Achieve Together Limited

Ivers

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Ivers is a residential care home providing accommodation and personal care to up to 25 people. The service provides support to younger adults who have learning disabilities and / or autism. At the time of our inspection there were 12 people using the service which increased to 13 on our last visit.
The provider was also registered to provide domiciliary care. When we inspected, 4 people living locally received support however no regulated activities were provided to them at this time.

The care home could accommodate 9 people in the main house including the self-contained flat. There were 4 additional bungalows on the same site, each able to accommodate 4 people. At the time of our inspection 1 of these properties was vacant. A person was using a bungalow as an emergency return placement and had their own package of care from a separate service provider.

People's experience of using this service and what we found
We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

Right Support:
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.
Risks had been assessed; however, people were able to take positive risks and lead fulfilling lives. People were kept safe by staff who had been appropriately trained and who were familiar with people's care plans. There were sufficient staff deployed to meet people's needs and, while there had been significant reliance on agency staff, this was now decreasing as the provider had recruited new staff and would be fully staffed soon.

Right Care:
Care plans were person-centred, and staff told us they provided clear information about how to support people. Staff had completed training in a range of areas that were specific to the people they supported and responded to situations such as managing seizures or choking according to people's care plans.
People and their key workers met monthly and completed a 'wheel of engagement' meeting. They spoke about progress made towards goals and about their aspirations in life. Positive achievements were also displayed on a blackboard in the main house.

Right Culture:
The registered manager led by example and worked alongside their teams in the care home and bungalows,

covering shifts and spending time observing staff and people. There had been several changes to the management team however there was now a more stable team in place providing strong leadership.
We received positive feedback about the leadership of the service. The registered manager was aiming for the service to become more involved in the local community, and had arranged events to include relatives where possible.

For more details, please see the full report which is on the CQC website at
Rating at last inspection and update
The last rating for this service was requires improvement (published 27 April 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found improvements had been made and the provider was no longer in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 15 March 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve person-centred care and need for consent.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the key questions safe, effective, and well-led which contain those requirements.

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.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from requires improvement to good. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Ivers on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

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 Health and Social Care Act 2008.

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 1 inspector. Following our inspection, an Expert by Experience telephoned people's relatives to obtain feedback about the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Ivers is a 'care home.' People in care homes receive accommodation and nursing and / or personal care as a single package under one contractual agreement dependent on their registration with us. Ivers is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ivers also provides a domiciliary care service to people living in the local community. However, at the time of inspection, no one supported by Ivers in the community was receiving regulated activities.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since our last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with or observed 9 people receiving a service at Ivers. The Expert by Experience contacted 12 relatives by telephone speaking with 8 of them about the service people received. We spoke with 5 staff members including the registered manager and support workers and received email feedback from 7 staff. We looked at 3 people's care records and 5 staff recruitment records. We reviewed a variety of documents and policies relating to the safe management of the service. We sought feedback from 3 health and social care professionals receiving a response from 1.

Good

Is the service safe?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
• Staff told they would report any safeguarding concerns to senior staff and knew which agencies they could contact should this not be possible. Staff were aware of the possible signs and symptoms of abuse.
• The provider had an electronic system and any safeguarding concerns, once alerted to the local authority, and notified to CQC, would be shared with senior management and the internal safeguarding team using the system. This enabled live information sharing and enabled off site staff to review and advise on the concerns. The same system was used for accidents and incidents.
• Staff had been trained in safeguarding and updates were held regularly to ensure their knowledge remained current. Most safeguarding training was current, and courses were booked for staff due a refresher.
• A staff member told us how they would safeguard people, telling us, "By being vigilant and keeping aware with what is happening when supporting people, and also understanding the areas where people may need to be kept safe. If I suspected abuse, I would raise this firstly with the person on shift that was in charge, the assistant manager or the [registered] manager."
• Accidents, incidents, and near misses were recorded and reported. Incidents were reviewed both by the registered manager and by the providers health and safety team.
• A person told us, "I feel safe, most definitely."

Assessing risk, safety monitoring and management
• The premises had been refurbished and there was an ongoing programme of improvements. Maintenance concerns were reported, and actions taken at the earliest opportunity to address them.
• Regular health and safety checks of the premises took place, and a monthly health and safety audit ensured all necessary checks were completed.
• Risks associated with people's health, needs and well-being had been assessed, and actions taken to mitigate residual risks as far as possible.
• People were encouraged to take positive risks which contributed to them having fulfilling lives. For example, people went horse riding and swam, and there were animals including sheep and ponies that people cared for on site. Risks had been assessed and actions taken to ensure safe participation in these activities.

Staffing and recruitment
• Sufficient staff had been deployed to meet the needs of people living at Ivers. Some people had complex needs and staff were deployed to support them on a 1 to 1 basis whereas, other people needed less support and staff worked with small groups.
• Staff members were safely recruited. All required pre-employment checks had taken place including a

Disclosure and Barring Service (DBS) check. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• Staff completed a thorough induction before commencing shadowing shifts.
• The provider had recently managed to recruit additional staff and were now close to being fully staffed. Reliance on agency staff had significantly reduced however they were still needed for annual leave and sickness cover.

Using medicines safely
• Medicines were safely managed. People received their medicines as prescribed. Most people needed support with medicines and staff administered them according to their medicines administration records (MAR) and care plans.
• One person who self-administered medicines told us what their medicines were and why they were taking them. Staff completed regular counts of their medicines to ensure they had been taken as prescribed.
• All medicines were stored in locked cabinets in people's bedrooms. There was also a central store for overstock and items for return.
• MAR were fully completed, and care plans were available for everyone, including protocols for as and when medicines.

Preventing and controlling infection
• The premises were homely and lived in but were kept clean by people and staff. There were cleaning schedules completed by night staff and all areas were well ventilated. Bedrooms were regularly deep cleaned.
• In the event someone became unwell, additional personal protective equipment (PPE) such as masks and aprons were worn, particularly if the person had symptoms of COVID-19 or a stomach bug. Additional cleaning would take place and the person would be isolated as far as possible until they recovered.
• Regular infection control checks were carried out and staff hand hygiene was assessed monthly.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was supporting people living at the service to minimise the spread of infection.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was using PPE effectively and safely.
• We were assured that the provider was responding effectively to risks and signs of infection.
• We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
• We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
• The providers current visiting policy aligned with current government guidance that visiting, when there were no infection outbreaks, was not restricted. Relatives usually telephoned the service to book a visit, not as a requirement but due to the flexible nature of life in the service. People would often go on unplanned outings with staff for example, when the weather was good.
• The registered manager was aiming to increase visits to the service and become more of a part of the community. During the summer there would be a camping event for people living an Ivers, relatives and others. Tents would be set up and people would enjoy a festival like event.

Good

Is the service effective?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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

At our last inspection, care plans did not always accurately describe people's care needs, or the care being delivered by staff. This was a breach of Regulation 9 (Person-centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvements had been made and the provider was no longer in breach of Regulation 9.

• We looked at 3 care plans. All had been fully replanned since we last inspected and now reflected people's needs and how they needed or wished their care to be delivered.
• There were useful details that would be very helpful to staff when supporting people. For example, a person enjoyed going for drives in the car. They did not like a short journey of 5 minutes and would not get out of the car. The care plan instructed staff to ensure journeys were 15 to 20 minutes. This was useful, if the person had an appointment a 5-minute drive away, staff knew to leave early for a longer drive before arriving, to minimise upset for the person.
• We asked staff if care plans had enough information to enable them to support people. They told us, "Yes everything is clear and instructs the correct way to complete day to day tasks for each service user." A second staff member told us, "The care plans are very informative and do explain people's likes and dislikes and how best to support them, and by spending time with the person you understand what they like to do."
• There were detailed epilepsy care plans that had been approved by a healthcare professional. Again, these had useful details and described people's different seizures to enable staff to decide what actions they should take.
• The provider also completed nationally recognised assessments for example, to monitor people's skin integrity, weight, and risk of falls.

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 MCA 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).
When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

At our last inspection, people's legal rights under the MCA had not been fully adhered to when undertaking mental capacity assessments and best interest decisions. Records of people's capacity to make decisions and best interest decisions were inconsistent and were sometimes contradictory. This was a breach of Regulation 11 (Need for Consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, all MCA work had been reviewed and most had been redone to properly reflect people's needs, capacity, decisions and how they arrived at them. The provider was no longer in breach of Regulation 11.

• The registered manager had significantly improved all aspects of the MCA documentation and staff had all retrained in the MCA.
• Mental capacity assessments and, as appropriate, best interest decisions had been completed for a wide range of aspects of people's lives. For example, in one person's care record we saw their money being managed for them and accessing it with staff support, for having food locked away to keep them safe from choking, and for having support in the community due to their limited road safety awareness.
• The same person had made some choices themselves, an example of which was they had ticked 'yes' on a form with symbols and simple words to indicate they were happy for staff to check on them at night. This was also linked to a best interest decision to agree hourly night checks as the person may cough excessively when waking.
• Staff supported people to make choices. A staff member said, "I support individuals every day making choices and really enjoy this, as they have many different communication needs, and they enjoy the chance to have choices in everything they do." Another staff member said they used objects and different types of food to aid people making decisions.
• DoLS applications had been made and when applicable applications were made in a timely way to obtain authorisations when existing ones expired.

Staff support: induction, training, skills and experience
• Staff completed an induction on commencing with the provider and, if they were new to their care careers, they would complete the Care Certificate. The Care Certificate is an agreed set of standards that define the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It is made up of the 15 minimum standards that should form part of a robust induction programme.
• The training provided to staff working for the provider consisted mainly of eLearning, most of which was current at Ivers. In addition, there were face to face training sessions including practical first aid or moving and assisting. The provider also had service specific courses, staff at Ivers also needed to complete buccal Midazolam (this is a rescue medicine for people with epilepsy) administration, gastrostomy, and autism training to ensure staff were competent to meet the needs of people.

• Staff gave positive feedback about training. One staff member said, "I am happy with the training I received when I started the job, and I am happy with the ongoing training. I have gained so much confidence with day-to-day tasks."
• Supervision, or 1 to 1 meetings with senior staff took place approximately every 6 weeks. Staff met with the registered manager to discuss their training needs, concerns, and successes at work and to receive support should they need it. There was also an open-door approach, the management team were based in the reception area, not in an accommodation area and staff regularly approached them for advice as they needed to.
• A staff member said, "We have supervisions throughout the year, but I also feel able to bring up any issues that I have with whoever is on the shift, for example, a supervisor, the assistant manager or registered manager."

Supporting people to eat and drink enough to maintain a balanced diet
• People helped plan the menu and were supported by staff to help to cook meals.
• If someone showed symptoms such as coughing while eating, they were referred to the speech and language therapist, (SaLT) for a safe swallow assessment.
• A person needed their meals prepared so they were appropriate for them to swallow safely. They were aware of their needs however, at times would attempt to get foods that were not safe to eat. There had been 2 recent incidents of choking due to the person having foods they could not manage. Actions had been taken to ensure they were always on a 1 to 1 basis with staff at mealtimes to reduce risks.
• Foods had to be kept locked away however, people were able to access snacks when they wanted by asking staff. This was for safety reasons to minimise access to unsafe food items.
• Staff had been trained in food safety, fluids and nutrition and dysphagia and were aware of the different textures' foods could be prepared to.
• Records were maintained of people's food and fluid intake if necessary and actions to follow up should a person not have sufficient fluids for example to aim to increase this.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The registered manager advocated for people, and ensured they received the health and welfare support they needed from health and social care professionals.
• Currently people had access to SaLT, their GP surgery, dental services, chiropody, and hospital specialists.
• The registered manager had struggled to get support for a specific eating disorder. The registered manager was pursuing this with care managers and healthcare professionals to obtain a positive outcome for the person.

Adapting service, design, decoration to meet people's needs
• The premises were undergoing refurbishment and completed areas were in good decorative order. The grounds were also being improved, mostly through people and staff working together in activities.
• A games room had been added and there was a great deal of outside space for people to access for leisure and to calm should they need to.
• People's rooms were decorated as they chose, or if not able to choose for themselves, relatives had done so. One person had a sensory type of bedroom with lots of lights and mobiles. Other people had chosen the colours of their walls for example.
• The premises provided ample ground floor accommodation accessed by ramps for people as well as accommodation in the main house which was on 3 floors. Sufficient aids such as grab rails were in place to enable people to access the area safely.

Good

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. At this inspection, the rating has changed to good. This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive, and empowering, which achieves good outcomes for people
• The registered manager had worked to unite the staff team and support them in working to provide person-centred care to people. Without exception, we received positive feedback about the management team from staff.
• There had been several changes to the management of the service and for approximately 6 months a regional manager was deployed to manage the service while recruitment for the position took place. We spoke with the regional manager, and they were proud of the numerous improvements that had taken place at Ivers since the new manager was appointed.
• Relatives were mostly positive about the management team. One relative said, "It is the best place they could be potentially, and we cannot get that level of service elsewhere. The building is well maintained. The leaders have learnt lessons and are open to comments. The model they have now seems to be working."
• Other relatives told us, "Good leadership in place and things are getting better," "Better and has improved," and "It is well led now…better staff. They seem to have the right team together."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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; Continuous learning and improving care
• The registered manager submitted notifications to CQC to tell us about significant events in their services such as safeguarding concerns or events that stop the service.
• The registered manager was committed to providing positive leadership to staff members and led by example showing positive values and respect for people.
• Staff feedback was very positive about the management team. A staff member said, "Yes. Since we have had [registered manager] in post, everything is getting sorted, and the place is looking so much better. They are easy to talk to if you have any concerns or worries. They are a great leader and is not afraid to get stuck in and help out… They pop over each day to check staff are ok and see if there are any issues."
• Other staff comments included, "Having a manager who I have the upmost respect for is a great feeling and I am proud to say I work at Ivers now", and "We have been through some really hard times and a huge number of managers, but now due to a lot of hard work things are really good, and most staff seem to be working together."
• The registered manager understood their responsibilities under the duty of candour. The duty of candour requires registered persons to act in an open and transparent way with people receiving care or treatment

from them. The regulation states how registered persons must apply the duty of candour if notifiable safety incidents occur.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• A quality assurance questionnaire had been issued to staff and relatives. Results showed staff were happy with their management team. Relatives noted a significant improvement in Ivers since the current registered manager commenced in post.
• Staff meetings were held regularly and there were daily handover meetings to ensure all staff were aware of events of the previous day.
• Residents' meetings were held, and people discussed food, activities and there was a regular topic such as safeguarding, or health and safety discussed.

Working in partnership with others
• The registered manager had established positive working relationships with stakeholders. These included relatives, health and social care professionals and funding authorities.
• Referrals were made appropriately, and staff did not hesitate to report concerns to the management team who would refer to professionals for advice as needed.