Caring Homes Healthcare Group Limited

Ivy Court

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 caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 8 January 2018 and was unannounced. We returned on the 9 January 2018 to complete the inspection. The management team was given notice of the second date, as we needed to spend specific time with them to discuss aspects of the inspection and to gather further information.

At our last comprehensive inspection on 4 and 5 May 2017 the overall rating of the service was, 'Requires Improvement'. This summary rating was the result of us rating the key questions 'safe', 'effective', 'caring' and 'responsive' as, 'Requires Improvement'. At our last inspection for the key question, 'is the service safe?' we found three breaches of regulations. The provider had failed to ensure that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. People's medicines were not always managed safely. The management of the service had failed to have sufficient numbers of staff. The management of the service had failed to have effective systems in place to ensure suitable staff were employed.

At our last inspection for the key question, 'is the service well led?' we found one breach of regulation, and gave a rating of 'inadequate'. The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. We found the manager had failed to maintain accurate and complete care records in respect of each person. We also found the culture of the home was not open. Care staff, relatives, and people who lived at the home were not being involved in the development of the service. We were told that the management team and provider were not making opportunities for staff to share their views about the home. Meetings were poorly attended and care and nursing staff had limited supervisions. Their competency to ensure their care practice was safe and effective had not been assessed for some staff and was periodic for others.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions to at least good. At this inspection we found significant improvements had been made and maintained, resulting in the overall rating of the service changed to, 'Good'.

At this inspection for the key question 'well led' we have rated it as 'Requires Improvement'. We found although there were significant improvements in the care planning time was still needed to ensure they were accurate and fully completed. The provider agreed with our findings and gave a target of April 2018 for completion. The home has been opened since July 2015 and since this time has had two registered managers and two appointed home managers at different times. Some staff and relatives expressed their concerns about this. We found that this had impacted the home and improvements were needed to how information was being communicated, particularly around staffing levels. This had impacted staff behaviour leading to serious conduct issues and how relatives felt their loved ones needs were being met.

Ivy Court is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. The Care Quality Commission regulates both the

premises and the care provided, and both were looked at during this inspection.

Ivy Court accommodates 71 people in one adapted building. There were 58 people living in the service at the time of our inspection visit.

Although there was an appointed manager in post at the time of our visit, they had not registered with the Commission. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations. The appointed manager was not available at the time of our visit. However we met with two peripatetic managers, one of whom works full time at Ivy Court managing the service in the managers absence. They had been based at Ivy Court since September 2017. We were told the role of a peripatetic manager supports registered managers in their role and moves from service to service offering advice and guidance.

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. In addition, the necessary provision had been made to ensure that medicines were managed safely. Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. Background checks had been completed before care staff had been appointed. People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

Care staff had been supported to deliver care in line with current best practice guidance. People enjoyed their meals and were supported to eat and drink enough to maintain a balanced diet. In addition, people had been enabled to receive coordinated and person-centred care when they used or moved between different services. As part of this people had been supported to live healthier lives by having suitable access to healthcare services so that they received on-going healthcare support. Furthermore, people had benefited from the accommodation being adapted, designed and decorated in a way that met their needs and expectations.

People were treated with kindness, respect and compassion and they were given emotional support when needed. They were also supported to express their views and be actively involved in making decisions about their care as far as possible. Confidential information was kept private.

People received personalised care that was responsive to their needs. Care staff had promoted positive outcomes for people who lived with dementia including occasions on which they became distressed. People's concerns and complaints were listened and responded to in order to improve the quality of care. In addition, suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

There was a positive culture in the service that was open, inclusive and focused upon achieving good outcomes for people. People benefited from there being a management framework to ensure that staff understood their responsibilities so that risks and regulatory requirements were met. The views of people who lived in the service, relatives and staff had been gathered and acted on to shape any improvements that were made. Quality checks had been completed to ensure people benefited from the service being able to

quickly put problems right and to innovate so that people consistently received safe care. Good team work was promoted and staff were supported to speak out if they had any concerns about people not being treated in the right way. In addition, the management team worked in partnership with other agencies to support the development of joined-up care.

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.

Care staff knew how to keep people safe from the risk of abuse.

People had been supported to avoid preventable accidents and untoward events.

Medicines were safely managed.

Suitable arrangements had been made to ensure that sufficient numbers of suitable staff were employed to support people to stay safe and meet their needs. Background checks had been completed before new care staff were appointed.

People were protected by the prevention and control of infection and lessons had been learnt when things had gone wrong.

Is the service effective?

Good

The service was effective.

Care was delivered in line with current best practice guidance.

People enjoyed their meals and were helped to eat and drink enough to maintain a balanced diet.

People received coordinated care when they used different services and they had received on-going healthcare support.

The accommodation was adapted, designed and decorated to meet people's needs and expectations.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance.

Is the service caring?

Good

The service was caring.

People were treated with kindness, respect and compassion and they were given emotional support when needed.

People were supported to express their views and be actively involved in making decisions about their care as far as possible.

People's privacy, dignity and independence were respected and promoted.

Confidential information was kept private.

Is the service responsive?

Good

The service was responsive.

People received personalised care that was responsive to their needs.

Positive outcomes were promoted for people who lived with dementia.

People told us that they were offered the opportunity to pursue their hobbies and interests and to take part in a range of social activities.

People's concerns and complaints were listened and responded to in order to improve the quality of care.

Suitable provision had been made to support people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Requires Improvement

The service was not always well led.

Care plans were in varying stages of completion. This resulted in records not always being accurate, complete and contemporaneous in respect of each person.

Communication between 'management' to staff and relatives needed improving to increase morale and promote trust and good conduct.

There was an open culture and people benefited from staff understanding their responsibilities so that risks and regulatory requirements were met.

People who used the service, their relatives and staff were engaged and involved in making improvements.

There were suitable arrangements to enable the service to learn, innovate and maintain its sustainability.

Quality checks had been completed and the service worked in partnership with other agencies.

Ivy Court

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 checked 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.

We visited the service on 8 January 2018 and the inspection was unannounced. We returned on the 9 January 2018 to complete the inspection. On the first day the inspection team consisted of one inspector, one inspection manager and one specialist nurse advisor. There was also an expert by experience. An expert by experience is a person who has personal experience of using this type of service. On the second day one inspector completed the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We reviewed information we held about the service, including safeguarding concerns shared with us from the local authority, previous inspection reports and notifications of significant events the provider sent to us. Notifications are events that the provider is required by law to inform us of.

Due to the nature of people's complex needs, we were not able to ask everyone direct questions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing people in areas throughout the home to see interactions between people and staff. We observed people as they engaged with their day-to-day tasks, the care they experienced, including the breakfast and lunchtime meal, medicines administration and activities.

We spoke with eight people who lived in the service and with nine relatives. We spoke with both of the peripatetic managers, regional manager, and deputy manager. We also spoke with two registered nurses, three members of care staff and two activity co-ordinators. We also spoke with three visiting healthcare professionals for their views.

We looked at the care plans and associated records for nine people. We looked at five people's medication records. We reviewed other records, including the provider's internal checks and audits, staff training records, staff rotas, accidents and incidents, menu's, relative questionnaires, and health and safety checks. Records for six staff were reviewed, which included checks on newly appointed staff and staff supervision records.

Good

Is the service safe?

Our findings

At our last inspection in May 2017 for the key question, 'is the service safe?' we found three breaches of regulation. The provider had failed to ensure that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. People's medicines were not always managed safely. The management of the service had failed to have sufficient numbers of staff and effective systems in place to ensure suitable staff were employed.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found improvements had been made and these regulations were now met.

People who were able to told us they felt safe and our observations confirmed people who were unable to initiate communication were regularly asked throughout our visit if they were comfortable. Staff confirmed that people who appeared upset or not their usual selves were checked to see if they were in pain or needed assistance, which we observed.

One person said, "I am alright here. I am not that steady but there are mats at the side of my bed that alert staff if I fall." Another person told us, "My health has actually improved in the two years I've been here. I can manage well on my own, so I am comfortable here, without worries."

A relative told us, "We have no anxieties about [person]. The building is safe and secure. They [staff] make sure [person] is safe walking with her frame." Another relative told us, "I'm comfortable leaving [person]. She's secure, warm and well fed." Another relative told us, "[Person] is looked after so feels safe and I feel comfortable leaving her."

There were systems, processes and practices to safeguard people from situations in which they may experience abuse. Records showed care staff had completed training and had received guidance in how to protect people from abuse and this was included in the induction for newly appointed staff. We found that care staff knew how to recognise and report abuse so that they could take action if they were concerned that a person was at risk. They told us they were confident that people were treated with kindness and they had not seen anyone being placed at risk of harm.

We found that risks to people's safety had been assessed, monitored and managed so they were supported to stay safe while their freedom was respected. This included measures that had been taken to help people avoid preventable accidents. We saw that hot water was temperature controlled and radiators were guarded to reduce the risk of scalds and burns. In addition, people were provided with equipment such as walking frames and raised toilet seats to reduce the risk of falls. We viewed nine peoples care records which included risk assessments regarding nutrition, possible falls, diabetes, choking and the risk of skin damage. There were also risk assessments regarding negative behaviours people might exhibit. There were corresponding care plans to show how the risks were to be mitigated and instructions for staff.

Two people had a record to show they were repositioned at regular intervals to relieve the pressure on their

skin due to prolonged immobility. The care plan included instructions of how often this repositioning should take place.

Moving and handling assessments gave staff clear guidance on how to support people when moving them. People were safely supported to move from their chairs to wheelchairs and to sit at the dining table for their meals. We observed staff communicating with people during transfers to check people felt safe and comfortable. We noted suitable equipment such as hoists and wheelchairs were available for staff to use and each sling was for one person's use only.

The premises were purpose built and the layout was such that it did not present significant difficulties in evacuating people in the event of an emergency. People had individual Personal Emergency Evacuation Plan (PEEP) in place on how they should be supported to evacuate the building in the event of a fire. An environmental risk assessment was in place which identified risks to people, staff and visitors. Daily, weekly and monthly health and safety checks were carried out. Fire drills took place and equipment such as fire, electrical, moving and handling equipment was serviced and fit for purpose.

The peripatetic manager told us that suitable arrangements had been made to ensure that sufficient numbers of suitable staff were deployed in the service to support people to stay safe and meet their needs. However, most of the people we spoke to including relatives and care staff raised concerns about there not being enough care staff on duty. We fed this back to both peripatetic managers and the area manager.

We saw that the peripatetic manager had established how many care staff needed to be on duty at each time of day based upon an assessment of the care each person required. This was reviewed as a minimum monthly. We were told that there was always 12 carers and one senior carer in the building from 7am to 7pm. With three registered nurses on site, in this time to oversee the clinical needs of individuals. We were told that the management team have listened to the concerns of people, their relatives and staff and have put in place an additional carer to work a 'twilight' shift from 6pm to midnight to help with personal care. From 7pm to 7am we were told there were two nurses and five carers on shift. Rotas we sampled reflected what we had been told.

Records showed that apart from three days preceding our inspection visit the planned deployment of care staff had always been met. They also showed that on most days the number of care staff on duty had met the minimum level that the peripatetic manager considered to be necessary. Although we were told that a small number of care staff shifts had not been filled in the month preceding our inspection visit, we concluded that in practice there had been enough care staff on duty to provide people with the assistance they needed. This was because we were assured that when care shifts had not been filled members of the management team and other members of staff worked flexibly either to provide care themselves or to relieve care staff from having to undertake non-essential duties.

The peripatetic manager told us if agency staff were needed, they were allocated from an approved list. To ensure people were supported safely, we were told, they requested specific agency staff who knew the home to cover shifts and records confirmed this. Records confirmed that agency staff received an induction when first working at the home and given sufficient information about people who lived at the home to provide safe care. This included information about moving and handling and eating and drinking.

In addition to the care staff, the service had a team of four housekeeping staff from 8am to 3pm each day, with an additional head housekeeper who provided additional support and covered any shortages. There were two chefs and one kitchen assistant each day. We were told if a chef is not available, there was an additional kitchen assistant available to cover at short notice. There were two hostesses' each day who

supported the care staff with the dining experience of people. There were three activity coordinators each day. This enabled the care staff to attend to people and their needs.

The area manager told us, there was a range of health needs to be met in the home, for example, nursing care, dementia care, personal care and due to the layout of the building and where people were living in the building this impacted how quick staff could respond to people's needs. We have commented on this in the key question, 'is the service well led?' During the course of our inspection visit we observed people receive care and support in a timely fashion and call bells were responded to promptly. We observed staff having time to interact with people positively throughout the inspection. Staff acknowledged they were getting used to new systems and paperwork which put pressure on their time.

Recruitment practices were robust. Staff files showed references were obtained from previous employers and checks with the Disclosure and Barring Service (DBS) were made regarding the suitability of individual staff to work with people in a care setting. Checks were made that nurses were registered with the Nursing and Midwifery Council (NMC). There were records to show staff were interviewed to check their suitability to work in a care setting.

At this inspection we found that the necessary arrangements had been made to ensure the proper and safe use of medicines. There were reliable arrangements for ordering, administering and disposing of medicines. There was a sufficient supply of medicines and senior care staff who administered medicines had received training. Records demonstrated arrangements had been made for all trained staff to be assessed to ensure their competence to undertake this annually. This is an observation of how staff safely handle and administer medicines, which is recommended in the Royal Pharmaceutical Society guidance, 'The Handling of Medicines in Social Care.' We saw them correctly following the provider's written guidance to make sure that people were given the right medicines at the right times.

We observed that unused medicines were discarded safely and in accordance with the administration of medicines policy. Stocks of medicines showed people received them as the prescriber intended. When people had their medicines administered on an 'as required' basis there was a protocol for this which described the circumstances and symptoms when the person needed this medicine. The temperature of the medicines storage room was monitored as was the temperature of the fridge used to store medicines. These were within the recommended safe limits.

There were suitable systems to protect people by the prevention and control of infection. Records showed that the management team had assessed, reviewed and monitored what provision needed to be made to ensure that good standards of hygiene were maintained in the service. We found that the accommodation was clean and had a fresh atmosphere. We also noted that equipment such as hoists and commodes were in good condition, had washable surfaces and were clean. In addition, we noted that soft furnishings, beds and bed linen had been kept in a hygienic condition. Overall we saw that care staff recognised the importance of preventing cross infection. They were wearing clean uniforms, had access to antibacterial soap and regularly washed their hands. During our visit we observed one registered nurse not wearing gloves whilst delivering personal care. This put one person at risk of cross contamination. We spoke to the peripatetic manager and area manager about this at the time. They immediately addressed the issue with the registered nurse and we did not see any other occurrence of this nature.

We found that the peripatetic manager had ensured that lessons were learned and improvements made when things had gone wrong. Records showed that they had carefully analysed accidents and near misses so that they could establish how and why they had occurred. We also noted that actions had then been taken to reduce the likelihood of the same thing happening again. These actions included considering the

need to refer people to specialist healthcare professionals who focus on helping people to avoid falls. They also included practical measures such as when using agency staff they are always paired with an experienced carer or registered nurse who is employed by the service.

Good

Is the service effective?

Our findings

Our observations showed staff were confident and knew how to support people in the right way. Throughout our inspection, we saw that people, where they were able, expressed their views and were involved in decisions about their care and support. We observed staff seeking consent to help people with their needs.

We found that robust arrangements were in place to assess people's needs and choices so that personal care was provided to achieve effective outcomes. Records showed that the peripatetic manager had carefully established what assistance each person needed before they moved into the service. This had been done to make sure that the service had the necessary facilities and resources. Records also showed that the peripatetic manager's assessment had suitably considered any additional provision that might need to be made to ensure that people did not experience discrimination. An example of this was the peripatetic manager clarifying with people if they had a preference about the gender of the care staff who provided them with close personal care.

All new staff were required to complete the Care Certificate, covering 15 standards of health and social care topics. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. This ensured people received effective care from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. Inductions also included areas such as the geography of the home, communication systems, policies and procedures. Induction training was followed by a minimum of four shadow shifts.

The provider maintained a spreadsheet record of training in courses completed by staff which the provider considered as mandatory to providing effective care. This allowed the provider to monitor when this training needed to be updated. These courses included fire safety, infection control, moving and handling, health and safety, food safety, safeguarding people, care planning and the Mental Capacity Act (MCA). Additional training was available to staff in specific conditions such as end of life care, nutrition and hydration, and dementia. In addition, they had also received on-going refresher training to keep their knowledge and skills up to date. We found that care staff knew how to care for people in the right way. An example of this was care staff knowing how to provide clinical care for people who lived with particular medical conditions. Other examples were care staff knowing how to correctly assist people who experienced reduced mobility or who needed help to promote their continence. One relative told us, "They [staff] do know mum's needs. They seem well trained and are never rough with her when they use the hoist."

We also noted specific training was available for registered nurses. These included gastrostomy training, male and female catheterisation and pressure area and tissue viability care. Staff confirmed they received training which they said was of a good standard and that they were able to suggest relevant training courses which were then provided. Registered nurses said they were supported to complete training in order to maintain their registration with the Nursing and Midwifery Council (NMC).

Staff were supported to attain the National Vocational Qualification (NVQ) in care or the Diploma in Health and Social Care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard.

Staff received supervisions with the peripatetic manager approximately three times per year and notes of supervision meetings confirmed this. Staff told us they found supervision meetings helpful. We reviewed records of staff supervision which noted that the focus was clearly on staff welfare. It was evident staff could raise issues of importance to them. The staff we spoke with confirmed this.

We found records demonstrating other ways staff were supported. This was through staff monthly meetings and residents' monthly meetings. Minutes of these discussions demonstrated staff discussed residents' needs, activities, changing policies and procedures, safeguarding and training needs. Without exception, staff told us this worked for their service and that the peripatetic manager had an open door policy where they could talk to them anytime they needed to. It was clear staff possessed a high degree of knowledge about the people they were caring for. This was confirmed in our discussions with staff.

People told us that they enjoyed their meals. One of them remarked, "I do like the food, it's very nice." Another person on a pureed diet told us, "The food is always beautifully presented and tastes good." A relative told us, "We've eaten here, the food is fantastic. It is laid out beautifully on the plate, not just thrown on. They [staff] offer alternatives." Another relative told us, "The food is good and I can tell you that because I've tried it."

We were present at lunch time and we noted that the meal time was a relaxed and pleasant occasion. The dining tables were neatly laid, people were offered a choice of dishes and the meals were attractively presented.

We found that people were being supported to eat and drink enough to maintain a balanced diet. People had been offered the opportunity to have their body weight regularly checked so that any significant changes could be brought to the attention of a healthcare professional. People had been assessed, using a combination of height, weight and body mass index, to identify whether they were at risk of malnourishment. The peripatetic manager had completed these assessments using the Malnutrition Universal Screening Tool (MUST), a tool designed specifically for this purpose. We observed people's likes and dislikes were documented and kept in the kitchen, accessible to staff. The chef received written information from care staff about people's preferences and requirements when someone came to live at the home.

We also noted that care staff were making sure that people were eating and drinking enough to keep their strength up. This included assisting some people to eat their meals and gently encouraging others to have plenty of drinks.

Suitable arrangements had been made to ensure that people received effective and coordinated care when they were referred to or moved between services. An example of this included care staff readily having to hand important information about a persons' care so that this could be given to ambulance staff if someone needed to be admitted to hospital.

People were supported to live healthier lives by receiving on-going healthcare support. Records confirmed that people had received all of the help they needed to see their doctor and other healthcare professionals such as dentists, opticians and dieticians.

One relative told us, recently their loved one had a swollen hand and the staff arranged medical attention without delay. The relative complimented staff because they were kept up to date with the outcome.

On the day of the inspection a community healthcare assistant told us that "referrals made by the care home are appropriate and that staff follow any instructions given". She also reported that she had "no concerns". Two visiting continuing healthcare nurses also complimented the staff. We were told, "The communication between the staff and nurses is excellent. They [nurses] give you time and they know exactly what is happening with each person." We were also told, "I couldn't fault the trained nurses."

In addition, we noted that care staff informed people about the healthcare they were receiving. An example of this was a member of care staff who we overheard explaining to a person why a community dentist was visiting and what to expect from the appointment.

We found that people's individual needs were suitably met by the adaptation, design and decoration of the accommodation. People were able to move about their home safely because there were no internal steps and there was a passenger lift between the two floors. There was sufficient communal space in the dining room and in the lounges. In addition, there was enough signage around the accommodation to help people find their way around. Everyone had their own bedroom that was laid out as a bed sitting area so that people could spend time in private if they wished. Furthermore, people told us that they had been encouraged to bring in items of their own furniture and we saw examples of people personalising their bedrooms with ornaments, personal memorabilia and photographs.

Suitable arrangements had been made to obtain consent to care and treatment in line with legislation and guidance. This involved the peripatetic manager and care staff following the Mental Capacity Act 2005. This law provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The law 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We found that the peripatetic manager and care staff were supporting people to make decisions for themselves whenever possible. They had consulted with people who lived in the service, explained information to them and sought their informed consent. Records showed that when people lacked mental capacity the peripatetic manager had ensured that decisions were taken in people's best interests. An example of this was the registered nurse liaising with relatives and healthcare professionals regarding a person who was diabetic wanting to eat sugared sweets. The person was receiving daily blood glucose recordings, which were above the recommended level. However, the registered nurse reported that the person was eating sweets and was aware that this would have an impact on the blood glucose levels, but has the capacity and freedom to make an individual choice.

People can only be deprived of their liberty in order to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Records showed that the peripatetic manager had made the necessary applications for DoLS authorisations so that people who lived in the service only received lawful care.

The deputy manager described how she provides 'person centred care'. "I know what their [people] wishes are, how they like things to be done. I am aware of people's capacity and help them to be independent by encouraging and supporting them to do as much as they can. If I do things for them I will be taking away their skills'.

Good

Is the service caring?

Our findings

We observed the way staff and people interacted and the care that was provided. Our observations showed us people were positive about the care and support they received. People smiled, laughed, nodded their heads and told us they liked the staff. All interactions we saw were comfortable, friendly, caring and thoughtful. Staff behaved in a professional way. People enjoyed the relaxed, friendly communication with staff. There was a good rapport between people; they chatted happily between themselves and with staff. When staff assisted people, they explained what they were doing first and reassured people.

One person told us, "The carers are all kind to me. I know they care about me and that helps me feel at home here." A second person told us, "Everyone is very kind and they will get whatever I ask for." A third person told us, "I can have a laugh with the staff. Staff say I am a friendly person."

One relative told us, "The carer's are very kind and respectful towards my mum." A second relative told us, "Quite often a couple of the carers will call in and give mum a cuddle after their shift. That is such a lovely thing and she is so lifted by that." Another relative told us, "They [staff] do their very best and are kind and caring."

Records indicated there were a number of people with a diagnosis of dementia, we observed staff interacting with people with in a calm, friendly manner. Throughout the inspection the atmosphere was relaxed and there was no evidence of people experiencing distress. A relative told us, "There is a human touch. They [staff] call [person] by their name. They chat to her though she does not really respond."

We saw that the service ensured that people were treated with kindness and that they were given emotional support when needed. Care staff were informal, friendly and discreet when caring for people. We witnessed positive conversations that promoted people's wellbeing. An example of this occurred when we overheard a carer talking to a person, taking time to listen to them and making comments with some humour involved. The conversation was unrushed. Staff spoke with people as they went about their work and spent time with people who were cared for in their rooms. We observed staff kneeling down to speak with people, stroking their arms and backs and calling them by their names.

Care staff were considerate and we saw them making a special effort to welcome people when they first moved into the service so that the experience was positive and not too daunting. We noticed that care staff had sensitively asked people how they wished to be addressed and had established what times they would like to be assisted to get up and go to bed. Another example was people being consulted about how often they wished to be checked at night. People were asked if they would prefer a bath or shower. Whether people wanted to be supported with having a wet or electric shave. Records demonstrated that choices were being met and documented.

Personal histories had been completed for people and provided staff with information about people's earlier lives, their food likes and dislikes, travel, music and activities they liked to do. Any special dates were also recorded, so staff could support people to remember happy times or sad times. This enabled staff to

see what was important to the person and how best to support them.

We found that people had been supported to express their views and be actively involved in making decisions about their care and treatment as far as possible. Most people had family and friends who could support them to express their preferences. Records showed that the management team had encouraged their involvement by liaising with them on a regular basis. Care plans included people's preferences around clothes and gender of care staff they wished to be supported by.

People's communication needs were detailed well in care plans and support was provided in accordance with people's needs. For example, one person's support plan for communication noted they wore a hearing aid and it could be difficult to communicate with the person without it. Staff checked the person was wearing this at the start of the day. We also observed the person remove the hearing aid during the day. Each time staff communicated with them, the person was encouraged to put in their hearing aid.

People's privacy, dignity and independence were respected and promoted. We noted that care staff recognised the importance of not intruding into people's private space. Bedroom, bathroom and toilet doors could be locked when the rooms were in use. In addition, people had their own bedroom that they had been encouraged to make into their own personal space. We also saw care staff knocking and waiting for permission before going into bedrooms, toilets and bathrooms.

We found that people could speak with relatives and meet with health and social care professionals in private if this was their wish. In addition, care staff were assisting people to keep in touch with their relatives by post and telephone.

Suitable arrangements had been made to ensure that private information was kept confidential. We saw that written records which contained private information were stored securely when not in use. In addition, computer records were password protected so that they could only be accessed by authorised members of staff. Records showed that care staff had been given training and guidance on the importance of maintaining confidentiality and we found that they understood their responsibilities in relation to this matter.

Good

Is the service responsive?

Our findings

We found that people received personalised care that was responsive to their needs. This was demonstrated through our observations and from information people and staff shared with us. Although there were significant improvements in the care planning, time was still needed to ensure they were accurate and fully complete. We found this had not impacted people and have therefore covered this in the key question, is the service well led?

People told us, staff had carefully consulted with them how they wanted their personal care delivered. Overall care plans were being regularly reviewed to make sure that they accurately reflected people's changing needs and wishes. One relative told us, over the time that their loved one has resided at Ivy Court their needs had changed and they have been fully involved in all of the care reviews.

Other records confirmed that people were receiving the personal care they needed as described in their individual care plan. This included help with managing a number of on-going medical conditions, washing and dressing, changing position safely and promoting their continence.

We saw that care staff were able to promote positive outcomes for people who lived with dementia. The management team had made appropriate referrals to the Dementia and Intensive Support Team (DIST) when required. The DIST team offer assessment and interventions for adults with age related needs suffering from mental health problems including anxiety, depression, confusion and dementia.

People told us that they were offered the opportunity to pursue their hobbies and interests and to enjoy taking part in a range of social activities. One person told us, "There's enough for me to do if I want to do it. I have been on a trip to the pantomime." Another person told us, "I do quizzes and craft things. I go outside in better weather. I have my books, my newspaper, TV and my friends so I am happy."

A relative told us, "Mum goes to the cinema and does the quizzes. She liked it when some children visited. She watches TV. She is not bored. She rests and dozes a lot." Another relative told us, "[Person] has been on a trip to the Cathedral and the Plantation gardens. He goes to this cinema and does sing along. He enjoys the quizzes but his memory is very poor. At least he is involved and does not seem bored." Another relative told us, "[Person] does colouring and has been helped to do some baking. She's been on trips which she loves. She watches TV. Staff do look in her room from time to see if she is all right." Another relative told us, "[Person] has never really been a 'joiner' in terms of activities but does like going out on the regular trips." The relative confirmed that regular trips are arranged.

Another relative told us, "We are so so so happy. The nurses and care staff go the extra mile. Our daughter is getting married in the summer and two carers have already volunteered to take [person]. They [staff] are so lovely with [person]."

On the day of our visit the activities co-ordinator was observed after lunch running a quiz with seven people. The activity was led by asking people to identify 'famous' individuals. People were encouraged and people

who found the activity more challenging were given extra time.

Other activities offered at the time of our visit were art and crafts and a music session where people listened to music or chose to dance. Most people were engaged in the sessions, for example no one was asleep, some people hummed and danced. Ivy Court has a cinema room, which we observed people regularly using. A hairdresser was on site who visited weekly. We observed many people popping in the salon for their hair appointments. In the main entrance was a list of activities for the month ahead which included community trips to a bowling club and visiting Wroxham Worlds.

We saw that suitable provision had been made to acknowledge personal milestones. An example of this was people being helped to celebrate their birthdays in a manner of their choice which usually involved the chef baking them a special cake. One relative told us, "For [person] 90th birthday a family lunch was held at the home and the room had been decorated for the occasion." Additionally the activities co-ordinator told us, there was a person who liked to sweep leaves and used a leaf blower on a regular basis. The person was awarded honorary employee of the month.

We noted that care staff understood the importance of promoting equality and diversity. This included arrangements that had been made for people to meet their spiritual needs by attending a religious service. One relative told us [person] had been involved in the Salvation Army for many years. Records confirmed that the Salvation Army visited the service to meet the person's spiritual needs.

In the entrance hall was a 'wish tree'. People and their relatives were encouraged to hang a wish from the tree, once the wish had been met, a painted star was added. One person had wished for a glass of wine each day, we observed this wish had been met.

There were robust arrangements to ensure that people's concerns and complaints were listened and responded to in order to improve the quality of care. Most people told us that they had not needed to make a complaint about the service. However, they were confident that if there was a problem it would be addressed quickly. People's concerns and complaints were encouraged, explored and responded to in good time. Formal complaints were dealt with by the management team, who would contact the complainant and take any necessary action. Complaints were listened to, investigated and managed in line with the provider's policy. People said that they would be confident to make a complaint or raise any concerns if they needed to.

People were supported at the end of their life to have a comfortable, dignified and pain-free death. Records showed that the management team had consulted with people about how they wanted to be supported at the end of their life. This included establishing their wishes about what medical care they wanted to receive and whether they wanted to be admitted to hospital or stay at home. We noted the management team had ensured the wishes of one person's decision to donate their brain for research was included. We also noted that care staff had supported relatives at this difficult time by making them welcome so that they could stay with their family member during their last hours in order to provide comfort and reassurance.

In the main entrance hall was a 'memory tree'. For each person who had died, relative's had been encouraged to add the persons photo as a way for other people living at the service to remember their friend.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in May 2017 for the key question, 'is the service well led?' we found one breach of regulation. The management of the service had failed to have effective systems and processes in place to monitor and improve the safety of the service provided. We found the manager had failed to maintain accurate and complete care records in respect of each person. We also found the culture of the home was not open. Care staff, relatives, and people who lived at the home were not being involved in the development of the service. We were told that the management team and provider were not making opportunities for staff to share their views about the home. Meetings were poorly attended and care and nursing staff had limited supervisions. Their competency to ensure their care practice was safe and effective had not been assessed for some staff and was periodic for others.

We made requirements for this to be addressed and the provider sent us an action plan. At this inspection, we found substantial improvements had been made and the regulation was now met.

We found although there were significant improvements in the care planning, time was still needed to ensure they were accurate and fully completed. For example for two people who could not manage to eat and drink orally and who had feeding tubes (PEG - percutaneous endoscopic gastrostomy) in place lacked guidance in the care plans. These involve placement of a tube through the abdominal wall into the stomach or direct to the intestine through which nutritional liquids and medicines can be infused, when taking in food and drink orally was limited or no longer possible. Staff were knowledgeable about the management of these; nursing staff had been trained in this area. The care plans, monitoring charts and information in people's rooms was accurate and reflected the care we observed them receiving. However, information was not always included regarding the type and timings of feeds, positions people needed to be in when receiving food and fluids and bed elevation afterwards to reduce risk of choking, additional fluid requirements, tube sizes, rotation of PEG tube and care of stoma sites. This was raised with the management team on the first day of our visit. On the second day of our visit the care plans had been reviewed and were more comprehensive.

We also found for people with diabetes, their care plans lacked clear, comprehensive guidelines with regard to when to seek advice for a blood glucose recording outside of the normal range. We found no person to have been impacted by this but was an area requiring improvement. The provider agreed with our findings and provided assurances that everyone's care plans would be reviewed and completed on the provider's new format by April 2018. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

The home has been opened since July 2015 and since this time has had two registered managers and two appointed home managers at different times. All of the staff and relatives we spoke to expressed concerns about the quality of leadership, while expressing support for the current manager. We found that this had impacted the home and improvements were needed to how information was being communicated, particularly around staffing levels. This had impacted staff behaviour leading to serious conduct issues, low morale and how relatives felt their loved ones needs were being met. The peripatetic manager told us, it was

their intention to make an application to The Care Quality Commission to become the registered manager.

One person told us, "The place is falling apart. I have been here a long time and I am a mobile, active person who gets about the place, so I know. There is discontent amongst the carers. I have had those conversations that prove it to me. The last six months have seen a decline in the quality of the place. You need to look at the staff changes and if you really look, you will find out they left because of overwork and low morale. The changes here have really led to a decline. [Peripatetic manager] is lovely I have to say. We have a laugh and she is so approachable."

One relative told us, "I know that there are not enough staff when needed. They just rush around. One actually said to me, I'm sorry, I'm just rushed off my feet." Another relative told us, "The problem is simple. They [staff] are rushed off their feet and are demoralised. One who left told me she was going because the workload was too much for her." Another relative told us, "I have to criticise the home for the fact that residents have to wait too long to be seen to. I categorically say there are not enough staff." Another relative told us, "I am very disappointed that there have been so many changes of managers. The place just cannot move forward. [Peripatetic manager] is very pleasant." Another relative told us, "One of the carers spoke to me about the work stress she feels. Overall I'm content with my wife's care but manning problems affect her." Another relative said, "There have been too many changes. Mum cannot forge relationships with staff. Carers have told me they do not feel supported. Four managers in a year say it all. At the relatives' meeting, my [relative] said staffing was a problem. They [management] said it was going to be sorted, but we've seen no change. The people who own it are only interested in making money. Another relative told us, "I don't really know the management. I know the carers. Maybe he or she can't come out and meet relatives? I feel confident if I needed to raise anything I could find someone in charge." Another relative also did not know who the manager was.

Care staff told us they had experienced a lot of changes in management which had led to inconsistencies in approach with regard to the role of activities and how care was being delivered. Staff told us different managers had put in place a different emphasis on areas of service delivery that had caused confusion. Although all staff had complimented the current peripatetic managers and felt they would be able to restore confidence. This echoed what relatives told us, for example one relative said, "[Peripatetic manager] is very nice and is the first one who gets around the building. She's the only one I can talk to about issues and she tries to sort things. Others brush you off." Another relative said, "[Peripatetic manager] will get things done, like chasing up about sorting mum's hearing aids. I will not move mum because she is content here and feels safe." Another relative told us, [Peripatetic manager] is easy to talk to. Overall I am satisfied with the place."

We shared how people, relatives and staff were feeling to the management group. The area manager told us, there was a range of health needs to be met in the home, for example, nursing care, dementia care, personal care and due to the layout of the building and where people were living in the building this impacted how quickly staff could respond to people's needs. The area manager told us this had directly resulted in relatives and staff feeling there is not enough staff to manage people's needs.

The area manager had recognised the change in management had impacted staff morale and with staff believing they are working below numbers this had led to staff sharing their frustration with relatives. Although we found staffing levels to be at a safe level and at a level to be able to deliver good quality personalised care, there were missed opportunities and poor communication between the provider and people, relatives and staff regarding what is the expected staffing levels and what were the constraints of meeting people's needs regarding the layout of the building. The area manager agreed this was an area requiring improvement.

The management team demonstrated they had found possible solutions to the layout of the building and were in the process of suggesting these ideas to the staffing team. On the day of our visit, the area manager reviewed the newsletter that was about to be shared with people and relatives, to ensure it included more information around the staffing levels needed for Ivy Court. The area manager had already started to address these areas in a recent staff meeting and relatives meeting but offered assurances this would be an area followed up on in future meetings which were monthly. We will not be able to confirm if sufficient action has been taken until we next inspect the home.

Quality assurance systems were in place that included audits by the peripatetic manager and quality assurance manager. The audit conducted in November 2017 identified that further work was needed in relation to some people's care plans for specific health needs and also aspects of mental capacity assessment. Action had been taken to ensure mental capacity assessments were completed.

Records showed that the peripatetic manager had regularly checked to make sure that people were reliably benefiting from having all of the care and facilities they needed. These checks included making sure that personal care was being consistently provided in the right way, medicines were being managed correctly and staff had the knowledge and skills they needed. In addition, records showed that fire safety equipment, hoists and kitchen appliances were being checked to make sure that they remained in good working order. The last monthly medication audit in December 2017 identified some staff competency concerns. These issues had been addressed.

We found that the peripatetic manager understood and managed risks and complied with regulatory requirements. Records showed that the peripatetic manager had subscribed to a number of professional websites in order to receive up to date information about legal requirements that related to the running of the service. This included CQC's website that is designed to give providers and registered manager's information about important developments in best practice. This is so they are better able to meet all of the key questions we ask when assessing the quality of the care people receive. In addition, we noted that the peripatetic manager had correctly told us about significant events that had occurred in the service. These included promptly notifying us about possible safeguarding incidences. Furthermore, we saw that the peripatetic manager had suitably displayed the quality ratings we gave to the service at our last inspection.

Staff were clear about their responsibilities. We noted that each shift was led by a senior member of care staff. These members of staff shared an office and worked closely together. We heard them discussing the personal care needed that day by each person who lived in the service. We then noted that this discussion was reflected in the tasks we saw care staff being asked to complete. In addition, we were present when a senior member of care staff met to hand over information from one shift to the next. We noted the meeting to be well organised so that detailed information could be reviewed in relation to the current care needs of each person.

People who used the service, their relatives and staff were engaged and involved in making improvements. Documents showed that people had been invited to attend joint residents' and relatives' meetings at which they had been supported to suggest ideas about how the service could be improved. We noted a number of examples of these suggested improvements being put into effect. An example of this was changes that had been made to the menu so that it better reflected people's changing preferences. Another example was introducing a 'suggestion box' in the main entrance for people, relatives and staff to make anonymous suggestions. We saw this had been actioned.

We looked at how the provider formally sought the opinions of people using the service and their families. We noted satisfaction surveys were sent to people and their relatives annually with the last being in

December 2017. We noted all expressed a degree of satisfaction, particularly in the areas of staff attitudes and quality of care. Where issues were identified, people and their relatives stated that they were listened to and those issues were resolved in a timely manner.

Care staff told us there was a 'zero tolerance approach' to any member of staff who did not treat people in the right way. As part of this they were confident that they could speak to the peripatetic manager if they had any concerns about people not receiving safe care. They told us they were sure that any concerns they raised would be taken seriously by the peripatetic manager so that action could quickly be taken to keep people safe.

We found that the peripatetic manager had established suitable arrangements to enable the service to learn and innovate. This included members of staff being provided with written policies and procedures that were designed to give them guidance about their respective roles.

We noted that the peripatetic manager adopted a prudent approach to ensuring the sustainability of the service. This included operating efficient systems to manage vacancies in the service. We saw that the management team carefully anticipated when vacancies may occur and liaised with local commissioning bodies so that new people could quickly be offered the opportunity to receive care in the service. Records showed that these arrangements had been largely successful in that relatively good levels of occupancy had been maintained. This helped to ensure that sufficient income was generated to support the continued operation of the service.

Information was available to people and visitors in the hallway of the service. These included the provider's Statement of Purpose and satisfaction survey forms for people to complete. This facilitated communication channels between people and the service's management.

We found that the service worked in partnership with other agencies. There were a number of examples to confirm that the provider recognised the importance of ensuring that people received 'joined-up' care. One of these involved the provider's membership of a county-wide association that worked to identify how commissioners and service providers could better develop a cross sector approach to delivering high quality care.