Greenhill Care Homes Limited

Ilsham Valley Nursing Home

Inspection report

Ilsham Close
Torquay
Devon
TQ1 2JA

Tel: 01803292075
Website: www.ilshamnursing.com

Date of inspection visit:
31 July 2017

Date of publication:
19 October 2017

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

Ilsham Valley Nursing Home is a care service with nursing registered to provide accommodation and care for up to 23 people. Most but not all of the people living at the service are older people. The service does not offer care to people with dementia as a primary diagnosis but some people may have some early memory loss associated with other illness or disability.

The service is set over two floors, with a lift to access the first floor. It is set in the Wellswood area of Torquay, close to the sea and local shops and services.

At the last inspection on 15 and 19 May 2015 the service was rated as good in all areas apart from well led, where it was rated as requires improvement. The overall rating was good. At this inspection in July 2017 we found the service had not sustained some of this good practice. We also identified a number of concerns and breaches of legislation. The service has been rated as requires improvement overall.

We found the service did not have strong, effective and robust systems of governance and management. Although we did not identify that people had suffered harm as a result, the failure to have clear accountability for actions within the management structure left people at risk of receiving poor or unsafe care. Some systems for audit had lapsed, and where concerns had been identified by the organisations own processes, such as with fire precautions or infection control there was no clear and well understood plan of action shared within the management team to address them.

Risks to people's health or well-being were not always robustly assessed and managed and some records regarding their care were inconsistent or did not contain easily available information on people's current needs. This meant the records could not always be relied upon to provide evidence of changes in people's needs or health conditions. We have made a recommendation about the updating of care plans. The service had activities available for people to take part in and people's care plans contained contain information about what interests people had, so staff could tailor these accordingly.

Incidents such as falls or accidents were not currently being analysed and an incident where a person had suffered harm when a bed rail was not put in place had not been reported to the appropriate agencies as it should have been. The service had investigated and taken appropriate action themselves. This did not demonstrate openness or transparency as a service.

People did not always receive safe care in an environment where action was consistently taken to reduce assessed risks. The service had undertaken audits or commissioned risk assessments, some of which had identified concerns about the premises, such as fire precautions, carpets needing replacing or the laundry and sluice areas. While some smaller actions had been taken there was no available or well understood action plan in place for when larger areas would be addressed. This could leave people at risk, and does not demonstrate effective management of the service. The environment was however, homely and comfortable.

We also had concerns there was no person at the service with nursing experience leading the nursing team or assessing the quality of their clinical practice. The provider has told us the registered manager, deputy and nursing staff "work collectively as a Nursing Team to lead the service on a collective basis" and have taken advice from Skills for Care on how this can be demonstrated.

Records were not all well maintained, and appropriate notifications had not always been made to the Care Quality Commission or other services as required by law.

People told us the service met their needs and they were happy with their care. We saw many examples of positive practice in place, with staff supporting people in a gentle and caring fashion. People and staff had developed good relationships and staff told us it was a happy place to work.

People received their medicines safely and as prescribed. We saw people being given their medicines at their own pace, including medicines that needed to be given at specific times, such as antibiotics. People's healthcare was supported and we saw evidence of people receiving support from paramedics, GPs and other specialist community support teams.

There were sufficient staff on duty, with a registered nurse available 24 hours a day. Staff were working through a programme of training and told us they felt they had received enough training at Ilsham Valley Nursing Home or at other services to give them the skills and knowledge they needed. Systems were in place for the recruitment of staff and we have made a recommendation in relation to these to ensure they are robust in keeping people safe.

People received a well-balanced and nutritious diet. People told us they ate well. Staff understood when people had specific dietary needs or swallowing difficulties and how to support them with this.

People's rights regarding capacity and consent were understood and supported. Relatives were able to continue to be involved with their relations care and could visit the service after 11am or at other times in particular circumstances. People's privacy and dignity was respected, however we have made a recommendation in relation to the use of positive and respectful language when completing records or discussing people's needs.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People did not always receive safe care in an environment where action was consistently taken to reduce assessed risks.

Risks to people's health or well-being were not always robustly assessed and managed and some records regarding their care were inconsistent.

Incidents were not being analysed to identify trends and an incident where a person had suffered harm had not been reported to the appropriate agencies.

There were sufficient staff on duty, but we have made a recommendation in relation to the staff recruitment systems.

People received their medicines safely.

Is the service effective?

Good

The service was effective.

Systems for staff training and support were in place.

People received a well-balanced and nutritious diet.

People's rights regarding capacity and consent were understood and supported.

The environment was homely and comfortable.

Is the service caring?

Good

The service was caring.

Staff had built positive relationships with people and supported them to be as independent as they were able.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People received individual care in accordance with their agreed care plan; however some plans and records needed updating to reflect changes in people's needs. We have made a recommendation about this.

The service had activities available for people. People's care plans contained information about what interests people had.

Systems were in place for the management of complaints.

Is the service well-led?

Requires Improvement

The service was not always well led.

We did not see evidence of good leadership in place or evidence of a positive and open culture. However we did not identify people had suffered harm as a result.

Some management or governance systems were not effective in making changes and improvements at the service.

Records were not all well maintained, and appropriate notifications had not always been made to the Care Quality Commission or other services as required by law.

People told us they were happy with the services they received.

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 checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This was a comprehensive inspection which took place on 31 July 2017. The inspection was unannounced, and was carried out by one adult social care inspector.

Prior to the inspection we reviewed information we held about the service, and notifications we had received. A notification is information about important events, which the service is required by law to send us. We contacted professionals involved with the service such as the local authority quality team for their views on the service.

During the inspection we spoke with or spent time with seven people who lived at the service, two relatives, nine members of staff including registered nurses, care and support staff, cleaning and catering staff. We also spoke with the registered manager and deputy manager. We spent time observing how people spent their time as well as how people were being supported by the staff team.

We looked at the care records for four people with a range of needs. These records included support plans, risk assessments, health records and daily notes. We sat in on two handover meetings, one for trained nurses and one for care support staff to see how information was shared and how duties were delegated for the day. We looked at records relating to the service and the running of the service. These records included policies and procedures as well as records relating to the management of medicines, food, and health and safety checks on the building. We looked at two staff files, which included information about their recruitment and other training records. We also viewed a number of audits undertaken by the service or commissioned by them to identify any concerns to people's health and well-being.

Requires Improvement

Is the service safe?

Our findings

At the last inspection of Ilsham Valley Nursing Home in May 2015 we rated this key question as good. On this inspection we identified some concerns and the service was rated as requires improvement.

People were not always being protected from risks associated with their care, because the service had not consistently assessed, monitored and reduced risks to people. One person was living with epilepsy. We found care records and assessments were not detailed or consistent in relation to the actions staff should take when the person had seizures. We found a record stating the person had a series of minor seizures, which had lasted "most of the morning". The registered manager later clarified with us this was "not an actual petit mal but a prelude to a possible seizure". This was not recorded in the person's daily notes, which said they had been free from "apparent symptoms". Risks to this person were increased because the poor monitoring and recording of seizure activity, meant the records and assessments could not be relied on to guide staff as to any potential deterioration in the person's condition, or alert them as to when to seek medical or emergency support.

One person was living with diabetes. A registered nurse on duty told us the person's usual blood sugar levels varied considerably throughout the day. Registered nurses had been thoughtful in trying to make improvements for the person, for example by moving their mealtimes to allow for a more even spread throughout the day. However, there was no clear risk assessment, or management plan for staff on how to support this individual person with this condition, or when to seek medical support because their condition was placing them at risk. A registered nurse told us the person's blood sugar could be raised "very high" at times, and we saw that at times registered nurses had correctly omitted the person's insulin because their blood sugar was low. However there was no written protocol for what 'at risk' looked like for this person, placing them at risk of harm or potentially inconsistent care.

We spoke with the registered nurse on duty and registered manager about these risks. The registered nurse demonstrated a good knowledge and understanding in relation to the management of each individual's long term health conditions. However, these management strategies were not recorded in people's assessments for care staff to follow.

People were at risk of not having distressed behaviours understood. We heard some inappropriate language or terminology being used that did not show the person was being respected. For example one person's behaviour was referred to as "can play up" when referring to behaviour that might be the result of anxiety or distress. We saw in this person's records their care plan referred to "difficult behaviour". This did not demonstrate an understanding of why the person was behaving in a particular way, or give guidance on how to support them positively to reduce risks and distress. This put the person at risk of not having their care needs met, because their behaviour was not understood.

Incidents and accidents had been analysed up until several months before the inspection. The registered manager confirmed the systems had not been used since then. This meant that active systems were not in place to ensure any themes or patterns in relation to accidents and incidents were identified.

We identified an incident that had resulted in harm to a person receiving care at the service. This had involved a bed rail not being put in place, and the person not having access to their call bell to summon support when they fell from the bed. The service had investigated the incident and taken disciplinary action. However, this had not been reported to the safeguarding authority or to the Care Quality Commission as it should have been and had been triaged by the registered manager as a 'near miss'. This meant the incident had not been subject to external scrutiny and review.

People were not being protected from harm because risks to their well-being from the environment were not being managed. The service had commissioned a Fire Precautions Workplace risk assessment in December 2016. The assessment had made a number of recommendations in relation to fire safety improvements that were needed, including additional external lighting, portable appliance safety and additional smoke detectors being needed. The portable appliance testing had not been carried out since May 2015. The registered manager told us the required works had not been completed, and was not aware if there was an action plan or schedule for these works to be carried out. Some areas identified as needing attention such as putting up a sign in the laundry had been carried out.

Following the inspection we contacted Devon and Somerset Fire and Rescue service to share our concerns. They told us they would visit the service.

Best practice in Infection control was not being carried out which exposed people to the risk of cross infection. The service's laundry was not clean, and could not be kept free from infection risks easily as surfaces were rough and the floor rough and unpainted. The service's own infection control assessment carried out in September 2016 and updated in April 2017 had indicated a risk was presented in this area as there was no hand washing sink in either the sluice or laundry room, but no action had been taken to address this. A person living at the service had been diagnosed with a known infection control risk. The registered manager told us they had not carried out an assessment of the risks this infection presented or provided guidance for staff. The registered manager told us this was managed because staff 'wore gloves' and 'did not come into contact with bodily fluids'. The lack of a proper assessment or guidance left people and staff at risk of cross infection.

The provider and registered manager had failed to take sufficient action to ensure care and treatment was provided in a safe way, and that identified risks were being mitigated or managed.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at two staff files, and saw staff recruitment procedures were in place. However we identified there was no record of risk assessing any declared convictions staff may have. The registered manager told us where staff had any criminal convictions they would discuss any issues with the staff concerned and make an informed decision. They later told us there was a system in place to record these risk assessments. However in the instance we saw there were no records in the person's file to records how this process had taken place. Staff files showed evidence that pre-employment checks had been made including written references and satisfactory disclosure and barring checks (police checks). Evidence of staff identity had also been obtained.

The provider was recommended to ensure that any risks associated with the staff recruitment process were fully risk assessed and recorded. This included any actions to be taken in relation to nurse registration identified subsequent to their employment.

Staff understood about abuse and how to report any concerns they had about people's well-being. Policies and procedures were understood. Information about how to raise concerns was on display in the service's hallway and office. One person told us "I feel safe here. They look after me well." Staff told us they would not hesitate to raise any concerns and knew where to find information to do so. One told us "It's my reputation as well." There were no current safeguarding concerns.

Some risks to people were being assessed and managed. Assessments had been undertaken of risks to people from malnutrition, skin damage from pressure, falls, and moving and handling. Appropriate actions were then taken to reduce foreseeable risks. For example some people had been assessed as being at high risk of skin breakdown. They had been provided with a specialist pressure relieving mattress, which we saw was adjusted correctly to ensure they operated effectively. People were moved regularly to relieve pressure and this was recorded to ensure staff were aware of the appropriate position to move them to. People's fluid and dietary intake charts were balanced each day and were up to date to ensure there was a clear record of the amounts taken by the person to maintain their health. One person's file said they were at risk of choking. Information on actions to be taken to prevent the person choking had not been updated or printed off, but the registered manager did so while we were at the service and placed them in the person's file. A staff member we spoke with was clear about the thickness of fluids needed by the person. We also observed good practice in relation to moving and handling people, which was in line with people's assessments.

There were enough staff with appropriate skills on duty to meet people's needs. People told us staff responded quickly when they needed assistance. One person told us "I have this thing here and I only need to press it and they come, day or night. You wouldn't get that at home." A registered nurse was always on duty, and the service had a regular team of nursing staff, and bank staff to support to provide more flexible cover.

Other risks to people's well-being from the environment were being managed. Lifts, hoists, and bath hoists were maintained and serviced regularly on a contract and regular tests carried out of fire alarms and by the service's maintenance person. People had personal evacuation plans in place to ensure their safety in case of a fire and emergency equipment was regularly tested and reviewed. Risk assessments were undertaken of safe working practices for staff to ensure they were protected and there were emergency plans and contact numbers in place for staff to use.

People received their medicines safely. Medicines practice at the service had been audited in March 2017 by the supplying pharmacist with no significant concerns identified. An audit of medicines needing increased security with storage and administration had been completed in April 2017. We discussed the administration of medicines with the registered nurse, and viewed the systems in place. Records were completed which showed medicines had been given to people in accordance with the prescribing instructions. Additional records were completed where for example there were variable prescriptions or where medicines required additional precautions due to their strength or effects. Medicines were stored safely in locked boxes in people's rooms, or for those needing additional security in a central double locked cupboard. On a tour of the service we saw two containers of a prescribed thickening agent had been left out in the lounge. The registered manager removed these immediately. We saw people being given their medicines, which was done with enough time to enable the person to take them at their own pace.

Staff had access to gloves and aprons and we saw these in use throughout the inspection. The registered manager told us linens and towels were on contract hire, so only people's personal laundry was done at the service. The registered manager told us each person's laundry was washed individually.

Good

Is the service effective?

Our findings

Staff we saw had the skills they needed to carry out their role. We saw support staff using equipment competently to move and position people, and demonstrating good practice when supporting people to eat. Staff told us they felt they had the training they needed, and many of them were experienced carers from other services who had completed training prior to coming to work at Ilsham Valley Nursing Home. The service had a training and development plan and matrix however this had been completed without some dates of training having been entered. This meant it was not easy to see when updates were due, or when people had actually completed the training. The registered manager agreed they would amend this. People told us the staff who supported them had the skills to do so. A relative told us of their relation "If he wasn't getting the nursing care he wouldn't be here."

Some training such as moving and positioning of people could be delivered in house by the registered manager and deputy who were trained to do so. Much of the other training was delivered by DVD format with a short quiz at the end. We found the training matrix covered core areas of training but did not demonstrate training had been provided in areas of care such as diabetes or epilepsy, which were conditions people were living with at the service. The matrix indicated that training or updates were needed for many staff in certain areas of practice, for example only four staff out of 33 had undertaken training in the Mental Capacity Act 2005, which relates to people's capacity to consent to their care. The registered manager told us staff were working through the programme, and most staff had completed this training elsewhere, although this was not always recorded. Following the inspection the registered manager told us nine of the staff who had completed their Care Certificate award "which would have incorporated a thorough induction on MCA 2005 training, and a full understanding of Best Interest. All staff have access to the 'Easy Read' "The Mental Capacity Act 2005, Deprivation of Liberty Safeguards."

We saw good practice in action where the deputy manager had worked alongside a member of staff to review their performance and skills. Care support staff told us they felt supported to carry out their role, and that they worked well as a team to support each other.

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's consent to their care and treatment was sought in line with legislation and guidance. We heard staff asking people for their consent when carrying out care tasks and offering them choices. Assessments had been made to assess some people's capacity to consent to care or specific situations, but the registered manager told us this was not in all their files yet. One person and their family had been involved in a 'best interests' decision in relation to the person's welfare and well-being. This had involved external agencies, including the Office of the Public Guardian, to ensure the person's best interests were being upheld. One person had chosen to make decisions that could be considered unwise or were against professional advice.

The person making these decisions had the capacity to do so, so this was recorded in their file, along with their relative's agreement.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care services and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The registered manager had made applications where appropriate for authorisation to deprive people of their liberty, which were awaiting approval by the local authority.

People were supported to eat, drink and maintain a healthy balanced diet. People told us the food was good and they ate well. One person said "It's very good" and they were trying to lose weight as they had put on weight since moving to the service. The main lunch on the day of the inspection was chicken or omelettes and salad. The evening meal was soup, scrambled egg on toast or sandwiches and a mousse dessert. One person told us they were enjoying taking their time over their tea and another said "I eat well. Sometimes they tell me I haven't eaten much, but I think it's enough."

Some people needed their food presented in different textures, due to swallowing difficulties and some people needed support to eat and drink. We heard staff discussing supporting one person at handover who was no longer able to take fluids through a straw. Staff were preparing to support the person by giving them drinks on a spoon to help ensure they drank enough to maintain their health.

People were supported to have access to good healthcare. Throughout the inspection we saw evidence of the service liaising with other agencies such as GP practices, pharmacies, community nurses and paramedics. One person was supported and assessed by a paramedic while we were at the service. They arranged for the person's GP to prescribe antibiotics for them following their assessment. People's files contained evidence of podiatry and optical services visiting the service.

Ilsham Valley Nursing Home provided a comfortable environment for people to live in. The shared lounge/dining room was small but 'lived in' and comfortable. Not everyone at the service was able to use these areas due to significant ill health or personal frailty, but people were encouraged to do so if they wished. People all had single rooms and some of these had en-suite facilities. People were encouraged to personalise their own rooms, and although not everyone had chosen to do this to a large extent, most rooms had family pictures and items of personal value. There were small gardens with a ramp, and a sunny seating area to the rear of the service which one person helped to garden in. Clinical and service areas were located at the rear of the service and there was some on-site parking. Some corridors were quite narrow but one person who used an electric wheelchair told us they managed well. There was a passenger lift to access the upper floor. Odour control was very good, despite people's needs being very high. Staff understood how to manage clinical waste to reduce the risks of odours.

The service had a CCTV system in place. This covered the exterior areas of the property and main entrance, and was observed on a live feed in the registered manager's office. This did not impact on people's personal care, and was mentioned in the service user's guide, so people were aware it was there.

Good

Is the service caring?

Our findings

People told us they felt the staff were kind and caring. One person said "the staff are kind" and another said "we all have a laugh." A relative said "It's not the plushest place, but it's the staff that make all the difference." Another commented their family member had been in a previous care home and had not received the appropriate care but now their relative was at Ilsham Valley they could relax and know their loved one was cared for properly.

People's privacy and dignity were respected in the interactions we saw taking place. People received care and support in private in their rooms where staff closed their doors.

People were supported by staff who took a positive approach towards their care. We saw many examples of staff supporting people to maintain lifestyle choices or interests. For example a visitor bought a small dog into the service. The nurse on duty took the dog around people's rooms to be patted which people had really enjoyed. They told us one person had "lit up" when they saw it. Another person's family were on holiday. It was their practice to come to the service every day to sit with their relation and give them a glass of brandy at tea time. Staff ensured this was continued while the person's family were away because "it is important to them." One person told us "It's the little things that matter."

We observed people were supported by staff with kindness and compassion. We saw people being supported by staff to eat and with moving and positioning tasks. Staff delivered care gently and spoke to the person throughout to ensure they felt comfortable and safe, or that the mealtime was an enjoyable experience for them. People were given choices such as where they wanted to spend time or what they wanted to eat. Staff celebrated achievements with people, such as walking a distance with staff support or finishing a meal when the person had recently had a poor appetite. We saw one person patted the staff member's hand and smiled after they had supported them to transfer to their chair. Staff took time to ensure people understood communication, including making sure they were speaking in people's 'good ear' or getting close to them and repeating conversation at the person's own pace. We observed staff cleaning people's glasses and ensuring they fitted well. One person said "Oh that's better" when their glasses were returned to them.

The registered manager told us visitors were welcome to the service after 11am, although they confirmed that visitors were able to come in at other times in specific circumstances, for example if someone was unwell.

People were supported to maintain their independence. We saw care plans indicated activities of daily care people could do for themselves and any equipment that may support them to maintain or improve this. We saw for example one person being supported to walk. Staff moved in front of them to ensure their pathway was clear, and their chair was ready for them at the end of the walk. The staff member said they would get the person "a cup of tea. You deserve it (person's name) after all that walking".

At the time of the inspection no-one was receiving end of life care at the service, but staff had experience of

supporting people at this time. Most people's care plans included clinical tools completed by the GP indicating if the person wished to have significant medical intervention in the case of a sudden serious deterioration in their health. Some people had requested full support be given, others, or their families where appropriate had made the decision this would not be in their relations best interests. One file we saw had a clear advanced directive from the person about their end of life care wishes.

Good

Is the service responsive?

Our findings

People told us they were supported well. One person said "I am well looked after, thanks" and another person said "very good" and nodded when we asked if they felt they had the care they needed. Staff were positive about the care they gave to people. One told us "I think the care is very good here" and compared it favourably with other places they had worked.

Each person living at the service had a plan of care, based on assessments of their need. Plans were wherever possible signed by the person or their relatives to confirm agreement. We looked at the plans for four people in detail and sampled others. We identified plans were not all up to date or did not contain consistent information about people's needs. This could mean people did not receive appropriate care as a result. For example one person's "monthly update sheet" had not been completed since 29 March 2017, despite them having had changes to their health since then. Another file did not contain up to date information about a person's risk of choking. The changes to their care plan were printed off and put in their file while we were at the service.

A communication sheet noted that for one person there was no decision recorded as to whether resuscitation should be attempted. However on their file there was a clear treatment escalation plan identifying it had been decided it was not appropriate or in accordance with the person's wishes that resuscitation be attempted. This could have led to the person receiving care that was against their wishes. We discussed this with the registered manager who agreed to amend this without delay.

Plans focussed on the person's healthcare support needs and did not always include sufficient detail in relation to the social care support people may wish or need. Plans had a greater focus on 'managing conditions', and did not always identify the person's strengths or goals for their care.

The provider is recommended to ensure plans and records for people receiving care and support were reviewed regularly and reflected best practice in care planning.

The registered manager told us they were working through plans putting in indexes to make the plans more organised and easier to read, but this was 'work in progress'.

We saw good examples of people being supported in accordance with their plans. For example we observed staff supporting one person to move to the lounge. They were assisted to move with a frame and wheelchair. The person told us they had chosen to sit where they did as it was close to the toilet They said "I don't walk very well. Only to the loo.. which is round to my left. That's why I like this chair." Staff told us the person tried to walk but when they were tired was happy to use a wheelchair. Their care plan stated they needed the help of one carer to mobilise and stand, and any further moving needed to be in a wheelchair. Some plans contained good clear information about people's needs. For example one person's plan included a clear level of detail of how they liked their care to be delivered. It said they liked to "wash with foam and a cloth. (Person's name) does not use deodorant but uses a body spray."

The registered manager told us people were supported to follow their interests or experience activities, and that they felt the provision of activities at the service was "100% better" since the last inspection. People's files contained information about things people liked to do, their hobbies and interests to help guide staff. As a part of the service's participation in the NHS Living Well with Activity project a book was available in each person's room for staff to record discussions they had had with people they were supporting, and efforts staff were making to 'stimulate people's lives'. This was also discussed at a resident's family forum meeting. We looked at one of these which showed staff had engaged the person in discussing a top of interest to them on several occasions in the preceding weeks. One person told us they liked to "keep my hands busy and my mind". They carried out craft work which they really enjoyed, and showed us work they had recently produced. Other people enjoyed music, and the registered manager told us about members of staff who were frequently heard singing with people. The deputy manager told us about activities that were on offer which included bingo, hand massages, colouring, painting, reading, games, nail painting, and a visiting animal service. One person told us they enjoyed reading. They used the "Ilsham library of books sourced from donations primarily by the staff and also supported by a Domiciliary Devon Library". Some men living at the service enjoyed being taken out by a male carer, and another person enjoyed gardening in the area to the rear of the building.

The service had a complaints procedure that was on display in the hallway. When we arrived this contained incorrect information but was updated by the registered manager while we were present. We looked at the services records of complaints and concerns that had been raised with them. We saw there were clear records on how these had been managed including the involvement of other agencies where this had been needed. People we spoke with told us they would speak to the staff or a relation if they had any concerns.

Requires Improvement

Is the service well-led?

Our findings

In May 2015 we rated the service as requires improvement. On this inspection in 2017 we found some previous improvements had not been sustained, and we identified some new concerns. We have rated this key question as requires improvement.

Although we did not find that people had been harmed by what we had identified, we found people were at risk of not receiving consistent high quality or safe care because governance systems were not robust or being operated effectively. There was a lack of clear leadership at the service, and systems to assess the quality and safety of services had not always led to improvements to people's experience or safety.

The Ilsham Valley Nursing Home Health and safety policy statement said "Where risks to safety or health need to be assessed under a specific duty or regulation we will ensure that an assessment is carried out and that all actions shown to be necessary are implemented."

We looked at the assessments and audits made to ensure people's health and safety was maintained. We found that although a number of audits were being undertaken, people's safety or quality of experience was not improved because action was not always being taken as a result. For example, an infection control audit had been carried out by the registered manager in September 2016 which had been updated in April 2017. It had identified concerns such as there not being wash hand basins in the laundry or sluice room, despite there being known infection control risks at the service. The assessment had also identified that pillows did not have impervious covers, and the records stated this was to have been achieved by the "end 2016". An environmental audit carried out in March 2017 had identified some carpets needing renewal and updating was needed to the sluice and laundry areas. The registered manager told us they did not know of any action plan in place to progress any of these issues.

Since the last inspection in May 2015 the registered manager had been registered with the Care Quality Commission. The registered manager was aware of issues that had been identified by internal or external audits. They told us with regard to the fire precautions works that the provider dealt with this. However we found action had not been taken.

Effective managerial oversight of the service was not being operated by the providers. The providers visited regularly to complete a monthly report. We saw visit reports from March 2017 and July 2017. The reports stated the purpose of the visits was in part to "assess repairs and maintenance of the service". Both reports stated the provider had "Inspected the service and it was fresh and clean and tidy". No reference was made to the outstanding fire precautions works from December 2016, and the visit of July 2017 did not make reference to the annual environmental audit carried out in March 2017. The providers were not addressing issues raised with them. Following the inspection the registered manager told us "The reports by the providers are not intended to be an "all encompassing" oversight of current issues, but a factual reflection of their visit on that day."

The registered manager did not have an understanding of which areas were a priority or what action was

being taken by the providers. We asked the registered manager if they had any evidence of requesting information about improvements needed and they told us "we just ask for it all the time". We identified on this inspection a number of concerns about the operation of the service which were not identified in the providers visit reports or by the registered manager. This told us governance systems were not being effectively operated.

Where changes had been made following the previous inspections we found improvements had not always been sustained. For example in the inspection of May 2014 we found that recruitment procedures were insufficient to ensure people were protected from the risks of unsuitable people being employed by the service. The registered provider told us they would have procedures in place to protect people by June 2014. At our inspection in May 2015 this had improved, but on this occasion we again needed to issue a recommendation in relation to the recruitment process.

People were at risk because some communication systems were not effective and records were not all being well maintained. We identified areas where records contained conflicting information, for example with regard to a person's resuscitation status, or long term health conditions. The care plans we saw were inconsistent in their format and content, which made it difficult to locate information quickly. The registered manager told us they were working on this; however one of the files we had looked at was one that had the new index process installed.

Some documents, policies and procedures were out of date or incorrect. The registered manager acknowledged this and made some changes to the service's complaints procedure while we were at the service once we had identified to them they were not correct. The service had a business continuity plan in place, but this had last been recorded as being reviewed in October 2014. The statement of purpose contained out of date information and was amended while we were at the service.

The failure to establish and operate effective systems to assess monitor and improve quality and safety; assess, monitor and mitigate risks and maintain accurate records was a breach of Regulation 17 Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

We identified an incident that had resulted in harm to a person receiving care at the service. This had involved the failure to put in place a bed rail and the person not having access to their call bell to summon support. Action had been taken against a member of staff as a result. This had not been reported to the safeguarding authority or to the Care Quality Commission. Providers are required to notify the Care Quality Commission of any neglect or acts of omission which cause harm or place people at risk of harm.

This was a breach of Regulation 18 Care Quality Commission (Registration) Regulations 2009.

Other notifications had been sent to the CQC as required.

The provider's website stated "We also maintain a comprehensive quality assurance programme to regularly monitor the standard of services that we offer in the service". We found there was a formal quality assurance system in place. This included sending questionnaires to people living at the service, their relatives, staff and visiting professionals. The registered manager showed us examples of questionnaires that had been returned but said they hadn't had enough back yet to collate and analyse them for this year.

The registered manager had previously been supported by a clinical lead nurse. However they had left and the registered manager told us there were no plans to replace them. There was no clear understanding of how the roles previously carried out by this person, such as operating effective oversight of the nursing and

clinical care delivered were to be fulfilled. Following the inspection the provider told us the registered manager, deputy and nursing staff "work collectively as a Nursing Team to lead the service on a collective basis". However, we had identified some re-assessments for example of people's care plans and the analysis of incidents had ceased around the time the clinical lead nurse had left. This told us the key responsibilities previously managed by this person were not fully being carried out.

People told us they felt the quality of the care they received was good. One person told us the service had "met all my expectations", and a registered nurse told us "I wouldn't work here if I didn't think it was good." A relative told us "We are very happy with the care and nursing (person's name) gets".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents
Treatment of disease, disorder or injury	The registered persons had not notified the commission of an incident where a person had suffered harm. Regulation 18 (5) (1) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. (Safe Care and treatment) Care and treatment for people was not being provided in a safe way. The registered persons had not done all that was reasonably practicable to reduce risks to people. The registered persons had not ensured the safety of the premises, including for the prevention of infections. Regulation 12 (2) (a) (b) (d) (h)

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	Systems had not been operated effectively to assess, monitor and improve the quality and

safety of the services provided, or mitigate the risks.

Records were not well maintained.

Regulation 17 (1)(2) (a), (b) (c)