HC-One Oval Limited

Ilsom House Care Home

Inspection report

Ilsom
Tetbury
Gloucestershire
GL8 8RX

Tel: 01666817552

Date of inspection visit:
13 March 2018
22 March 2018

Date of publication:
02 July 2018

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

This unannounced comprehensive inspection took place on 13 and 22 March 2018.

Ilsom House provides nursing, residential, and respite care for up to 38 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 25 people were living there.

Ilsom House provides accommodation over two floors with bedrooms located on the ground and first floors. There was a passenger lift and stairs to access both floors.

Ilsom House Care Home was registered under a new legal entity on 31 January 2017 and this is the first inspection of the home since then. Staff and the registered manager at Ilsom House transferred across to the new owner and remain in post at the home. At the time of this inspection, the home was beginning the transition toward operating within the HC One infrastructure. For example, the systems and policies in use had yet to changeover, so belonged to the previous owner. The changeover process was expected to be completed within six months.

There was 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.

People told us they felt safe living at the service. Staff knew how to keep people safe from harm but the way in which staff were deployed sometimes resulted in lack of support for people. The registered manager is reviewing this. Staff had been employed following appropriate recruitment and selection processes. People lived in a safe environment but we have made a recommendation to support the manager to develop a dementia friendly environment.

People made most decisions and choices about their care when possible. When people did not have the capacity to make decisions staff followed the Mental Capacity Act guidance to protect them. People had access to healthcare professionals and their health and welfare was monitored by them.

People were treated with kindness and respect. They told us staff were kind when they supported them with their care. People were supported by staff that were well trained and had access to training to develop their knowledge.

People joined in with activities provided which included musical entertainment, crafts and exercises. People also had some engagement with the local community.

The registered manager was approachable with people and their relatives. The registered manager monitored the quality of the service, supported the staff team and ensured that people who used the service were able to make suggestions and raise concerns. We saw from recent audits that the registered manager was making progress in improving the quality of the service but some areas still required 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?

Requires Improvement

This service was not as safe as it could be.

People's medicines were not always managed safely but recent audits had highlighted where improvements could be made and this was progressing.

Some equipment was not always used correctly when two staff were required.

There were not always sufficient staff deployed in certain areas of the service to ensure people's needs were met in a timely manner

Staff required information in a format they could use to ensure people were safe at all times.

Recruitment procedures were safe to ensure staff were suitable and of good character.

Is the service effective?

Good

This service was effective.

People's dietary needs were met and they were assisted with their meals when required.

People's needs were met by staff who were up to date with their training and had individual supervision meetings.

People made most decisions and choices about their care when possible. When people did not have the capacity to make decisions staff followed the Mental Capacity Act 2005 guidance correctly.

People had access to healthcare professionals and their health and welfare was monitored by them.

Is the service caring?

Good

The service was caring.

People were treated with compassion and kindness..

People were treated with respect and supported with patience when they had diverse needs.

Is the service responsive?

Good

The service was responsive.

People had person centred care plans with sufficient detail to meet all their individual needs.

People took part in varied activities and there was engagement with the local community.

Complaints were investigated and responded to appropriately.

Is the service well-led?

Requires Improvement

The service was not as well led as it could be.

The quality monitoring tools had not always been effective in identifying areas for improvement which were identified during the inspection.

Regular staff and resident meetings were held and people and staff were able to discuss any required improvements.

The registered manager was approachable with relatives, staff and people.

Ilsom House Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 13 and 22 March 2018 and was unannounced.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

We spoke with nine people using the service, the registered manager, the area quality director, the activities coordinator, the head chef, four members of care staff, the maintenance person, one of the domestic staff and two nurses. We observed lunch times and staff engagement and reviewed five people's care plans and three recruitment records. In addition we looked at medicine records, management records and staff training records.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law. We contacted healthcare professionals and Gloucestershire commissioners to gather information about the service.

Requires Improvement

Is the service safe?

Our findings

People received their medicines as prescribed however some improvement was needed to ensure good medicine management practices would always be adhered to. Short term medicine plans were seen, for example, when people required antibiotics. One person's medicine chart to monitor their blood pressure and pulse before giving their medicine was completed. However, another person recently had a review of their diabetic medicine by the diabetic nurse and a revised protocol was in use for when the person had low blood glucose. The diabetic nurse had asked the staff to send a copy of one week's blood glucose readings to them to monitor the medicines and this had not been completed. Improvements were needed to ensure monitoring charts were shared with healthcare professionals and they would have the information they required to monitor the effectiveness of people's medicines.

The provider had identified through an audit in February 2018 that improvements were needed to the service's medicine practices. As part of the provider's medicine improvement plan a new system had been introduced whereby staff audited five random medicines daily to ensure the medicine stock was accurate. We found one check was incorrect as the carried forward stock count was unclear. All medicines on the monitored dosage system were checked monthly when they arrived and medicine in separate containers were checked weekly. One medicine that required additional safe storage was not recorded on the person's medicine record and although not in use may not be correctly checked. Improvements were also needed to ensure when medicines were disposed of two staff signed the disposal record. Some time was needed for the provider's medicine improvement plan to be completed to ensure good medicine practices would always be followed.

People were risk assessed when they were self-medicating and this was reviewed monthly and medicines were safely stored. One person had recently declined their self-medication as they were feeling unwell and the staff had completed another risk assessment. Topical creams were applied using a body chart to inform staff where each cream should be applied. There were clear protocols recorded for 'as required' medicine. Medicine errors where staff had given a tablet and not signed were reported and investigated to help ensure the tablet counts were correct.

People were usually protected from the risk of abuse as staff understood their role in protecting people. People told us they felt safe in the home. One person told us, "I feel safe, secure building, room fine. All very good, all [staff] very trustworthy." Staff completed annual safeguarding training. Staff we spoke with had a good understanding of how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. There were clear policies and procedures for safeguarding people which included 'whistle blowing'. The staff we spoke with knew about 'whistle blowing'. Whistle blowing is a term used when staff report an allegation of abuse by another staff member. However during the inspection one member of staff reported to us poor moving and handling practice by other staff and we asked the registered manager to look into this. This was substantiated and the registered manager arranged for the staff involved to repeat moving and handling training. The staff had not used the internal 'whistle blowing' process to inform the registered manager or provider about this and the registered manager reminded them of the correct procedure to use when they had concerns about staff practice.

The registered manager told us staffing levels were based on people's support needs and they completed a monthly dependency assessment to determine the staffing levels. This information was intended to help the registered manager to provide good quality care for people by supporting decisions on the overall staffing of the home. They told us there were sufficient staff and that staffing was provided at the level indicated by the dependency tool but this contradicted feedback we had received from people, staff and relatives that suggested there were not enough staff.

When we looked at the way staff were working around the service; it was clear that some areas required more support. We observed over the two days that staff were busy completing care tasks and did not always stop to spend time with people. People had access to call bells to request staff support. We saw one person was becoming distressed when they waited for their call bell to be answered and we had difficulty finding a member of staff to assist them due to the layout of the building. The registered manager told us there was always a regular member of care staff in the lounge when meals were served who should know the diets people there had. People we spoke with gave varied responses when asked if they thought there were enough staff on duty. People told us, "Staff are very caring but have no time for anything." One person told us, "The only criticism is that you are left on your own for long hours." Three people told us there was a concern getting hold of staff.

We recommend the service seek advice based on current best practice, around how to use staff most effectively.

Handover information between staff at the start of each shift could be more comprehensive to ensure that important information relating to people's risks were shared and recorded with all the care staff. For example; whether people were at risk from choking or required two staff to move safely. This would help to ensure people's needs were known by all staff, including agency staff who might not know people well or had the time to read people's care records at the start of the shift. There was no diet list for staff to follow when they served a variety of food to people from a hot food trolley in the lounge to ensure that those people at risk of choking would receive the appropriately textured meals. One staff member told us there may have been changes to people's eating risks since they were last on shift and without this information to refer to they might not know what support people needed.

Individual risks were identified and minimised to maintain people's freedom and independence. The care plans had clear risk assessments for people for example; falls, moving and handling and for bed rails. The risks were reviewed monthly and any changes were noted and action taken to minimise risks and deterioration in health and wellbeing. Incidents and accidents were recorded and the registered manager looked at each one. There was a monthly audit to identify any trends. Reflective practice was not always evident to look at preventative measures straight away. However one falls record had reminded staff to always use the Standaid equipment when one person slipped to the floor holding a bed rail. People were protected from falling down the many staircases when doors leading to them were keypad protected. People were able to access the lift freely.

Safe recruitment practices were followed before new staff were employed. The correct checks had been completed to safeguard people and ensure staff were suitable and of good character. The recruitment records we checked were complete. Potential new staff were interviewed to ensure they would be suitable for their role.

People were cared for in a safe and well maintained environment. The safety of equipment and the environment was monitored and weekly monthly and six monthly checks were completed. The maintenance person completed any issues staff had noted daily and dated them when finished. Three

monthly health and safety meetings were held and the January 2018 meeting identified that some windows needed to be replaced and this was planned. People were protected from risks associated with Legionella disease, fire and electrical systems. People had individual emergency evacuation plans in place to ensure their safety in an emergency and there were general contingency plans for all emergencies.

We observed the home was clean. One relative said the bedroom was usually clean but not always. A member of the housekeeping team we spoke with was aware of their responsibilities for staff storage of cleaning substances and had completed infection control training. Staff used personal protective equipment to minimise the risk of cross infection. People praised the laundry system and said, "Laundry service is brilliant." and "Laundry very good. Put it out and it comes back perfect."

Good

Is the service effective?

Our findings

People's dietary needs were met and they had an eating and drinking care plan where their weight was monitored. Staff assisted people to eat, where necessary, in a calm and unhurried manner and described what they were eating. We observed people had access to drinks in their rooms and communal areas where staff provided regular hot and cold drinks. One person's eating and drinking care plan advised staff to provide a late evening snack to minimise the risk from low blood sugar.

Care plans were reviewed and people at risk of weight loss were monitored more frequently and had prescribed supplementary meal drinks and fortified meals to support them to gain weight. People were supported by a speech and language therapist to assess their risk from choking. When required people had prescribed drink thickener agents administered by the nursing staff to minimise their risk of choking. People told us generally they liked the food and comments included, "Food pretty good, lots of fish and I like that. Will make me something else if I don't like the choice", "Very good food can't say anything bad about it" and "Food nice, good choice, well cooked, tasty and hot." Two people told us they would like a better menu and ingredients. The registered manager told us there were regular meal surveys of people's dining experience and discussions with people at residents meetings where menu suggestions were looked at.

People's needs were met by care staff that received suitable training. Records showed staff had received training in relevant subjects, for example; infection control, moving and handling people, nutrition and fire safety. There were no records of staff's continued observed competency, for example in moving and handling. The provider information return (PIR) told us all staff undertook four days induction training when they started. There was a programme of follow up training to ensure staff maintained and updated their knowledge and skills. Ten care staff had completed NVQ or diploma in health and social care training to level two or above. Staff told us their training was up to date but two staff wanted additional dementia care training as more people were living with dementia in the home. The registered manager told us there were plans to improve dementia care training for staff.

Staff had regular individual supervision or group supervision meetings. One nurse told us they had individual clinical supervision meetings every six months to discuss clinical issues. The registered manager's supervision plan for care staff to discuss their progress and training needs had been completed monthly. Three care staff told us they had individual supervisions and group supervisions. One care staff member told us they had recently requested additional dementia and Parkinson disease care training and was told this would be arranged. One relative told us, Staff are very good, I am sure they know what they are doing." One person said, "Staff do understand my eye condition." The staff were able to tell us the person was living with reduced vision.

Staff had knowledge of the Mental Capacity Act and people's rights were upheld. 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. People told us they were able to make choices around when they get up, go to bed and the gender of care staff providing personal care. We saw that staff

supported people to access different parts of the home.

When people lacked mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People had a pre-admission assessment of their needs and their preferences were respected. Staff actively engaged with people to gain their consent prior to providing personal care and support. People had a 'Best Interest' record when they were unable to consent. We found a clear example of a 'best interest' decision when one person was unable to use their walking aid alone but lacked the capacity to make the safe decision to walk with staff. After consultation with their relatives the record stated that staff needed to ensure the person's walking aid was out of their sight, in their best interest, to prevent them using it on their own and falling.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA. The registered manager showed us a new application for a DoLS for one person who had refused personal care and was living with dementia. There were no other DoLS applications. The person's mental health and wellbeing care plan identified their deteriorating health and the need for staff to speak calmly to them and in short sentences. A relative had agreed staff could contact them if the person needed additional support. The person's GP had recently visited when the person's appetite was poor.

There was liaison with social and healthcare professionals when required to help ensure people had the care and treatment they required. The GP visited weekly. One healthcare professional told us, "I have always found the staff and home to be professional, safe and particularly caring to its residents. I have no concerns about the home and would recommend it to a relative." People told us the managers arranged hospital transport for health appointments and provided care staff to accompany those who required support. Records in people's care plans indicated they had been seen by their GP and other healthcare professionals for example; speech and language therapists, opticians and consultant psychiatrists.

People told me that they liked their rooms. Most rooms we visited had personal items including family photographs and ornaments people had brought with them. There natural daylight in the home and good artificial lighting. This supported people living with sight impairment. Many people were living with dementia. The home lacked dementia friendly features such as pictorial signage and colour on the walls to assist people around the home. Peoples' bedroom doors had numbers which some people living with dementia may not recognise. The registered manager told us they provided signage for people that needed it but would consider additional features when required.

We recommend that the environment is assessed for all people living with dementia and reflects the latest best practice to orientate people to their surroundings.

Good

Is the service caring?

Our findings

People and their relatives told us the staff were kind and caring. We saw how staff spoke kindly to people. One person told us, "Carers are very nice. I would say the staff are kind people." Another person said, "Lots of different carers but all very nice." The registered manager told us they used one agency to provide staff consistency for people.

The PIR told us about the named nurse and staff key worker system in place which provided people and their relatives with a familiar point of contact to support good communication. The home encouraged people and their relatives to write about their life story which was shared with staff. This enabled the staff to gain further insight and understanding of the person's background and interests to help ensure the care and support met their cultural, spiritual needs and lifestyle preferences. One life story we looked at recorded all family connections and who visited the person. Their hobbies and what they liked to join in with at the home. One relative told us the person cannot see the numbers on their telephone and staff helped them to dial.

People were able to be part of their care plan decisions. Some people told us they had seen their care plan and staff had sat with them to go through it. Others said they were not involved in planning their ongoing care. One person told us, "One of the girls [carer staff] will go through my care plan and will listen to what you say and want". Another person told us, "I have reviewed my care plan and I am happy with things as they are." One relative told us "We had a care plan review last week". They went on to say about the changes that had been started with regard to the person's safety razor and their radio to help ensure they remained calm.

People were treated with dignity and respect. People's privacy was respected and staff knocked on people's door before entering and asked them for consent to provide personal care. One person told us, "There is absolute respect and dignity and privacy when you want it." Another person said, "Staff knock on my door and they are respectful when they are showering me." One friend told us the person couldn't be cared for any better than they are and praised the staff saying, "Very good carers they are wonderful and respectful." One relative said, "The staff are lovely" and went on to describe one staff member who was good and always cheerful. We observed staff were polite and respectful to people. Staff we spoke with knew people well and wanted to support them when they were living with dementia but they said they needed more dementia training. They told us three people had their name on their bedroom door to help them identify their bedroom.

Good

Is the service responsive?

Our findings

People had person centred care plans where all aspects of their care, for example physical, mental and emotional were identified. The care plans we looked at had been evaluated and changes were made when people's needs changed. One example was when a health care professional had changed how a person living with diabetes should be supported with low blood sugars. The change recorded was for the person to have a sandwich instead of sugar to improve their unstable diabetes. The person's evaluation record said they were happy with the food provided. Wound care was well recorded. There was photographic evidence of the healing rate for one person's varicose ulcer. The person had attended a varicose ulcer clinic and was now able to walk. another person was well supported by the mental health team and their care plan had information of how staff supported them. The care staff completed daily records in people's bedrooms which were signed by the nursing staff to ensure the information was known by all staff and added to the nurse's daily records.

People had a variety of activities to choose from and additional activity staff were being recruited. An activity coordinator worked 30 hours per week and provided a variety of activities. These included, knitting and crochet, board games, films, craft mornings, skittles, cake decorating, a poetry group and social events. People told me that the coordinator came to visit them and one person told us they always tried to get them to join in. A professional fitness instructor, entertainers, a theatre group and musicians were a regular feature in the activity programme. An outside activity person had involved people in a sensory activity which involved people touching images projected onto a table and the images reacted to touch. One relative told us this activity was "amazing". They also told us how care staff supported the person with using their talking book as their sight was impaired. A Pets as Therapy (PAT) dog was a regular visitor to the home. Outside areas were used for garden games and gardening activities. One relative told us one person helped with tomato plants in the summer. People were encouraged to access the local community and two people attended a local day centre twice a week. Peoples' spiritual needs were met with regular all faith services being held in the home.

Activity records detailed people's participation and were used to identify those who may need additional support to encourage them to take advantage of the activities or to identify those who would prefer individual activities. Ilsom House contributed to the wider community in a variety of ways. Pupils from local schools had the opportunity to complete work experience or the social aspect of their Duke of Edinburgh Award. Students studying health and social care at a local college have had placements at the home. Plans were in place to invite a local children's playgroup to interact with people. At present some relatives brought their grandchildren with them and the activity coordinator set up activities for them and encourages people to join in. The activity coordinator told us, "One resident was a manager all their life and still has an urgency to do things. They will sit with children and do puzzles with them." They told us about another person who liked dogs and brushing the PAT dog had reduced their anxiety. One person told us, "I join in with lots of different things. I like the singing and the shows." Another person said, "I like the exercises and the knitting, especially making poppies." One person told us, "I have not been on any trips out yet." One relative told us there had been no trips out. The registered manager told us an additional activity coordinator had been appointed and would be starting soon. This would enable trips out to be organised.

People and their relatives had access to a clear complaints procedure. Any concerns raised were taken seriously and acted upon to people's satisfaction. The complaints procedure was clearly displayed in the home and outlined how to make formal complaints and if necessary how to escalate them to the provider organisation. People we spoke with told us they had not had any major complaints. The only complaints people had made were related to food and menus. One person told us "If anything was not right I am sure they would put it right." The provider information return told us there had been three complaints in the last 12 months and 27 written compliments. For example one person wrote, "...I am looked after so well and am very happy here."

The PIR informed us the compliments were normally received following a person's end of life care with regards to the care given to family members and the kindness shown by staff. Currently no person required 'end of life' care but anticipatory medicine had been prescribed for one person. The PIR told us three staff had completed end of life care training. There were Do Not Attempt Resuscitation agreements in place and most people had a care plan in place that set out their advanced care preferences when they were near the end of their life.

Requires Improvement

Is the service well-led?

Our findings

Ilsom House changed ownership in December 2017. The management team at the home had not changed there was the same registered manager and deputy manager. The process of moving to new ways of working had begun. For example, the new owner's values and philosophy were displayed in the home's entrance: Their website stated, "Each HC-One resident will receive help and support tailored to his or her needs, delivered with kindness and humanity."

The new provider had also introduced new governance procedures and these were in the process of being implemented to help ensure people received safe and effective care and treatment. A bi-annual quality check had recently been completed by the new provider and identified some improvements were needed. There were still areas that needed work and these were part of an internal action plan. For example; the provider representative completed a monthly visit and the last report in February 2018 had highlighted some gaps in medicine administration. We found progress was being made against the medicine improvement plan. However, the medicine practice shortfalls we found showed that more time was needed for the service to complete their medicines improvement plan before we could evaluate whether this plan had been effective in ensuring all staff followed good medicine management practices.

There were some areas of improvement that needed to be consolidated. Although the tool used by the manager to determine staffing levels at the service indicated there were sufficient staff this was not reflected in our observations and feedback from people. When we looked at this in more detail there appeared to be difficulties with meeting people's needs in some areas of the service due to staff not being deployed effectively. Handover information could be more comprehensive to ensure all staff would be up to date with people's current risks at the start of each shift. A staff member told us about people being at risk from moving and handling. The poor practice was substantiated and the registered manager took appropriate action to ensure safeguarding concerns were effectively raised and dealt with to ensure people's safety.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. Quality assurance systems included regularly asking people and their families about the service. The last survey completed in December 2017 had good results in five areas. The lowest score was in the activities provided and the provider had acted on this feedback. Since then a new activity co-ordinator had been employed and an additional one was to join the activity team soon.

People, their relatives and friends had attended feedback meetings. One friend of a person living in the home told us the registered manager provided them with a record of resident meetings that detailed what was happening now and future plans. People we spoke with knew who the registered manager was and said that she was usually "around and about." One person told us, "The manager is great, very caring and is seen. She makes sure she talks to you." Another person said, "The manager does come in for a chat." One healthcare professional who visited the service regularly told us, "It [the home] appears well led and organised and the staff are always happy to consider each resident as an individual and is flexible to the individual's needs."

Governance systems included short daily meetings with the registered manager and heads of departments for example, catering and housekeeping staff. The meetings had been recorded and important information was shared. The registered manager told us they completed a daily walk round and talked to the nurses about any clinical issues. The 'walk round' records had recorded that one person had told the registered manager they wanted to be dressed earlier, a lack of hot water was identified and an odour issue was noted and all of these had been resolved.

Staff told us they were mainly well supported and the registered manager was accessible to them. They had staff meetings to discuss changes and the provider's new way forward. Staff group meetings were held every two months. Records of the January 2018 staff meeting recorded two staff were to become dementia champions to cascade their knowledge to other staff. The record also informed staff about the new care plans and HC-One's new policies and procedures to be implemented. The registered manager told us that nurses had three monthly group clinical meetings and bi annual individual performance reviews.