

Greenhill Care Homes Limited

Ilsham Valley Nursing Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

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

We carried out this unannounced comprehensive inspection on 15 October 2018.

Ilsham Valley Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. The service provides care and accommodation for up to 23 people. On the day of the inspection 20 people were living at the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in July 2017 the overall rating for the service was Requires Improvement because people were not always protected from risks associated with their care, and fire prevention and portable appliance testing (PAT) were not safe. We also found, the recruitment of staff was not always carried out safely, and people were not always protected from infection control practices. In addition, people's records relating to their care were not always accurate and the provider's systems to monitor the quality of care people received were not robust, in identifying when improvements were needed. Following our inspection, the provider submitted an action plan to the Commission, detailing how improvements were going to be made. However, whilst some reactive improvements had been made as a consequence of our previous inspection findings, we found there was a continued breach of regulation and 17 of the Health and Social Care Act 2008 (Regulated Activities 2014), and additional areas were now requiring action. Therefore, the rating of Requires Improvement remained.

People were not always protected from risks associated with their care. People had risk assessments in place to help guide staff to deliver safe care in line with people's individual needs, such as moving and handling, skincare, personal care and behaviour. However, people's risks assessments did not always provide sufficient detail about how to mitigate associated risks. This meant people may not receive consistent and safe support.

People's medicines were not always managed safely, because the medicines fridge was found to be unlocked, people's medicine records were not always accurately and topical creams were not always dated upon opening. People were supported by sufficient numbers of staff and a consistent staff team, with one person telling us "I see the same carers and nurses, the faces don't change much".

People and families told us they felt "Safe", with one person commenting "I feel safe and comfortable here".

People were protected from abuse. Staff told us they would not hesitate to raise any concerns with the registered manager if they felt someone was being abused, mistreated or neglected.

People, at our last inspection in July 2017, were not protected by the provider's own recruitment procedures, but at this inspection we found action had been taken to ensure people were fully protected.

Overall, people were now protected by infection control practices. There were paper towels, soap and pedal bins in bathrooms. People now lived in a safe and secure environment. Action had been taken to ensure the premises met fire regulations and PAT had been carried out.

Overall, lessons were learnt when things went wrong, and the learning used to help improve the service. For example, the provider had acted to improve the service following our last inspection.

People's needs were assessed prior to them moving into the service. This pre-assessment was then used to help create a person-centred care plan for all staff to follow. However, the pre-assessment was completed by either the registered manager or deputy manager who had no clinical experience. This meant, people's clinical needs may not be effectively and correctly assessed before moving into the service.

People received care and support from staff who had undertaken training the provider had deemed to be mandatory. The registered manager was passionate about high quality training telling us "You are nothing without your staff".

The service worked well with external organisations to the benefit of people, a GP who visited the service frequently told us they felt the service met people's needs effectively, and that the service communicated well.

People were encouraged to live healthy lives. People were encouraged to eat a balanced diet. Overall people told us the food was lovely.

People lived in a service which had been designed to help meet people's needs. A Summer garden project had been successful in creating a woodland garden, with raised flower beds with wheelchair access.

People's care plans included a section regarding their mental capacity and how they should be suitably supported. The registered manager and staff had undertaken training in the Mental Capacity Act (2005) and had a good understanding.

People's consent to their care was obtained and recorded in their care plans. This included consent to photographs being taken, and for them to be used in the promotion of the service.

People's communication needs were documented in their care plans, and staff told us how they adapted their own communication styles to help people to understand them.

People were complimentary of the caring staff that supported them, commenting "It's like being at home. I'm not lonely and I'm well looked after here", "I'm treated here as well as I could be" and "I have a laugh with everyone".

Relatives were also positive about the caring nature of the staff telling us, "She's so happy here and really well looked after. She gets her makeup done, they all hold her hand and give her a kiss".

Staff spoke fondly and respectfully of the people they supported. Comments included, "I love it here...I love my job", and "I always treat people as I would want to be treated if I was in a care home".

People were encouraged to be involved in their care, to help promote their independence. People's privacy and dignity was promoted. Staff knocked on people's bedroom doors prior to entering them. People looked well dressed and staff made people feel and look nice.

People's religious, spiritual and cultural needs were detailed in their care plans, and visiting clergy attended each month to carry out a service and to meet with people on a one to one basis, should they wish.

People had care plans in place to help provide guidance and direction to staff about how they wanted to receive their care and support. Care plans detailed people's health and social care needs, and were updated and reviewed on a monthly basis.

People told us they felt confident to raise any concerns. Telling us, "I've never had a complaint but if I had I'd ring for the senior person in charge" and "It's very nice here, I have no complaints."

People were supported with dignity, at the end of their life. Staff had received palliative care training and the service had a close link with the local hospice.

The registered manager had a variety of quality audits which were used to help monitor the quality of the service. Audits were completed on a monthly and annual basis by the registered manager, and designated staff. However, despite these being in place, they had failed to identify the areas found to require improvement as part of this inspection, as cited above in each key question.

Despite the registered manager and deputy manager having many years of care home management experience, they had no nursing qualifications, and formal arrangements had not been made for any clinical input to feed into the provider's overall governance framework. For example, clinical staff were not always involved in the monitoring of clinical provision.

The provider carried out a visit to the service to monitor quality and to obtain people's views. However, the most recent visit which had taken place in September 2018 had failed to identify the areas found as part of this inspection.

The registered manager ensured that they kept their knowledge up to date. People lived in a service with a positive, empowering and inclusive culture which had been created by the registered manager.

Staff were motivated by the people they supported and wanted to do a good job. Staff told us they enjoyed working at the service, and felt supported.

People's feedback about the service was sought and their views were valued and acted upon. The service worked positively with external agencies in order to help continuously learn and improve. A GP told us the service engaged positively and that they had no concerns.

The service held a strong link with the local community. The registered manager had notified the Commission appropriately in line with their legal duties. For example, when someone had passed away. The rating of the provider's last inspection was displayed in line with legal requirements.

We found a breach of regulation. Full information about CQC's regulatory response to the more serious

concerns found during inspections is added to reports after any representations and appeals have been concluded.

In addition, we recommend the provider ensures the pre-assessment processes takes account of clinical expertise. We also recommend the provider takes account of the Accessible Information Standard (AIS) in the design and delivery of the service, and that they consider guidance set out by the Royal College of Nursing (RCN) and the National Institute for Clinical Excellence (NICE) with regards to the implementation of assistant care practitioners. As well as strengthening their processes for checking medicines administration, to help ensure that they are robust in identifying areas requiring improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Aspects of the service were not safe.

People continued to be at risk of harm or illness because documentation regarding the management of risk was not always accurate.

People's medicines were not always managed safely.

People were supported by sufficient numbers of staff. However, potential risks associated with the development of care staff into clinical roles, had not been effectively assessed. Consideration had not been given to the impact on nursing accountability and responsibility.

Overall, people were now protected by infection control practices.

People were protected from abuse. There were now safe recruitment practices in place.

People now lived in a safe and secure environment.

Overall, lessons were learnt when things went wrong, and the learning used to help improve the service.

Requires Improvement ●

Is the service effective?

The service was effective.

People's needs were assessed prior to them moving into the service.

People received care and support from staff who had received training to meet their needs.

People received enough to eat and drink, and told us the food was nice.

The service worked well with external organisations to the benefit of people.

Good ●

People were encouraged to live healthy lives, and their overall wellbeing was promoted.

The design and decoration of the service met people's needs.

People's communication needs were known by staff.

People's human rights were protected.

Is the service caring?

Good ●

The service was caring.

People received care from kind and compassionate staff.

People were involved in their care, as far as possible.

People's privacy, dignity and independence was promoted.

People's individual equality and diversity needs were met and respected.

Is the service responsive?

Good ●

The service was responsive.

People received personalised care. However, we have recommended that people's clinical care plans, take account of relevant best practice.

People told us they felt confident to raise any concerns.

People were supported at the end of their life with compassion.

Is the service well-led?

Requires Improvement ●

The service was not always well-led.

People continued to live in a service that the provider did not effectively and safely monitor. The provider's systems and process were not robust and had failed to identify the areas which had been found to require improvement, as part of this inspection.

The provider had failed to ensure there was clinical oversight and support to the management team to ensure safe and up-to-date nursing practice was followed.

There was a positive, empowering and inclusive culture which

had been created by the registered manager.

Staff were motivated by the people they supported and wanted to do a good job.

People's feedback about the service was sought and their views were valued and acted upon.

The service worked positively with external agencies in order to help continuously learn and improve.

Ilsham Valley Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 15 October 2018 and was unannounced. The inspection was carried out by one adult social care inspector, a specialist advisor for older people's nursing care, and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we contacted Healthwatch Torbay, and a GP practice for their feedback about the service. Where this was given, it can be found throughout the report.

Prior to the inspection we reviewed records held about the service. This included the Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed previous inspection reports and notifications. Notifications are specific events registered people have to tell us about by law. In addition, we reviewed information that had been shared with us, such as complaints, and compliments, as well as information from the adult social care safeguarding team.

During the inspection we spoke with six people and two relatives.

We reviewed seven people's care plans, as well as other associated care records such as food and fluid charts, re-positioning charts, bed rails, mattress pressures, personal care records, topical (cream and lotion) application charts, and 20 medicine administration records (MARs). We also spoke with seven members of staff and reviewed one staff personnel record and the training records for all staff. Other records we reviewed included the records held within the service to show how the registered manager and provider reviewed the quality of the service. This included a range of audits, questionnaires to people who live at the service, minutes of meetings and policies and procedures.

Is the service safe?

Our findings

At our last inspection in July 2017, the rating for this key question was Requires Improvement because people were not always protected from risks associated with their care and fire prevention and portable appliance testing (PAT) were not safe. In addition, the recruitment of staff was not always carried out safely, and people were not always protected from infection control practices. Whilst some improvements had been made, further improvements were still required. Therefore, the rating of Requires Improvement remained. The provider told us in their provider information return (PIR), that since the last inspection "Our care plan risk assessments have been improved". However, this is not what we found.

People were not always protected from risks associated with their care. People had risk assessments in place to help guide staff to deliver safe care in line with people's individual needs, such as moving and handling, skincare, personal care and behaviour. However, people's risk assessments did not always provide sufficient detail about how to mitigate associated risks, and did not always reflect best practice guidelines. This meant people may not receive consistent and safe support.

People who had epilepsy did not have detailed care plans about what action to take in the event of a person having a seizure. For example, one person's care plan did not detail any information about the duration, the importance of verbal support and incontinence. In addition, it did not detail the instructions to take if the seizure had not stopped, and if and when medicines should be administered. Another person who received medicines to manage their epilepsy did not have a care plan or risk assessment in place. The registered manager told us the reason for this was because they had not had a seizure in over a year. However, this did not follow best practice guidelines laid out by the National Institute for Clinical Excellence (NICE).

People who could become distressed and who were on medicines to help reduce their anxiety did not have behavioural care plans or monitoring charts in place to help identify triggers, themes and trends. This meant the person may experience unnecessary periods of anxiety that could be managed more effectively, rather than with management of medicines, such as by social interaction. One person who had experienced suicidal thoughts and had previously tried to take action to end their life by using the cord from their care bell, was found to have a call bell with a long cable in their bedroom. The registered manager told us the person had the mental capacity to make a decision to have a call bell, however confirmed that they did not know it was in the person's bedroom. Despite, the person having mental capacity, there had been no risk assessment completed with the person, to determine whether the call bell posed an unnecessary risk for any future attempts. The registered manager told us she would take immediate action to speak with the person, complete a risk assessment and remove the call bell, as necessary.

People who had risks relating to their hydration had been prescribed supplements. However, the instruction for actions was inconsistent. For example, one person had a normal drink in their bedroom but was prescribed a thickener on their medicine administration records (MARs). Another person had been prescribed a supplement to thicken their drinks, however their care plan stated, 'no difficulty with swallowing'.

People who were at risk of not drinking enough also had this recorded, but there was no effective monitoring of the information so that proactive action could be taken as needed. For example, one person's monitoring charts for two out of five days showed consistently less than the required 1500mls, with only 850mls on one of the days. But no action had been taken. In addition, people's records were sporadically checked and their intake totalled. This meant that people could be at risk of not receiving enough to drink.

Risks associated with people's care were not always documented accurately to help mitigate ongoing risk of harm and/or reduce reoccurrences.

This is a breach of Regulation 17 of the Health and social care act 2008 (Regulated activities 2014).

However, despite people's records not being accurate, all staff knew people very well and how to meet their individual needs, and no one had come to harm. The registered manager told us they would take action to speak to nursing staff and improve care records.

Overall people's medicines were stored securely. Medicine trolleys were secured to the wall and medicines requiring additional security, were stored safely. However, the fridge containing people's insulin was unlocked. The registered manager told us a new fridge had been ordered, as they had been experiencing problems with it. The new fridge was due to arrive in November 2018. Whilst this was positive action, we explained the importance of risks needing to be mitigated in the short term. At the time of our inspection, the maintenance person managed to lock the fridge, and showed nursing staff how to do it.

People's topical medicines were not always dated when opened, and care records did not always detail where people's creams should be applied. For example, one person who had skin damage and needed creams to be applied did not have detailed information and/or a body map in place to show staff were to apply them. This meant there was a risk of topical medicines being used past their expiration date, and people not receiving creams as prescribed.

The registered manager used a monthly medicines audit to help highlight where improvements were required. However, the audit had not been effective in identifying what we had found at our inspection. Nursing medicines competency was assessed on an annual basis; however, this was carried out by the deputy manager, who did not have clinical experience. So, it was unclear how nursing competency was being safely and knowledgeably assessed.

We recommend the provider strengthens their processes for checking medicines administration, to help ensure that they are robust in identifying areas requiring improvement.

People who required time specific medicines had clear records in place as to when these should be administered. People's medicine administration records (MARs) were signed when medicines were administered. People had received an annual medicines review. One person told us, "The nurse gives me medicine and I take it whilst she's here".

People were supported by sufficient numbers of staff and a consistent staff team, with one person telling us "I see the same carers and nurses, the faces don't change much". The registered manager completed an assessment tool, which helped to ensure there were the right numbers or staff to meet people's individual needs. The registered manager told us the provider was flexible to staffing provision, and if they needed additional staff, for example if someone was at the end of their life this was authorised. People told us their call bells were answered promptly with one person telling us; "I use the call button to ask to be taken downstairs, they're pretty good and always answer the bell within a couple of minutes".

With a national shortage of nurses, the provider had decided to offer care staff the opportunity to undertake training to become assistant care practitioners, so that they could carry out practical elements of nursing care, such as medicines management, phlebotomy and catheterisation. This would then enable nursing staff to take on more of a supervisory role. However, whilst this was an exciting initiative to help ensure ongoing sustainability of the service and positive development of staff. Potential risks associated with the development of care staff into clinical roles, had not been effectively assessed, and consideration had not been given to the impact on nursing accountability and responsibility. Two nurse spoke of their feelings of 'vulnerability' and of the lack of clinical oversight at a management level.

We recommend the provider considers guidance set out by the Royal College of Nursing (RCN) and the National Institute for Clinical Excellence (NICE).

People were seen to comfortably approach and speak freely to staff. People and families told us they felt "Safe", with one person commenting "I feel safe and comfortable here". The provider had installed closed circuit television (CCTV) in outside/external areas to help ensure people's ongoing safety and signage to inform people was displayed.

People were protected from abuse. Staff told us they would not hesitate to raise any concerns with the registered manager if they felt someone was being abused, mistreated or neglected. The registered manager had a good understanding of their safeguarding responsibilities, and staff had received training and knew which agencies they could contact, such as the local authority safeguarding team or CQC.

People, at our last inspection in July 2017, were not fully protected by the provider's own recruitment procedures. This was because when Disclosure and Barring Service (DBS) checks had detailed that a potential employee had a previous criminal conviction, this had not been risk assessed to help ensure they were still suitable to work at the service. A DBS check is a mandatory check to help ensure that any employee choosing to work with vulnerable adults, is suitable and of good character. At this inspection we found action had been taken to ensure people were fully protected. The provider had now introduced a risk assessment which was completed when a DBS check showed a previous conviction. This additional assessment meant people were now fully protected by recruitment processes.

The provider followed their recruitment policy and undertook relevant checks of all new staff. This included a full employment history, as well as reference checks from previous employers and a Disclosure and Barring check (DBS). A DBS check is a mandatory check to help ensure that any employee choosing to work with vulnerable adults, is suitable and of good character.

Overall, people were now protected by infection control practices. At our last inspection improvements were needed to the laundry area and to staff training and competence. Action had been taken to make changes to the laundry facilities by installing a new sink, and staff had received a training update in infection control. Staff were seen to wear personal protective equipment (PPE) appropriately. There were paper towels, soap and pedal bins in bathrooms. However, both sluice areas were cluttered with commode pots, with a strong unpleasant odour and the clinical bin had a black bin liner instead of a clinical bag. This meant, there was a risk of clinical waste being thrown in the general refuse waste bin. The registered manager told us she would take immediate action.

People now lived in a safe and secure environment. At our last inspection recommendations made from an external fire precautions workplace risk assessment had not been carried out, and portable appliance testing (PAT) had not been completed since 2015. Action had been taken to ensure the premises met fire regulations and PAT had been carried out. The maintenance person had now also been trained to test items

as necessary, prior to the home's annual PAT assessment. In addition, all equipment was serviced in line with manufacturer's guidelines and people had personal emergency evacuation plans (PEEPs) in place, which helped to describe to the fire service what support people needed in the event of an emergency.

Overall, lessons were learnt when things went wrong, and the learning used to help improve the service. For example, the provider had acted to improve the service following our last inspection.

People were supported safely when mobilising, and wheelchairs were used appropriately with footplates. Staff informed people in a kind and caring way, to help reduce anxiety when being moved in hoists. People's accidents were reviewed, and themes and trends analysed so action could be taken to help minimise reoccurrences.

Is the service effective?

Our findings

At our last inspection in July 2017, the rating for this key question was Good. The rating has remained Good.

People's needs were assessed prior to them moving into the service. This pre-assessment was then used to help create a person-centred care plan for all staff to follow. However, the pre-assessment was completed by either the registered manager or deputy manager who had no clinical experience. The registered manager told us they did not feel that it was necessary to involve a nurse in the initial assessment and final decision about offering a person a placement, because they and the deputy manager had many years of care home experience. This meant, people's clinical needs may not be effectively and correctly assessed before moving into the service.

We recommend the provider ensures the pre-assessment processes take account of clinical expertise.

People received care and support from staff who had undertaken training the provider had deemed to be mandatory. The provider's training matrix, a document used to record all staff training in a centralised way, detailed training such as first aid, fire safety, moving and handling, and nutrition. The registered manager was passionate about high quality training telling us "You are nothing without your staff". They told us in their provider information return (PIR), "Our staff are trained by the local Torbay Hive [linked to the local hospital] and have all achieved good outcomes and five are currently developing their performance with Diplomas".

Nursing staff undertook relevant training and continued professional development (CPD), in line with their professional registration with the nursing and midwifery council (NMC). The service had a close link with the local hospital training department. They told us in their provider information return (PIR), "We have a nurse liaison who works with all the nurses for any advice and help they may require with their practice".

New staff joining the organisation had an induction period. They completed the provider's internal induction, which introduced them to people, the routines of the service, and to policy and procedures. The care certificate was completed when staff did not have experience in working in the health and social care sector. The care certificate is a national initiative, to help improve the consistency of staff induction across the health and social care sector.

The service worked well with external organisations to the benefit of people. A GP who visited the service frequently told us they felt the service met people's needs effectively, and that the service communicated well. People told us, and their care records showed, that they could see a GP as required, as well as other professionals such as an optician and chiropodist. The provider told us in their provider information return (PIR), that "We regularly liaise with other professional to achieve good outcomes in our care".

People were encouraged to live healthy lives. One person told us, "Once a month we have a gentleman come in to do chair exercises". Another person told us how they tried to exercise their upper body daily, to help with the use of their wheelchair.

People were encouraged to eat a balanced diet. People had care plans in place which detailed how they needed to be supported. People's likes and dislikes were known, and reviewed. Specialist's diets were also catered for reasons of health and/ or for spiritual or religious beliefs. Overall people told us the food was nice, commenting the "Food is excellent here" and "The food has been delicious". However, one person told us "Food is adequate, sometimes it's good, but there are too many sandwiches in the evening and only two choices at lunchtime". When required, people's weight was monitored to help identify quickly if action was needed to be taken. One relative told us how impressed they had been with how staff had supported their loved one with their nutrition telling us, "Since Mums been here, her weight has actually increased. In every other care home, she's struggled to stay the same weight and in some she's actually lost weight".

People lived in a service which had been designed to help meet people's needs. There were bathrooms which had been adapted to ensure they were suitable for wheelchair users and high toilet seats fitted to help support people to get up from the toilet easier. There was a shaft lift and chair lift to upper floors. A summer garden project had been successful in creating a woodland garden, with raised flower beds with wheelchair access. Photographs displayed in the entrance area showed how people had benefited from the outdoor space.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

People's care plans included a section regarding their mental capacity and how they should be suitably supported. The registered manager and staff had undertaken training in the Mental Capacity Act (2005) and had a good understanding.

People's consent to their care was obtained and recorded in their care plans. This included consent to photographs being taken, and for them to be used in the promotion of the service. Staff always asked people if they wanted to wear a clothes protector at meal times to prevent dropped food from spoiling their clothes.

People's communication needs were documented in their care plans, and staff told us how they adapted their own communication styles to help people to understand them. For example, people who were partially sighted, staff told us they took time to explain everything they were doing to help reduce anxiety, and involve them in their care. Staff told us how one person would squeeze their hand to help determine answers to what support they needed or how they were feeling.

Is the service caring?

Our findings

At our last inspection in July 2017, the rating for this key question was Good. The rating has remained Good.

People were complimentary of the caring staff that supported them, commenting "It's like being at home. I'm not lonely and I'm well looked after here", "I'm treated here as well as I could be" and "I have a laugh with everyone". One person, who had been staying for a short stay took time to tell staff verbally how they had made her feel commenting "Thank you for all you have done. You've all made me feel great"!

Relatives were also positive about the caring nature of the staff telling us, "She's so happy here and really well looked after. She gets her makeup done, they all hold her hand and give her a kiss. When mum was younger she was very sociable, so she loves the attention she gets here. I've not seen her as happy and content for years". Another relative told us, "When Mum first came here she was very poorly, she's so much better now I really can't rate the place highly enough. People are so caring here".

Staff spoke fondly and respectfully of the people they supported. Comments included, "I love it here...I love my job", "They [people living at the service] mean a lot", and "I always treat people as I would want to be treated if I was in a care home". Staff spoke with people positively, showed patience and engaged in a fun-loving way. One person was anxious about a member of staff who was leaving the lounge. Time was taken to assure the person that they would be back to see them, which helped to alleviate the person's anxiety levels. There was a happy and inclusive atmosphere within the service.

People were encouraged to be involved in their care, to help promote their independence. One person told us, "I ring the bell in the morning and my carer comes in to help me wash". Staff explained how they encouraged people to do as much as they could for themselves, for example asking people to wash their own hands and face, and doing up their buttons on their shirts or blouse.

The prevention of loneliness was considered by the staff, with one person telling us "Once you're upstairs in your room, you're not forgotten as people do come in". There was also a key worker system which meant that people had an allocated member of staff, who could spend quality time with them, getting to know them and providing personal touches to their care. Staff gave up their own time to accompanying people on social outings, for example to the theatre.

To help improve ongoing relationships and promote meaningful conversations the provider told us in their provider information return (PIR), that "We are also monitoring conversations between care staff and residents so that a dialogue can be continued on a daily basis thereby giving our residents a daily activity and improving carer resident relationship".

People's privacy and dignity was promoted. Staff knocked on people's bedroom doors prior to entering them. People looked well dressed and staff made people feel and look nice. For example, staff had taken the time with one person's eyebrows, to present them as they wanted them to be.

People's birthdays were celebrated with a cake, with one person telling us "Every time there's a birthday we have a party. Special food and games. It's great". People's family and friends, could visit at any time, and during our inspection visitors were always welcomed warmly by staff and offered a cup of tea.

People's religious, spiritual and cultural needs were detailed in their care plans, and visiting clergy attended each month to carry out a service and to meet with people on a one to one basis, should they wish. The provider had an equal opportunities policy which promoted "equal treatment for all employees and residents irrespective of race, colour, sexual orientation, nationality, ethnic origin, religion, political beliefs, age or gender". The provider told us in their provider information return, "We have a multi-racial home and it is important we work as a team. Equality is essential and the leadership at the home respects the skills of the team and encourages team input from everyone in the home including the residents so that fairness, respect and equality are forefront in how the home is lead making everyone autonomous and responsible for each other in their own environment".

Is the service responsive?

Our findings

At our last inspection in July 2017, the rating for this key question was Good, at this inspection the rating has remained Good.

People had care plans in place to help provide guidance and direction to staff about how they wanted to receive their care and support. Care plans detailed people's health and social care needs, and were updated and reviewed on a monthly basis.

People told us there were social activities for them to participate in, commenting "They have entertainment here, I was downstairs yesterday. I can't fault it", "We have concerts, we don't have quizzes every day. Music is played in the lounge and sometimes people sing to us. It's a great place" and "The band Spam Fritters come in to do old tunes. A lady comes in to do impressions of film stars. Another lady comes in to ask us quiz questions". On the day of our inspection there was entertainment in the morning, which people enjoyed joining in with. However, in the afternoon, there was little going on for people. People were mainly sat in chairs in the lounge with the TV on in the distance.

People told us they felt confident to raise any concerns. Telling us, "I've never had a complaint but if I had I'd ring for the senior person in charge" and "It's very nice here, I have no complaints. If I did I'd tell one of the carers". The registered manager told us there were no complaints being investigated. They told us there was a policy and procedure in place, and that people's complaints were always seen positively and used to help improve the service. The provider's complaints policy was displayed in the care home for people to access. However, the complaints policy was in the written word, was in small font and displayed high up on a notice board. Therefore, the design and position of this policy did not take into account people's individual communication needs.

We recommend the provider takes account of the Accessible Information Standard (AIS) in the design and delivery of the service.

People were supported with dignity at the end of their life. The provider told us in their provider information return (PIR), that they "Discuss any arrangements with family members and also residents so that if they require a tailor-made end of life we can accommodate this when the time comes and their choices are discussed and implemented". Staff had received palliative care training and the service had a close link with the local hospice. One of the nurses was undertaking accredited training with the hospice, and when completed would become an end of life ambassador for the home. They will then become the lead nurse in the home for end of life care, and ensure evidence based guidance is implemented and followed. As part of this role people's care plans were being re-developed by having conversations with people and their families to make sure they become more detailed and personalised. Pain management and end of life medicines were discussed with external professionals, and in place as needed.

Is the service well-led?

Our findings

At our last inspection in July 2017, the rating for this key question was Requires Improvement because people's care records were not always accurate and the provider's systems to monitor the quality of care and the service people received were not robust in identifying when improvements were needed. Whilst some reactive improvements had been made as a consequence of our previous inspection findings, we found there was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities 2014), and additional areas were now requiring action. This meant the provider's overall governance framework had not been suitably adapted and was still not effective in helping to drive and sustain improvement at the service. Therefore, the rating has remained Requires Improvement.

The provider had a quality policy statement, which stated "Ilsham Valley Nursing Home is dedicated to the provision of the finest care for its' residents. This will be achieved through the integration of efficient administrative practices". However, the findings of this inspection, indicated that the policy was not effective in achieving its' purpose.

The registered manager had a variety of quality audits to help monitor the quality of the service. Audits were completed on a monthly and annual basis by the registered manager, and designated staff. Some of these included, complaints, care planning, accidents, medicines, environmental and recruitment. However, despite these being in place, they had failed to identify the areas found to require improvement as part of this inspection, as cited above in each key question.

The registered manager and deputy manager had many years of care home management experience, but had no nursing qualifications. Therefore, the provider told us they employed a nurse liaison to ensure clinical practices were reviewed. However, no formal arrangements had been made for this clinical input to feed into the providers overall governance framework. For example, clinical staff were not always involved in the monitoring of clinical provision. The medicines audit which had been carried out by the deputy manager, who did not have clinical experience had not identified that improvements were needed. Care planning audits had not identified that clinical care plans did not always reflect best practice. Further information about this is detailed above in the key questions of safe.

There was an informal checking system in place to ensure the ongoing registration of nurses with the professional body, the Nursing and Midwifery Council (NMC), as well as when nursing re-validation was due. This meant, if nursing staff did not inform the registered manager themselves, registration may not happen, which could mean unregistered nurses working within the service. The registered manager acted to create a monitoring system at the time of our inspection.

The provider told us in their provider information return (PIR), that "Our staff have a floor leader who coordinates the floor and a care lead who leads all the carers and rotas the daily tasks for the residents to be cared for. The care is overseen by the deputy care who makes sure by checking various residents care that everything is being done correctly and residents are receiving the best care by the organisation". However, despite these roles being in place, they had failed to identify that records relating to people's care as

detailed above in the key question of safe were not being accurately completed.

The provider carried out a visit to the service, and people and staff confirmed that they visited the service unannounced most months, to monitor quality and to obtain people's views. A report was produced and action plans created. However, the most recent visit which had taken place in September 2018 had failed to identify the areas found as part of this inspection. In addition, the provider did not have clinical experience to review clinical practices within the service. This showed that these visits were not robust in helping to ensure quality and safety.

The registered manager explained and the provider told us in their provider information return (PIR), that "Over the next year the roles of floor senior carers will be taking on the carer practitioner roles and will be able to carry out observations, medication administration, catheterisation and venepuncture together with wound dressing etc. The new staff additions together with the lead care and deputy of care are all practically now skilled to carry out all nurse based practical tasks - this will now free up registered general nurses (RGNs) time to work on care plans and delivery a fuller experience to our residents". Whilst this was an exciting initiative to help ensure ongoing sustainability of the service and positive development of staff, consideration had not been given to the impact on nursing accountability, responsibility and their professional registration with the Nursing and Midwifery Council (NMC). In addition, related policies and procedures had not been developed.

The provider's value statement was: "As a Nursing Home, Ilsham Valley aim to provide accommodation and nursing care of the highest standard for our clients". However, the findings of our inspection demonstrated the provider had not effectively monitored the service, to ensure that their values are underpinning the practice of staff.

Since our last inspection in July 2017, despite the registered manager creating an action plan for improvement, the ratings for key questions have either remained the same and/or deteriorated. We also found continued breaches of the Health and Social Care Act 2008, with further breaches and additional recommendations being made. This meant people continued to live in a service that the provider did not effectively and safety monitor.

The providers governance framework continued to not be effective in helping to monitor the quality and safety of the service.

This is a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities 2014)

The registered manager ensured that they kept their knowledge up to date. The provider told us in their provider information return (PIR) that the registered manager was "Presently taking part in a creative management leadership program with local creative people working with the Creative Learning Group and Torbay Commissioning Group to bring together managers and assist with leadership skills".

People lived in a service which a positive, empowering and inclusive culture which had been created by the registered manager. The registered manager told us, "We come together and work on everything as a team...we can do so much more for our residents when we all work together". This was reflected in conversations with staff and our observations of people's care and support. One relative told us, "All the nurses or carers bring their paperwork into the lounge and sit at the centre table. I like that as there's always chatter going on".

Staff were motivated by the people they supported and wanted to do a good job. Staff told us they enjoyed working at the service, and felt supported. Although, there was a management structure in place staff felt that there was no hierarchical challenges between management, care staff and nursing staff. With one member of staff telling us, "I find everyone approachable".

Staff told us there was a whistleblowing policy in place and that they would not hesitate to report poor staff conduct to the registered manager, so that action could be taken. They also told us they had direct access to the providers contact details, should they want to speak with them directly.

People's feedback about the service was sought and their views were valued and acted upon. For example, quality questionnaires were issued to people and external professionals to obtain views. The registered manager told us if there were any concerns these would be dealt with on a one to one basis, so that they could be sorted out. However, the overall outcome of the survey was not shared or displayed in the service, which meant people were not always fully informed of the outcome of their contribution.

The provider was a member of www.carehome.co.uk, and encouraged people to write reviews. At the time of our inspection, the provider had a review score of 8.3 out of 10, and an average rating of 4.6 out of five from four reviews over all time, with the last review in June 2017.

The service worked positively with external agencies in order to help continuously learn and improve. A GP told us the service engaged positively and that they had no concerns.

The service held a strong link with the local community, with the provider telling us in their provider information return (PIR), that "We attend the memory cafe with residents and also go to events from our independent community Wellwood and Torwood who are the villages supporting Ilsham Valley Nursing Home, with transport and events they put on for elderly and disabled people".

The registered manager had notified the Commission appropriately in line with their legal duties. For example, when someone had passed away. The rating of the providers last inspection was displayed in line with legal requirements. At the time of the inspection the registered manager did not know what the Duty of Candour (Doc) was. However, they displayed openness and transparency throughout the inspection process, thus demonstrating the main principles of it.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Risks associated with people's care were not always documented accurately to help mitigate ongoing risk of harm and/or reduce reoccurrences. The providers governance framework continued to not be effective in helping to monitor the quality and safety of the service.

The enforcement action we took:

We issued a Notice of Proposal (NOP) to impose a positive condition on the providers registration.