

Providers are required by law to keep a record of the care they plan, offer and deliver to people. The records we looked at failed to accurately document people's needs and they had not all been reviewed when people's needs had changed. The providers own audits and checks had not always picked up on these issues when the quality of people's records was reviewed. This meant they had not always been effective to inform or prompt staff that people required additional nursing or care support. Failing to have systems and processes in place that will ensure compliance with regulations and which ensures people consistently receive care that meets their needs is a breach of the Health and Social Care Act 2008. Regulation 17.

We asked staff how the findings of the last inspection had been shared with them. Staff told us they had been included in open discussions, and given the opportunity to make suggestions and contribute in ways the service could improve and move forward. Comments from staff included, "They asked us what was wrong and we were able to tell them", "I felt listened too" and " [name of the acting manager] is very approachable."

In discussions, the acting management team were able to describe the events that the Commission should be notified about by law. Our inspection confirmed that incidents involving people using the service had been notified as is required by the law. This meant we had been able to monitor the events occurring in the home. However the registered provider had failed to notify us promptly about a change in the homes management as is required. We had to pursue the provider to confirm who was in day to day control of the home. Failing to notify the Commission of changes is a breach of Regulation 15 of the Registration Regulations 2009. At the time of our inspection the registered provider was failing to display the correct CQC rating awarded to Ivyhouse. Action was taken to correct this before the end of our inspection.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Essential clinical monitoring and nursing care had been omitted .This had placed people at risk of harm. Prescribed medicines had not been safely or effectively managed. They had not always been given as the Doctor had prescribed. People approaching the end of their life, had not always been supported to plan or receive good care.

The enforcement action we took:
We are currently considering what action to take and will report on this when our action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People had not always had access to adequate numbers of staff to meet their needs.

The enforcement action we took:
We are currently considering what action to take and will report on this when our action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People did not enjoy a home that was hygienically clean.

The enforcement action we took:
We are currently considering what action to take and will report on this when our action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Enforcement actions

People could not be certain their human rights would be protected.

People could not be confident they would receive person centred care, that included the provision of activities to offer stimulation and reduce the risk of social isolation.

The enforcement action we took:
We are currently considering what action to take and will report on this when our action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance There were inadequate systems and processes in place to ensure compliance with regulations and to ensure people would consistently receive good care. People who provided feedback could not be confident that changes would be made to improve aspects of the service so that the issue of concern would not occur again.

The enforcement action we took:
We are currently considering what action to take and will report on this when our action is complete.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes The registered provider had not informed the Commission about changes to the leadership of the home promptly, without this information being requested or within the timescale required.

The enforcement action we took:
We are currently considering what action to take and will report on this when our action is complete.