Regulation of Care Act 2013

Adult Care Homes

Gansey Unit

Unannounced Inspection

05/06/17 8.45 – 16.55
06/06/17 12.40 – 17.00

Registration and Inspection Unit 3rd Floor,
Murray House, Mount Havelock
Douglas, Isle of Man, IM1 2SF
Completing and returning your report

To complete your report form, enter text by clicking on the box see the instructions below.

Use the tab key to move to the next box.

1. Provider’s action plan
   a. Add details of your actions to complete the requirements/recommendations (if applicable)

2. Provider’s comments/response.
   a. Confirm you have read and agree/disagree the contents of the report by clicking on the appropriate box
   b. State any factual inaccuracies found, add comments (if applicable)
   c. Sign (type name when returning electronically) and date.

3. Return your report to randi@gov.im within 4 weeks.

4. Do not use any other method e.g. links to Cloud or other file sharing services

This report and grades represent our assessment of the quality of the areas of performance which were examined during this inspection.

Part 1: Service information

Part 2: Descriptors of performance against Standards

Part 3: Inspection Information

Part 4: Inspection Outcomes and Evidence and Requirements

When making decisions the Registration and Inspection Unit have regard as to how well the service meets the Adult Care Homes Standards (April 2017). Providers of services are required, as part of their conditions of registration, to fully comply with the minimum standards.

This report identifies strengths and areas of good practice as well as areas where, in order to meet the minimum standards, improvement is required. It also summarises the findings of an inspection of the service and any requirements and recommendations made. It will form the basis for decisions by the Registration and Inspection Unit regarding registration, any variation of registration conditions and any enforcement action.

Standard 1 - Introduction Assessment and Admission
Standard 4 - Environmental and Personal Safety
Standard 6 - Staffing

In addition the following areas will be considered in each inspection:
Standard 7.3 - Policies and Procedures
Standard 7.8 - Quality Assurance Systems
Standard 7.9 - Annual Reports

Part 5:   Provider’s comment/response
**Part 1 Service Information**

**Name of Service**  Gansey Unit, Southlands Resource Centre

**Tel No:**  (01624) 831825

**Care Service Number**  Not Applicable

**Registration number ROCA/P/**  Not applicable

**Address**

Southlands Resource centre  
Church Road  
Port St Mary  
Isle of Man  
IM9 5NL

**Conditions of Registration**

Gansey Unit is a Department of Health and Social Care establishment and therefore is not a subject to registration under current Isle of Man law. However, this Government resource is subject to inspection as an adult care home under the Regulation of Care Act 2013, Regulation of Care (Care Service) Regulations and the Adult Care Homes Minimum Standards April 2017.

**Email Address**  Edward.Humphreys2@gov.im

**Name of Registered Manager**  Edward Humphreys (not registered)

**Manager Registration number ROCA/M/**  Not applicable

**Date of latest registration certificate**  Not applicable

**Certificate of latest manager certificate**  Not applicable

**Date of any additional regulatory action in the last inspection year (i.e. improvement measures or additional monitoring).**  None

**Date of previous inspection**  11&18/01/17

**Number of individuals using the service at the time of the inspection**  8

**Person in charge at the time of the inspection**
Edward Humphreys  
Nurani Paul

**Name of Inspector(s)**  Egle Leadley
Part 2 - Descriptors of Performance against Standards

Inspection reports will describe how a service has performed in each of the standards inspected. Compliance statements by inspectors will follow the framework as set out below.

**Compliant**
Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken. In most situations this will result in an area of good practice being identified and comment being made.

Recommendations based on best practice, relevant research or recognised sources may be made by the inspector. They promote current good practice and when adopted by the registered person will serve to enhance quality and service delivery.

**Substantially compliant**
Arrangements for compliance were demonstrated during the inspection yet some criteria were not yet in place. In most situations this will result in a requirement being made.

**Partially compliant**
Compliance could not be demonstrated by the date of the inspection. Appropriate systems for regular monitoring, review and revision were not yet in place. However, the service could demonstrate acknowledgement of this and a convincing plan for full compliance. In most situations this will result in requirements being made.

**Non-compliant**
Compliance could not be demonstrated by the date of the inspection. This will result in a requirement being made.

**Not assessed**
Assessment could not be carried out during the inspection due to certain factors not being available.
### Part 3 Inspection information

The purpose of this inspection is to check:

- Is the care safe?
- Is the care effective?
- Is the care compassionate?
- Is the service well led?

<table>
<thead>
<tr>
<th>No</th>
<th>Standard</th>
<th>Requirements/recommendations from previous inspection</th>
<th>Met/not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.2</td>
<td>The manager must ensure that support plans are updated in line with needs and abilities assessment reviews.</td>
<td>Met</td>
</tr>
<tr>
<td>2</td>
<td>7.1 &amp; 6.4</td>
<td>There must be a written induction and a clearly identified process to assist and support the new manager to develop his management skills.</td>
<td>Partially Met</td>
</tr>
<tr>
<td>3</td>
<td>7.3</td>
<td>The manager needs to ensure that policies and procedures kept in the paper file correspond to the policies available to staff in the governments shared files.</td>
<td>Met</td>
</tr>
<tr>
<td>4</td>
<td>7.4</td>
<td>Policies and procedures need to be reviewed and updated within the timescales.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>5</td>
<td>7.8</td>
<td>The manager must ensure that an annual report introduces a written development/improvement plan based on the outcomes of the quality assurance assessment exercise, as well as list success of the service.</td>
<td>Not met</td>
</tr>
<tr>
<td>6</td>
<td>7.10 &amp; 7.12</td>
<td>The manager must ensure that supervisions and any performance management records are kept in line with Data Protection Act 2002</td>
<td>Partially Met</td>
</tr>
<tr>
<td>7</td>
<td>7.11</td>
<td>A written policy needs to be displayed in the home informing people of their rights to access their files and records at any time. Where access is restricted this is explained to individual.</td>
<td>Met</td>
</tr>
<tr>
<td>8</td>
<td>7.13</td>
<td>The service manager or the quality and performance improvement manager must conduct twice yearly visit to the home and assess in relation to the premises, staffing levels and skills, service user/representative satisfaction and record keeping. After which the reports must be produced and shared with the home manager for consideration when compiling the annual report for the service.</td>
<td>Not Met</td>
</tr>
<tr>
<td>9</td>
<td>1.1</td>
<td>The manager must review the statement of purpose to ensure it is accurate and contains up to date information.</td>
<td>Not Met</td>
</tr>
<tr>
<td>10</td>
<td>4.8</td>
<td>The manager needs to ensure that there is</td>
<td>Not Met</td>
</tr>
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<tr>
<td>one clear complaint policy and procedure for everyone to follow.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>4.3</td>
<td>The manager needs to evidence that a copy of the Isle of Man Government Inter Agency Adult protection Policy and Procedures 2016-2018 is read, understood and complied with by all staff at the home.</td>
<td>Met</td>
</tr>
<tr>
<td>12</td>
<td>4.3 &amp; 7.4</td>
<td>A confidential reporting (Whistle blowing) policy must be reviewed and updated accordingly.</td>
<td>Met</td>
</tr>
<tr>
<td>13</td>
<td>4.4</td>
<td>The manager must ensure that all staff members have Adult Protection refresher training in a timely manner.</td>
<td>Met</td>
</tr>
<tr>
<td>14</td>
<td>4.10</td>
<td>The Manager needs to ensure that weekly fire alarm tests; monthly firefighting equipment (Including emergency lighting) checks and bi annual fire drills are carried out and appropriately recorded.</td>
<td>Not Met</td>
</tr>
<tr>
<td>15</td>
<td>4.16</td>
<td>All portable electrical appliance tests must be carried out and recorded in compliance with current guidance and instructions.</td>
<td>Not met</td>
</tr>
<tr>
<td>16</td>
<td>4.16</td>
<td>Electrical installation certificate (or electrical installation condition report) must be available at the time of inspection</td>
<td>Met</td>
</tr>
<tr>
<td>17</td>
<td>6.3</td>
<td>The manager needs to ensure that pre-employment checks information for all the staff is available for the inspection.</td>
<td>Not Met</td>
</tr>
<tr>
<td>18</td>
<td>6.4</td>
<td>The manager must ensure that all new staff members have a written induction programme, which is followed and signed off by the supervisor and inductee.</td>
<td>Partially Met</td>
</tr>
<tr>
<td>19</td>
<td>6.6</td>
<td>The manager must ensure that all staff members have regular 1 to 1 supervisions to meet the requirements of the standard.</td>
<td>Met</td>
</tr>
<tr>
<td>20</td>
<td>6.7, 6.10 &amp; 6.14</td>
<td>The manager must ensure that all staff members receive all mandatory training and identified refresher sessions required in timely manner.</td>
<td>Ongoing</td>
</tr>
<tr>
<td>21</td>
<td>6.11</td>
<td>The manager needs to ensure that all staff members have an annual appraisal of their performance.</td>
<td>Met</td>
</tr>
<tr>
<td>22</td>
<td>6.18</td>
<td>Staffing levels and staff deployment need to be determined following a regular written dependency assessment of residents’ needs. The assessment needs to include reference to the layout of the home and skills mix and experience of the staff team.</td>
<td>Met</td>
</tr>
</tbody>
</table>

**Recommendation**
The manager should ensure that there is one consistent approach used to record and store residents records.
Feedback from relevant parties

During the visit the inspector had an opportunity to have conversations with three members of staff. Generally the feedback was positive. Staff showed understanding and knowledge of the complaint procedure as well as the process of reporting concerns. Questionnaires were left for staff to complete and sent out to relatives/representatives. Three relatives and three staff questionnaires were returned.

Some of the comments made:

By relatives/representatives:
- “Very grateful for amount of care given to my husband”;
- “(staff) very courteous, polite and friendly each time I visit”;
- “Should be a male staff on every shift!”;
- “I doubt very much a complaint would be taken seriously as from past experience re: ***”;
- “Staged admission was not appropriate due to dementia”;
- “*** has settled well in Gansey unit and has benefitted from the additional skills of the staff and the increased staff/resident ratio”;

By staff:
- “I think we offer an excellent service to residents and I am proud to be a part of the team providing excellent dementia care and support”;
- “I am concerned about the practical arrangements for the change of service as we seem to be admitting residents with high dependency”;

✔ In regards to feeling safe and supported at work:
  - “usually, although there seems to be a blame culture just recently”;
  - “Yes, I do at the moment. Eddie is really supportive, he is very good for the team”;
  - “Yes, I do. I enjoy coming to work”;

✔ In regards to staged admissions:
  - “yes, friendly visit, cuppa or lunch depends on the person”;
  - “Absolutely”;
  - “Yes, we had person to come and see the home, meet the staff and residents”;
  - “(visit for) activities – yes, meals – seems discouraged”.
PART 4 INSPECTION OUTCOMES AND EVIDENCE AND REQUIREMENTS

REGULATION OF CARE ACT 2013, PART 2 (37) AND CARE SERVICES REGULATIONS PART 3 (9)

STANDARD 1 - INTRODUCTION, ADMISSION AND ASSESSMENT

OUTCOME: People are confident that the home’s information reflects the services practice and that written information is accurate and current. The registered provider is able to clearly establish that the home’s facilities and staff can meet the individual's specific needs and requirements. The admission process is planned and people are clear on the terms and conditions surrounding their residency.

Our decision:

Substantially compliant

Reasons for our decision

The statement of purpose was readily available at the home. The document was updated in February 2017. However there were a few inaccuracies that must be addressed. Records of four residents were examined by the inspector. It was found that in two more recent admissions seen the pre-admission assessments were completed prior to the admission taking place. The other two files did not contain the same pre-admission assessments. One file contained an admission check list but no pre-admission paperwork was seen. The inspector did take into consideration the fact that in both cases the residents were admitted several years ago. In the recent pre-admission assessments examined by the inspector the involvement of the person/their representatives was well evidenced. Both documents were fully completed and signed by all relevant parties. The assessment covered the following areas:

- Social history and leisure interests;
- Physical and Mental health;
- Risk factors and awareness of environmental risk;
- Emotional and mental wellbeing;
- Needs which will challenge the service;
- Physical ability/mobility;
- Communication;
- Memory impairment/cognitive function;
- Cleansing & dressing;
- Elimination;
- Sleep pattern;
- Eating and drinking;
- Medication;
- Finance;
- Compatibility.

From the records it was evident that the assessments, where possible, took place outside the home. Potential residents and their relatives were invited to visit the home prior to admission. All files seen by the inspector contained signed contracts. The blank contact was emailed to the inspector to scrutinise. It included information in regards to all required areas. However the Registration and Inspection Unit address should be updated, also the section 12 (pg. 7) stated: “The Department is pleased to offer the Resident accommodation at Cummal Mooar Resource Centre, Queens Promenade, Ramsey, Isle of Man IM8 1EL” This must be changed.
### Requirements and recommendations

**Standard 1.1**

The manager must ensure that the information contained within the statement of purpose is accurate.

03/02/16  
**Timescale: May 2016**  
**Not Met**  
**Carried over**  
11 &18/01/17  
**Timescale: March 2017**  
**Not Met**  
**Carried over**  
05&06/06/17  
**Timescale: Immediately**

**Standard 1.6 & 7.11**

The manager must ensure that the information provided in the contract is accurate and up to date.

**Timescale: Immediately**

### Provider’s action plan

**Standard 1.6 & 7.1** The Statement of Purpose has been reviewed and copy is on the notice board outside Gansey Unit and has been emailed to R&I.

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### Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)

**Standard 4 - Environmental and Personal Safety and Comfort**

**Outcome:**  
Systems, checks, policies, procedures and staff training ensure that people’s dignity, well-being and safety is promoted and protected.

**Our decision:**  
Partially compliant

**Reasons for our decision**

The inspector had an opportunity to examine an environmental risk assessments file. The file contained a range of environmental risk assessments. A number of these risk assessments were past the review date indicated. Also the majority of the risk assessments were general and noted to be for “EMI service and Sweetbriar”. The manager must ensure that all environmental risk assessments are Gansey unit specific and reviewed within the timescale noted.

The home had a range of health and safety policies and procedures in place. The staff training matrix also includes a range of health and safety training including: moving and handling, food hygiene, 1st Aid etc.

An adult protection – safeguarding process was displayed in the office, alongside guidance on raising an alarm and the Isle of Man Inter Agency Safeguarding Adults, Adult Protection Policy 2016-2018. The Inter Agency policy was also located in the “Read & Sign” folder alongside the
signature of all staff members confirming that they read and understood the policy. All incident and accident reports were kept in the accidents/incidents file in the Gansey Unit shared files. Confidential reporting (Whistle blowing) policy and procedure was also found in the “Read and Sign” folder. The policy was dated September 2016. The training matrix showed that all staff members were up to date with adult protection training. The policy stated that all staff working within the service had “play it cool” and breakaway techniques training. However the training matrix did not include records of these training sessions. The manager explained that the training mentioned in the policy where no longer used and have been replaced by the Dementia Capable Care and Behaviour (DCCB) training which covered low level holds and blocks as well as how to manage challenging behaviours. The manager must ensure that policy and procedure is updated. The practice must be is in line with the homes policies and procedures.

Risk assessments in regards to managing violence, aggression and challenging behavior and safety of residents and staff were in place. Issues relating to deprivation of liberty had been considered in the home as risk assessments relating to the use of bed rails, security of the home and absconding etc. were in place.

The home had a complaint procedure displayed at the home. However the complaint procedure displayed was different from the procedure included in the home's statement of purpose. The manager needs to ensure that there is only one complaint procedure in place and everyone is aware which procedure to follow. The complaints book was seen by the inspector. Two complaints were recorded since the last inspection. Nature of complaint, action, outcome and follow up date were recorded. Records were signed and dated.

The fire safety file was seen by the inspector. It contained:

- Fire risk assessment dated 20/02/17;
- Records of weekly fire alarm tests. There were gaps in the records;
- Record of fire drill 19/04/17;
- Records monthly fire extinguishers checks. The fire log book had only one record of fire extinguisher checks since the last inspection (04/05/17). However separate records called "Monthly fire extinguisher and fire blanket inspection checklist" were also available. After looking at both records, the inspector found that the extinguishers were not checked between 05/12/16-02/03/17. Also the "Monthly fire extinguisher and fire blanket inspection checklist" template was used incorrectly. Rather than listing faults under "records of any problems with extinguishers of blankets", all equipment in the unit was listed. This made it appear that all of it was faulty.
- A record of monthly emergency lights checks had gaps: 04/01/17-24/03/17 and 24/03/17-08/05/17. Latest test recorded – 25/05/17. Also the entries made on 04/01/17, 24/03/17, 08/05/17 stated that many lights have failed, however no action recorded till 25/05/17;
- Sprinkler system check was recorded on 17/05/17;
- Evidence of the latest recorded fire training for the staff team was 27/03/17;
- The fire evacuation record – 27/03/17;
- Quarterly fire safety audit records; the latest recorded 04/03/17;
- Bi annual fire door maintenance check – 29/12/16;
- In date fire safety policy;
- The fire equipment annual service 02/08/16.

The home, as a part of Southlands resource centre was registered with the Department of Environment, Food and Agriculture as a food business.

The home had a file containing information in regards to the Control of Substances Hazardous to Health (COSHH). The file contained:

- COSHH assessment form dated 22/11/16, identified yearly review;
- A number of COSHH data sheets;
• COSHH guidance.
The RIDDOR reporting procedure and forms were in place. The home did not have any reportable incidents since the last inspection.

Electrical installation condition report was not available at the home for the inspector to see. The manager had tried to obtain the report from the maintenance services, to no avail and was able to evidence his efforts to chase it up. The inspector found a copy of the electrical installation condition report for Gansey Unit in the 2015 inspection evidence. The copy was passed on to the manager to keep.

Portable electrical equipment visual inspections have been done and recorded by the member of the staff. The home had a spreadsheet to log all visual inspections as well as PAT tests. However despite some evidence that PAT testing has been done (stickers), the actual log was not completed. The manager must ensure that the PAT testing is appropriately recorded and evidence is available for the inspector to see.

A legionella risk assessment was in place; however it was past the review date indicated. A water report dated 06/06/17 was sent to the inspector post inspection. The report noted that the analysis was satisfactory.

The inspector did not have an opportunity to examine evidence of monthly water temperature checks. However the record of the latest check was received post inspection. The check was dated 07/06/17 and the temperatures of all wash hand basins and baths were recorded. A number of temperatures recorded were above required temperature; however no actions to address it were identified.

Thermometers and recording books were kept in each bathroom for staff to record the water temperatures prior to assisting residents with a bath / shower. The inspector examined records from the bathrooms and found that there was number of gaps in the staff recording. Temperatures should be recorded each time a resident is assisted.

Gas service and oil firing servicing and commissioning reports dated 22/09/16 were available for the inspector to see.

Public and employer liability insurance certificate was in date and displayed at the entrance.

Requirements

Standard 4.1

The manager must ensure that environmental risk assessments are service specific and updated within the timescale set on the document.

Timescale: September 2017

Standard 4.5

The manager must ensure that Challenging behavior policy is updated.

Timescale: September 2017

Standard 4.8

The manager needs to ensure that there is one clear complaint policy and procedure for everyone to follow.

11&18/01/17

Timescale: March 2017

Not Met

Carried over
**Timescale: Immediately**

**Standard 4.10**

The Manager needs to ensure that weekly fire alarm tests; monthly firefighting equipment (Including emergency lighting) checks are carried out and appropriately recorded.

03/02/16
**Timescale:** Immediately 
**Not Met**
**Carried over**
11 & 18/01/17
**Timescale:** Immediately 
**Not Met**
**Carried over**
**Timescale:** Immediately

**Standard 4.16**

All portable electrical appliance tests must be carried out and recorded in compliance with current guidance and instructions.

03/02/16
**Timescale:** Immediate 
**Not Met**
**Carried over**
11 & 18/01/17
**Timescale:** May 2017 
**Not Met**
**Carried over**
**Timescale:** Immediately

**Regulation 22 (2)**

Bath and shower water temperatures should be checked using a thermometer and recorded, prior to a resident bathing / showering.

**Timescale:** Immediately 

**Standard 4.17**

The manager must ensure that the water temperature for wash hand basins does not exceed 41 degrees Celsius.

**Timescale:** Immediately 

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**Provider’s action plan**

**Standard 4.1** All environmental risk assessments are up to date. **Standard 4.5** The Challenging Behaviour policy has been updated and copies emailed to R&I. **Standard 4.8** The complaints policy has been updated. **Standard 4.10** Weekly fire alarm checks are being carried out they are diarised and a name person is responsible for documenting the outcome. The emergency lights have been checked for July (01/08/17) and the manager is in contact with estates regarding
any faults found in June’s check. **Standard 4.16** PAT is being undertaken and estates have a list of appliances that require PAT. **Regulation 22 (2)** Bath and shower water temperatures are checked using a thermometer and recorded, prior to a resident bathing / showering. **Standard 4.17** Gansey Unit Manager has contacted David Cain from Estates and he confirmed that the guidelines he works with, state that the water temperature should be up to 43˚+ or – 2˚. The HSE states that the temperature for care homes should not exceed 44˚. The environmental risk assessment has been amended to reflect this.

### Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
#### Standard 6 - Staffing

**Outcome:** Staff are recruited following a rigorous and robust recruitment programme. There are sufficient numbers of trained competent staff (including ancillary staff) to meet the needs of the people at the home. There are robust policies in place to ensure effective supervision and continuous professional development.

**Our decision:**

**Partially compliant**

**Reasons for our decision**

The home operated an equal opportunities employment policy when recruiting staff. The inspector had an opportunity to examine seven staff files. Three files seen contained the main terms and conditions of the employment; however two of the documents were not signed. Staff members spoken to by the inspector stated they were provided with accurate job descriptions and terms and conditions of the employment. All the files seen did not contain the evidence of the pre-employment checks, as these were still kept at the Human resources office. The inspector had a discussion with the manager in regards to this matter. The staff register contained some DBS check evidence (just date of last DBS and some certificate numbers), qualifications of staff and PIN number of all registered nurses. The manager also returned the “inspection questionnaire” to the inspector, which contained more evidence of staff DBS checks. The majority of staff had or were studying towards qualifications relevant to their post.

The statement of purpose stated that all new staff would have formal, written evaluation of their performance after each month for up to three months. The evidence of the induction process was not consistent throughout the files seen. The inspector did note that some of the files seen belonged to members of staff who were employed for a long time. Therefore only induction evidence for more recent employees was taken into account. One file seen contained a fully completed and signed induction work book. The second file contained an induction work book that was started in October 2016, however all three Inductors evaluations were written/signed in May 2017. A third induction seen by the inspector was started over 3 months ago and was in progress of being completed, however a lot of entries were only signed by inductee. Also 1st and 2nd monthly reports were written by the inductee, however monthly evaluations were not completed by the inductor.

Including the Care Certificate standards into the induction programme was discussed with the manager. The manager explained that the new workbook was in place and would be used with any new starters.

The manager explained that all new staff worked as a supernumerary for the required period of time, depending on the job role. This was also confirmed by staff. Since the last inspection the supervision records were re-located from the shared files to individual supervisor files, however some other confidential documents (staff sickness etc.) were still found.
in the shared files. A number of randomly selected supervision files were checked by the inspector. The frequency of supervisions was found to meet minimum standards. However some of the registered nurses files did not contain evidence of monthly supervisions to meet the requirements of the home’s policy and procedure.

The records of regular team meetings and team briefs were seen by the inspector. The training matrix was examined by the inspector it included all the mandatory training as well as some additional training. A number of gaps in training, as well as overdue refresher training was identified on the training matrix. Some of the training sessions needed had dates in near future identified.

The inspector checked a number of randomly selected personal development plans. All files checked did contain personal development plans, however due to the lack of appraisal targets from last year; the PDR’s only contained targets for the year ahead.

The manager was able to evidence regular dependency assessments took place and assisted in determining staffing levels. Staff members interviewed by the inspector were also able to give examples of increasing/decreasing staffing levels to meet the needs of the residents. Staff rotas seen were accurate and reflective of hours worked by individuals, changes were understandable. Registered nurses and seniors were clearly identified.

**Requirements**

**Standard 6.3**

The manager needs to ensure that pre-employment check information for all the staff is available for the inspection.

11&18/01/17  
**Timescale: April 2017**  
**Not Met**  
**Carried over**  
**Timescale: September 2017**

**Standard 6.4**

The manager must ensure that all new staff members have a written induction programme, which is followed and signed off by supervisor and inductee.

11&18/01/17  
**Timescale: Immediately**  
**Partially Met**  
**Carried over**  
**Timescale: Immediately**

**Standard 7.3**

The manager must ensure that frequency of the supervisions is in line with the homes policy and procedure.

**Timescale: Immediately**

**Standard 6.9, 6.10 and 6.16**

The manager must ensure that all staff members receive all mandatory training and identified
refresher sessions required in timely manner.

11&18/01/17
Timescale: August 2017

Standards 7.10 & 7.12

The manager must ensure that supervisions and any performance management records are kept in line with Data Protection Act 2002.

11& 18/01/17
Timescale: Immediately
Partially Met
Carried over
Timescale: Immediately

Provider's action plan

Standard 6.3 All staff folders have a checklist and the manager is liaising with OHR to obtain the information for the staff folders. Standard 6.4 All new staff have a written induction programme and signed off by both inductee and inductor. Standard 7.3 Supervisions are in line with the policy and procedure. Standard 6.9, 6.10 and 6.16 Staff attend mandatory training and have access to the training matrix. Standard 7.10 & 7.12 Supervision recorded are kept in supervisors password protected folder and those authorised only have access to the performance records., in line with Data Protection Act 2002.

ANY OTHER AREAS EXAMINED

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)

Standard 7.3- Policies and Procedures

Criteria

The registered person makes available to staff a comprehensive policy and procedure file. The policy documents cover all aspects of work including practical task, administrative tasks and legal/ethical responsibilities such as Health and Safety (legal), promoting dignity (ethical). The documents underpin all staff practice and provide a framework from which service is delivered. All policies and procedures should reflect current legislation and practice for the Isle of Man. The registered manager sets in place recorded systems to ensure the staff team are familiar with and comply with the policy documents whilst at work. People living at the home can ask for access to the policy and procedure documents. (A list of mandatory policies and procedures is available in Appendix A).

Our decision

Substantially compliant

Reasons for our decision

A wide range of policies and Procedures were available to staff. The policy documents covered all aspects of work including practical tasks, administrative tasks and legal/ethical responsibilities. All
policies and procedures were available staff on the governments shared files. The manager took the decision not to store paper copies of policies and procedure. Apart from recently updated policies, copies of which were found in "read and sign" file, to ensure that all staff were aware of the changes in policies. The inspector was re-assured that if residents/relatives wanted a copy of any policy this would be printed out for them. The policy documents utilised by the home are written and reviewed centrally by the Department, not by the manager. Some of the policies and procedures were overdue of the recorded review date.

Requirements and recommendations

Standard 7.3

Policies and Procedures need to be reviewed and updated within the timescales identified.

11&18/01/17

Timescale: August 2017

Provider’s action plan

Standard 7.3 All EMI Service policies and guidelines have been reviewed and updated.

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)

Standard 7.8 - Quality Assurance Systems

Criteria

Formal quality assurance systems are in place and the registered person uses a range of tools to measure the quality of the service provided. This will include:

- numbers and types of complaints received and any learning resulting from this;
- comments and compliments about the service from a range of stakeholders and any actions taken as a result of stakeholder feedback;
- accident and incident reports;
- observations of those using the service;
- views of staff working at the service;
- reports from the responsible person’s visits to the home (or their nominated person) which must include the notes of the visits.

Our decision

Partially compliant

Reasons for our decision

The statement of purpose listed a wide range of internal and external quality assurance audits. However a number of these audits were not available for the inspector to see. The inspector had an opportunity to examine the service manager monthly reports (completed by administrative office). The report covered:

- Accommodation performance feedback;
- Resident involvement;
- Resident welfare;
- Quality assurance;
- Health and safety;
- Staffing;
- Finance.

The care records audits were also available for the inspector to see. Three randomly selected care record audits were checked by the inspector. Two of these audits were not fully completed. There was an arrangement in place for the Compliance and Finance Administrative officer to carry out the quality assessment in relation to the premises, staffing levels and skills, resident satisfaction and record making, care planning, risk assessments etc. The latest quality assessment report was dated 29th November 2016 (prior to the last inspection). The manager explained that the next assessment was scheduled for August 2017.

**Requirements and recommendations**

**Standard 7.8 & 1.1**

The manager must ensure that evidence of audits listed in the statement of purpose is available for the inspector to see.

**Timescale: October 2017**

**Standard 7.13 (now 7.14)**

The service manager or the quality and performance improvement manager must conduct twice yearly visits to the home and assess in relation to the premises, staffing levels and skills, service user/representative satisfaction and record keeping. After which the reports must be produced and shared with the home manager for consideration when compiling the annual report for the service.

**11&18/01/17**

**Timescale: May 2017**

**Not Met**

**Carried over**

**Timescale: Immediately**

**Provider’s action plan**

**Standard 7.8 & 1.1** Current audits are in Statement of Purpose and are up to date and are available to the inspector. **Standard 7.14** An Internal Audit was undertaken on 27th July 2017. The Quality performance and Improvement manager will undertake a visit (email sent).

**Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)**

**Standard 7.9 - Annual Reports**

**Criteria**

An annual report lists the success of the service and introduces a written development/improvement plan based on the outcomes of the quality assessment exercise. The plan is displayed and available to all. The annual report could include:

- achievements in the year;
- plans for the future;
- outcomes of the quality assessment exercise;
- medication audits;
- equipment audits;
- care plan audits and;
- compliments and complaints received and any changes made as a result of concerns raised.

Our decision

Substantially Compliant

Reason for our decision

The annual report was available for the inspector to scrutinise. The report included:
- results of an annual survey (residents & families);
- audits undertaken;
- involvement of residents/carers/families;
- examples if development/inclusions of evidence based practice;
- personal development for staff (description of core competencies of the PDP);
- continuous professional development;
- new assessment tools/resources/policies etc.;
- new/reviewed policies;
- staffing;
- views of staff working at the service;
- views of professionals visiting the area;
- complaints received;
- compliments received;
- accidents and incidents reported;
- evidence of adhering to adult care standards;
- plans for the year ahead.

The inspector found that there were few areas for improvement within the report:
- Where the annual survey identified areas as “room for improvement” details of how it’s going to be addressed need to be included in the development/improvement plan;
- Continuous professional development contained the list of the training; however it was not clear how many staff attended which training in the year.
- There was no evidence of how staff and professionals views were collated.
- The outcomes of bi annual quality assurance visits were not included in the report.
- Complaints were noted, however no learning points recorded.

Requirements and recommendations

Standard 7.8 (now 7.9)

The manager must ensure that an annual report introduces a written development/improvement plan based on the outcomes of the quality assurance assessment exercise, as well as list success of the service.
Other Areas Identified during this inspection

Reasons for our decision

The inspector examined the records of four residents. The records were kept in three different locations: paper file, Rio electronic recording system and individual files within Gansey Unit shared area. In two of the cases seen by the inspector paper files were found to contain the paperwork that was past review date, although the electronic files had an up to date paperwork. The manager must ensure that if parallel records are kept, all file contents are up to date.

Requirements and recommendations

Standard 7.11

The manager must ensure that residents’ records are kept in good order and up to date.

Timescale: Immediately

Provider’s action plan

Standard 7.11 The residents records are up to date

Please complete the provider action plan sections beneath each requirements and recommendations providing details of action taken (or to be taken) with timescale for each.

The inspector would like to thank the management, staff and service users for their cooperation with this inspection.

If you would like to discuss any of the issues mentioned in this report please do not hesitate to contact the Registration and Inspection Unit.

Inspector: Egle Leadley Date: 04/07/17
To: The Registration and Inspection Unit, 3rd Floor, Murray House, Mount Havelock, Douglas IM1 2SF

From: Gansey Unit

I / we have read the inspection report for the unannounced inspection carried out on 5th & 6th June 2017 at the establishment known as Gansey Unit and confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s).

☒

I/we agree to comply with the requirements/recommendations within the timescales as stated in this report.

☒

Please return the whole report which includes the completed action sections to the Registration and Inspection Unit within 4 weeks from receiving the report. Failure to do so will result in your report going on line without your comments.

Or

I/we am/are unable to confirm that the contents of this report are a fair and accurate representation of the facts relating to the inspection conducted on the above date(s)

☐

Signed
Responsible Person
Date

Signed
Manager
Eddie Humphreys
Date 09/08/2017

Action plan/provider’s response noted and approved by Inspector:
Date: 11/08/2017 Signature/initials EL