Regulation of Care Act 2013

Adult Care Homes

3 Rosebank

Unannounced Inspection

Completed on

22 September 2017  12.00 – 13.00pm
25 September 2017  10.10- 12.00pm
26 September 2017  12.00 – 15.00pm
03 October 2017  9.35 – 14.00pm

Registration and Inspection Unit, Ground Floor, St George’s Court, Hill Street, Douglas, Isle of Man, IM1 1EF
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

<table>
<thead>
<tr>
<th>Name of Service: 3 Rosebank</th>
<th>Tel No: (01624) 656077</th>
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</thead>
</table>

**Care Service Number:** Not applicable

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

**Address:** 3 Rosebank, Vicarage Road, Farmhill, Braddan, IM2 2QW

**Conditions of Registration:** Not applicable

**Registered company name:** Department of Health and Social Care

**Email Address:** Hilary.Coulthard@gov.im

**Name of Responsible Person:** Not applicable

**Name of Service Manager:** Hilary Coulthard

**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:** 20/02/17 & 02/03/17

**Number of individuals using the service at the time of the inspection:** Four

**Person in charge at the time of the inspection:** Lee Mellor & Hilary Coulthard

**Name of Inspector(s):** Mandy Quirk
**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>
</table>
| 1  | 2.1      | The home should be kept in a good state of repair. The following should be remedied:  
- Paint bubbling / peeling in several areas of the home.  
- Marks on upstairs walls should be cleaned / redecorated.  
- Mark on wall in the lounge should be repaired.  
**Timescale: June 2017**  
**Carried forward October 2017** | NOT MET  
Additionally  
- The recliner chair in the lounge needs cleaning,  
- lounge and corridor paintwork needs refreshing  
- Photos in the lounge must reflect all service users in equal measure |
| 2  | 2.10     | Residents’ getting up and going to bed times – morning / evening routine should be recorded.  
**Timescale: June 2017**  
**Carried forward October 2017** | NOT MET |
| 3  | 2.15     | Where residents carry out light domestic tasks, what the person can do for themselves should be recorded as well as the assistance required from staff.  
**Timescale: June 2017** | MET |
| 4  | Recommendation | More pictures / artwork to be hung on the walls around the home to further enhance the homely environment.  
**Carried forward October 2017** | NOT MET  
The reason for the delay was shared with and accepted by the inspector |
| 5  | Recommendation | The home’s menus to be reviewed. The menus were reviewed subsequent to the inspection. | MET |
| 6  | 7.2      | Shift leaders should be qualified to, or are enrolled on a QCF level 3 Diploma in Health and Social Care.  
**Timescale: October 2017**  
**Carried forward October 2017** | NOT MET |
| 7  | 4.5 & 7.3 | The home should have a policy and procedure specific to physical intervention and restraint.  
**Timescale: August 2017** | MET |
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</table>
| 8 | 7.4 | Policies and procedures should be regularly reviewed. **Timescale: August 2017**  
Carried forward **October 2017** | NOT MET |
| 9 | 7.8 | An annual report should be written to include:  
- listing the success of the service  
- a development / improvement plan based on the quality assessment exercise  
**Timescale: August 2017**  
Carried forward **October 2017** | NOT MET |
| 10 | 7.9 & 6.6 | Staff members should receive formal 1:1 supervision at least every 2 months.  
**Timescale: Immediate**  
Carried forward **October 2017** | NOT MET |
| 11 | 7.9 & 6.11 | Staff members should receive an annual appraisal / PDR.  
**Timescale: Immediate**  
Carried forward **October 2017** | NOT MET |
| 12 | 7.13 | A quality assessment on the home should be carried out twice a year.  
**Timescale: On-going**  
Carried forward **October 2017** | PARTIALLY MET |
| 13 | 7.16 | The Registration and Inspection Unit must be notified of all incidents affecting the well-being of the residents.  
**Timescale: Immediate**  
Carried forward **October 2017** | NOT MET |
| 14 | 4.8 | The displayed complaints procedure should be amended to include the current contact details of the Registration and Inspection Unit and the current EMI Services manager.  
**Timescale: June 2017**  
Carried forward **October 2017** | NOT MET |
| 15 | 4.1 | All staff should regularly update their safeguarding training.  
**Timescale: Immediate**  
Carried forward **October 2017** | NOT MET |
| 16 | 4.10 | - all staff should receive fire safety at the required frequency  
- fire alarms should be tested | NOT MET |
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<table>
<thead>
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<tbody>
<tr>
<td>weekly</td>
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<tr>
<td></td>
<td>fire extinguishers should be checked monthly</td>
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<td></td>
<td>emergency lighting should be checked monthly</td>
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<tr>
<td><strong>Timescale: Immediate</strong></td>
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<td></td>
<td><strong>Carried forward October 2017</strong></td>
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<tr>
<td>17</td>
<td>4.17</td>
<td>MET</td>
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<tr>
<td></td>
<td>water tanks should be checked for the presence of legionella at the required frequency</td>
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<tr>
<td></td>
<td>thermostatic mixer valves / blenders should be tested at the required frequency</td>
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<tr>
<td><strong>Timescale: Immediate</strong></td>
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<tr>
<td>18</td>
<td>3.19</td>
<td>NOT MET</td>
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<td></td>
<td>Medication must be administered in a respectful and sensitive manner by competent trained staff</td>
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<td><strong>Timescale: Immediate</strong></td>
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<td></td>
<td><strong>Carried forward October 2017</strong></td>
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<tr>
<td>19</td>
<td>3.2</td>
<td>NOT MET</td>
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<tr>
<td></td>
<td>Assessment of needs must be regularly reviewed and updated in line with service users’ changing needs.</td>
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<tr>
<td><strong>Timescale: Immediate</strong></td>
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<td></td>
<td><strong>Carried forward October 2017</strong></td>
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<tr>
<td>20</td>
<td>3.15</td>
<td>NOT MET</td>
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<td></td>
<td>There must be risk assessments in place regarding any daily activities which constitute risk, advising how best to manage the presenting risk. These must be recorded and reviewed in line with changing needs.</td>
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<td><strong>Timescale: Immediate</strong></td>
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<td></td>
<td><strong>Carried forward October 2017</strong></td>
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<tr>
<td>21</td>
<td>3.4</td>
<td>NOT MET</td>
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<tr>
<td></td>
<td>Visits to health professionals must be recorded with staff responsibilities clearly identified</td>
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<td></td>
<td>health action plan must be completed</td>
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<td><strong>Timescale: Immediate</strong></td>
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<tr>
<td></td>
<td><strong>Carried forward October 2017</strong></td>
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<tr>
<td>22</td>
<td>3.3</td>
<td>NOT MET</td>
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<tr>
<td></td>
<td>There must be clear information about any known medical condition with instructions about how best to support / maintain / improve the person’s condition.</td>
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<td></td>
<td></td>
<td>Timescale: Immediate Carried forward October 2017</td>
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<tr>
<td>23</td>
<td>6.13</td>
<td>All staff must attend dementia training Timescale: Immediate Carried forward October 2017</td>
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<tr>
<td>24</td>
<td>1.5</td>
<td>During the admission process, the person being admitted and/or their representative are provided with a written contract. Timescale March 2016 Carried forward February 2017</td>
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<tr>
<td>25</td>
<td>6.7 &amp; 6.14</td>
<td>All staff should receive regular training on:   • Basic medication   • Communication   • Value into Practice (VIP)   • Infection control   • Food hygiene Timescale: July 2017 Carried forward October 2017</td>
</tr>
</tbody>
</table>

**Feedback from relevant parties**

**Feedback from service users**
Two of the four service users living in the home were present for part of the inspection. Both were observed to interact well with staff members and each other. They informed the inspector that they were “fine” living in the home. However the inspector was aware that the same service users had expressed different views recently to staff members and that this was linked to recent events which had impacted their wellbeing.

**Feedback from relatives**
None received at the time of writing this report.

**Feedback from professionals**
None received at the time of writing this report.

**Feedback from staff members**
Most staff members present during the inspection were not able to stop and chat to the inspector but questionnaires were left for completion. However, none had been received at the time of writing this report.
# 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:**

**Partially compliant**

**Reasons for our decision**

The home had a statement of purpose/service user guide in place which was on display in the entrance to the home. This document provided information about the aims and objectives of the service, the values upon which the service functions and important terms and conditions including what facilities are included. There was also information about the structure of the organisation, key policies and procedures and useful contacts including advocacy services and Registration and Inspections. However the address for Registration and Inspection was out of date and there was nothing about the experience and background of the manager. Since the document was written there have also been many changes to the staff team, a new service user had moved in and there had been changes in the information about the organisational structure of the service.

Information about the new service user had been shared with the manager and impact assessments undertaken. However there was no pre admission assessment of needs documentation completed. Through discussion with staff members and examination of the service users file it was possible to determine that a staged transition had been conducted which involved visits to the home to meet and spend time with other service users and staff members, whilst being supported by the previous staff team. The involvement of the service user in the process had been determined in line with his needs. Records evidenced that no issues to indicate that the move should not happen had been identified. The transition plan involved key staff members who knew the service user well. Subsequently for various reasons those staff members were no longer involved. Prior to the arrival of the new service user the home had only one permanent staff member in place in addition to the manager, which meant that a number of staff new to the service were involved. This made addressing subsequent issues that arose more difficult to address.

Examination of one service user file in detail showed that a written contract, which included all relevant details including services provided, additional charges, terms and conditions of residency, was not in place.

**Requirements and recommendations**

**Standard 1.1**

The statement of purpose must be reviewed and amended to update all details relating to:
• Staff working in the service
• The address for the Registration and Inspection Unit
• The experience and qualifications of the new manager
• The organisational structure of the service

**Timescale: 31 March 2018**

**Standard 1.2**
A pre admission assessment of needs must be completed by the manager for any new service user. Particular focus should be given to any mental health needs, dementia, behaviours that challenge, mobility, emotional needs and nutritional needs.

**Timescale: With immediate effect**

**Standard 1.6**
During the admission process, the person being admitted and/or their representative are provided with a written contract.

**Timescale March 2016**
**Carried forward February 2017**
**Carried forward October 2017**

**Provider’s action plan**
1.1 - Statement of purpose to be re-written March 2018
1.2 - HC to liaise with FC with regards to pre-admission assessment Dec 2017
1.6- Contracts in place for all S/U-Met

**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 service had in place a range of internal and external environmental risk assessments. These considered aspects of safety relating to the premises and the environment. However they were overdue review.

Staff working in the home had access to a copy of the inter agency safeguarding adult protection policy 2016-18, through access to the shared area on the computer, unfortunately there was not a paper copy in the office for ease of reference. The policy detailed the steps that staff must take in the event that they receive an allegation of abuse or suspect that abuse is occurring. They also had a quick guide to raising an adult protection alert. In addition to the adult protection policy basic training was provided for all staff. This was initially through attendance at a half day course, followed by annual elearning refreshers as stated in the DHSC mandatory training policy. However, from the information available within eight staff files, although all staff members had completed
their initial training, only four were up to date with refresher training. Furthermore, it was essential that adult safeguarding was discussed within the first week of the induction process for any new staff members. However, examination of the induction documentation showed that adult safeguarding was not part of the induction programme and there was no other evidence available that to show that this had been covered within the staff members first week of employment.

The home had raised a number of adult safeguarding concerns since the last inspection, in relation to all residents living in the home. Examination of residents electronic records showed that some, but not all, incidents had been appropriately recorded and reported. There was evidence from speaking to management that some staff members working in the home at the time of the events occurring were not confident about how to fulfill their duties and responsibilities with regard to recording and reporting incidents on to the adult safeguarding team or the registration and inspection unit.

There was also a whistleblowing policy which sought to encourage staff to raise any concerns they may have relating to the practice of other staff members. This had recently been reviewed.

In order to address the potential need for physical intervention when working with service users the service had recently put in place an interim policy on physical intervention, with the final version due in December 2017. There was also a training programme in place whereby all staff members received training and refreshers on an ongoing basis. Examination of training records for eight staff members showed that five were up to date with their training and refreshers whilst three were not. The focus of training was about diffusion and de-escalation; to anticipate and reduce the possibility of matters escalating to the point where physical intervention would be required. Examination of service user records showed that staff members had been called upon to utilise their training on a number of occasions, these had been logged on the service users electronic records. However, not all had not been reported to the Registration and Inspection Unit. No incidents had required a recording of injuries, diseases and dangerous occurrences regulations (RIDDOR) notification.

There was no evidence available to confirm that issues relating to deprivation of liberty and freedom of movement had been considered in the home.

A tour of the home was conducted on the day of inspection. It was found to be clean, tidy and odour free. The old office had been made into another small lounge area to address the needs of the service users living in the home. The office was now located in the staff sleep in room. The inspector noted that this made for a cramped workspace and when the new manager was seated at the computer the height of the monitor was not ergonomic. It was not possible to address this immediately as there was a shelf directly above.

The service had in place a range of health and safety policies and procedures available to guide staff practice, which included; infection control, moving and handling, c of substances hazardous to health (COSHH), fire safety, health and safety. The health and safety policy was still awaiting review. Staff members are provided with personal protective equipment (PPE). Training in infection control was not identified as mandatory for staff members. Examination of the training files of eight staff members showed that all staff within the home had attended or accessed infection control training, however only two were up to date with annual refresher training.
The service had a complaints policy and procedure in place which had recently been reviewed. The policy was accessible to staff members through the shared area on the computer. In addition to this the policy was on display in the entrance area of the home and there was an easy read version available. The document offered staff members’ guidance when dealing with any complaints received and included timescales for response. However the address for Registration and Inspection must be updated. Residents and their families are also provided with information about the complaints procedure as part of the home’s statement of purpose/service user guide. There was a complaints and compliments log book in the entrance area of the home. One compliment from a family member had been received but no complaints were recorded. The inspector whilst examining staff supervision records noted details of a complaint that had been received and investigated. However, there was no record of this within the complaints log.

The home had the following fire safety measurements in place:
- Fire safety file located in the office
- Fire safety policy 2016-19
- Fire procedure and easy read version
- Plan of the building layout
- Fire safety leaflet
- Fire exits were all found to be free from obstruction
- Personal Emergency Evacuation Plans (PEEPs) were found to be in place for all service users
- An annual fire safety audit
- Monthly emergency lighting checks
- A fire register
- Four fire drills had been completed since April

However:
- The fire risk assessment was overdue review
- A fire action plan was in place but overdue review
- The six monthly fire door checklist was overdue review
- The quarterly fire inspection checklist was overdue review
- The monthly fire extinguisher and blanket inspection checklist had not been completed since May
- The last monthly fire extinguisher test was in June
- Emergency lighting weekly visual checks had not been completed since May
- Weekly fire alarm checks had only been conducted twice since the beginning of July.
- Fire safety training had been completed by all staff members

The water tank had been checked for any risk of legionella and no issues found. Thermostatic mixer valves were identified, in the maintenance book for the home, as requiring six monthly checks. Records showed that although checks had been completed in May 2017, only one check per year was being conducted. Water temperature checks were to be done weekly. This was in place until the end of July after which only one check had been completed. Hot and cold water monitoring checks had been completed by DHSC Estates.

The last record of any electrical checks being conducted in the home was a visual check in April 2016. There was no electrical installations condition report available.

Monthly visual portable electrical appliance tests (PAT) had been conducted consistently. However there was no record of any periodic PAT checks being undertaken by a competent person.
The gas boiler had been serviced.

Valid public liability insurance was in place and on display.

Fridge and freezer temperatures were meant to be recorded daily. This was complete for April and May but there were gaps in the records for subsequent months. On examination of the fridge and cupboards in the kitchen open packages and jars were not all labelled on the date of opening. Staff members access food hygiene training as part of their induction followed by refreshers every three years. Records showed that six out of eight staff members were overdue training.

There was no COSHH file available but product leaflets were available for reference in the health and safety file. However there was no COSHH risk assessment available.

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Standard 4.3</th>
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<tbody>
<tr>
<td></td>
<td>• Detailed records must be made and retained on issues raised around safeguarding</td>
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<td>• There must be evidence provided to show that staff members have read, understood and comply with the inter agency safeguarding adult protection policy and procedures 2016-18</td>
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<tr>
<td>Timescale:</td>
<td>With immediate effect</td>
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| Standard 4.4                  | Safeguarding must form part of the induction process for new staff members and be discussed within their first week of employment. |
|                               | • All staff members must be up to date with adult protection refresher training |
| Timescale:                   | With immediate effect                             |

| Standard 4.7                  | Any issues relating to freedom of movement or deprivation of liberty have been addressed through a multi-disciplinary process and the outcomes recorded. |
| Timescale:                   | 31 January 2018                                   |

| Standard 4.9                  | Details of all complaints and their outcomes must be recorded in the log book |
| Timescale:                   | With immediate effect                             |

| Standard 4.10                 | Fire risk assessment must be reviewed |
|                               | Fire action plan must be reviewed        |
|                               | • A new 6 monthly fire door checklist must be completed |
|                               | • A new quarterly fire inspection checklist must be completed |
|                               | • Monthly fire extinguisher and blanket inspection checklists must be completed |
|                               | • Monthly fire extinguisher checks must be completed |
|                               | • Emergency lighting weekly visual checks must be completed |
|                               | • Weekly fire alarm checks must be conducted |
| Timescale:                   | With immediate effect                             |
| Carried forward:             | October 2017                                       |
**Standard 4.11**

A risk assessment must be completed in relation to the suitability of the workstation for the new manager. Any issues identified must be addressed.

**Timescale: With immediate effect**

**Standard 4.12**
- Staff members must access infection control training and annual refreshers in line with the homes training policy
- Infection control risk assessment must be reviewed.

**Timescale: 31 March 2018**

**Standard 4.13**

Food hygiene regulations must be complied with specifically:
- Fridge and freezer temperatures must be checked and recorded daily
- Open food packets in the fridge and jars in the cupboards must be labelled with the date of opening and use by date.

**Timescale: With immediate effect**

**Standard 4.14**

A COSHH risk assessment must be completed and reviewed regularly

**Timescale: 31 December 2017**

**Standard 4.16**
- A valid electrical installations condition report must be available for inspection
- PAT testing records other than visual must be available for inspection.

**Timescale: 31 March 2018**

**Standard 4.17**
- Weekly water temperature checks must be conducted and recorded
- Thermostatic mixer valves must be checked twice per year.

**Timescale: With immediate effect**

**Provider’s action plan**

4.3-Policy file to be updated to include signature sheets for staff to sign after reading.-Timescale March 2018.
4.4-Induction begun for new member of Team .Safeguarding has been raised and documented accordingly on his file-MET
AP refresher has been requested for all staff at recent supervisions. Time to be allowed for this to happen.-DEC2017
4.7- Team meeting on 10/11/17 discussed Dep of Lib with regards to using kitchen during mealtimes. Support plans/risk assessments now in place to reflect the fact that doors to kitchen are to be closed(or locked) due to risk.MET
4.9-Complaints/Compliments file in place. Complaints procedures discussed with families.MET
4.10-All fire file to be completely reviewed. Day to be agreed at team meeting on 29/11 for regular fire alarm activation. All PEEPS have been reviewed.PART MET/Nov2017
4.11- Occupational Health to be invited to check workstation for SRSW. IMMEDIATE
4.12-Infection control training has been requested by SRSW to all staff at recent supervisions. Time to be given to support this training. DEC 2017
Infection control risk assessment to be reviewed by SRSW. FEB 2018
4.13-New thermometers have been purchased. Daily recording of all fridges/freezers takes place. MET
Staff informed in team meeting (28/11/17) about need to have opening/closing dates on items in fridge. MET
4.14-COSSH file is up to date with all products currently used and risk assessments as required. Signitury sheet to be added. DEC 2017
4.16-Estaes to be informed to give quote for PAT testing. DEC 2017
SRSW to locate electrical installations report. If unable to find then to contact Estates for copy. NOV 2017
4.17-Water checks to be put in place with immediate effect. SRSW to locate mixer valve testing. Health and Safety file to be completely reviewed to include all of above so that it can be found quickly. FEB 2018

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<th>Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)</th>
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<tbody>
<tr>
<td><strong>Standard 6 - Staffing</strong></td>
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<tr>
<td><strong>Outcome:</strong> 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</td>
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<tr>
<td><strong>Our decision:</strong> Partially compliant</td>
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<tr>
<td><strong>Reasons for our decision</strong></td>
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<td>The service had in place an equal opportunities policy which linked with the recruitment of staff. Five of the eight staff files available in the home did not contain any information relating to recruitment. One file contained a signed contract of employment and a job description whilst two others contained only terms and conditions of employment. These records, for staff working in the home, are held by the DHSC human resources section, access to which was not available to the inspector. However the inspector was aware that a template form had been developed for completion by Human Resources which would then be shared with the homes manager. These sheets had not been completed for staff members at the time of the inspection. Staff files examined did however contain details of staff qualifications and certificates. Newly appointed staff members are subject to a six month probation period and there was an induction pack template for completion by the line manager and the inductee within that period. The content of the current induction documentation covered some but not all of the areas identified within the care certificate standards. The inspector was aware of a plan to move towards inducting new staff members using the care certificate standards however the process had not yet started. Eight staff files were examined but only two had an induction booklet completed, whilst six files showed no evidence of completing an induction pack. One of two completed was from 2009</td>
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and was only completed by the staff member and not the line manager. The other was from 2016 and found to be completed fully, signed and dated by both the manager and the staff member.

The eight staff records viewed showed that since the last inspection four staff members had no recorded supervision sessions. One staff member had four supervision sessions, two staff members had two sessions and one staff member had one session recorded and stored in their file. Moving on to annual appraisals, no staff files contained evidence that this process had been completed and recorded for the previous year. With supervision records being so limited it was not possible to confirm that training needs and gaps are being identified as part of the supervision process. Additionally it was not possible to confirm that the effect of training on the performance of both new and existing staff members was being evaluated due to a lack of information available within records viewed.

There was a written training policy in place for staff members. Staff training records were examined individually, in the eight staff files available, as no training matrix was found. Records showed that staff members had all completed first aid training but two were overdue refresher updates. Moving and handling training had been completed by all however, four staff members were overdue refresher training. All staff members had completed training in managing actual and potential aggression (MAPA) however, two were overdue refresher training. All but one staff member was up to date with basic medication administration and five yearly refresher training. Safeguarding training had been completed by all but annual refreshers were overdue for four staff members. All staff members were up to date with annual fire safety training. Six staff had completed one off training in communication awareness and values into practice but two had been unable to access either course as they are no longer being offered. Further to this no staff had accessed training in health and safety or nutrition.

It was noted that the home only had a small number of staff qualified to Quality Care Framework (QCF) level two or three. The service is required to commit to a minimum fifty per cent of the staff team being qualified to QCF level two or three.

Team meeting records were viewed and no records of team meetings during the last inspection year had been recorded.

Staff rotas were examined and found to be reflective of numbers of staff members and the hours they worked each day. A shift lead was not identified on the rota. This was discussed with the new manager who confirmed her intent to identify a key holder with responsibility for specific additional duties regarding medication in particular. Dependency assessments were not completed within the home. Staffing levels within the home have recently been increased to take account of the changing needs of service users.

**Requirements**

**Standard 6.2 & 6.3**

Staff files must contain details of the following: application form, interview notes, two references, DBS check, health statement and a contract including terms and conditions of employment

**Timescale:** 31 March 2018

**Standard 6.4**

A written induction programme should be in place for all new staff members and signed off by the
line manager and the inductee.

**Timescale: With immediate effect**

**Standard 6.5**
The induction pack must be amended to cover all aspects of the care certificate standards

**Timescale: 31 March 2018**

**Standard 6.8**
Regular supervision sessions must be conducted for all staff members

**Timescale: With immediate effect**

**Carried forward October 2017**

**Standard 6.9**
- All staff members must access mandatory training in communication, health and safety and nutrition, values in practice,
- All staff must update training in line with identified timescales. This includes moving and handling, food hygiene, basic medication and first aid.
- A training matrix must be in place which presents an overview of all staff training including mandatory and additional training along with timescales for refreshers.

**Timescale: 31 March 2018**

**Standard 6.11**
The impact of training on the inductee must evaluated and recorded by the manager prior to the confirming the staff member in post and recorded.

**Timescale: With immediate effect**

**Standard 6.12**
Individual training needs must be identified as part of a regular programme of one to one supervision

**Timescale: With immediate effect**

**Standard 6.13**
An annual appraisal must be completed for all staff members.

**Timescale: 31 May 2018**

**Standard 6.16**
A minimum of fifty per cent of the staff team must be qualified to Quality Care Framework (QCF) level two or three

**Timescale: Ongoing**

**Carried forward October 2017**

**Standard 6.18**
All training is evaluated to ensure that it is fit for purpose

**Timescale: 31 March 2018**

**Standard 6.19**
Team meetings must be conducted as a minimum of two per year and more during periods of change.

**Timescale: With immediate effect**
**Provider’s action plan**

6.2 & 6.3 - SRSW to liaise with FC to sort out locating relevant information from HR for staff files. MAR 2018

6.4 - New staff member has begun induction and paperwork has been signed as required. MET

6.5 - SNR Team to advise timescale

6.8 - Supervision shave been held with all staff. Dates ste for 2 months for next 1-1.3 Team meetings have taken place since 2/10/17 and have been recorded on supervision monitoring form in personal files. MET

6.9 - SRSW to update existing House training matrix and individual training records. MAR 2018

6.11 - HC to speak to FC

6.12 - Individual training needs have been identified in recent supervisions. Support to book training has been given and staff are awaiting dates. Fire safety/ap Safeguarding and infection control have all been prioritised at supervision. DEC 2017

6.13 - PDR will commence in April 2018.

6.16 - MET

6.18 - All training is fit for purpose. At team meeting on 28/11/17 extra support from MAPA Trainer was as this was an area highlighted as a priority for the House at this time.

6.19 - Due to fluid movement in support plans/risk assessments there have been 3 team meetings since 2/10/17. It is expected that there will continue to be a high frequency of team meetings for the foreseeable future.

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**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**

The service had in place a list of policies and procedures for staff members to read, digest and follow in their daily working practice. However on examination of the home’s policy index it was possible to determine that not all policies had an identified review date and some were overdue review.
Requirements and recommendations

Standard 7.3
Policies and procedures must be dated on completion, have a review date identified and followed up with a timely review.

Timescale: August 2017
Carried forward October 2017

Provider’s action plan
Policy and procedure file to be updated by SRSW. Signiture sheet to be added to ensure that RSWs can sign to say they have read and understood the policy. Policies can also be found in shared area and accessed by all staff. (this has been pointed out at supervision) MAR 2018

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 home had a range of quality assurance measures in place. These included complaints and compliments records and accident and incident records. However both the complaints records and the accident and incident records were found to be incomplete. There was a suggestion box in the entrance area to the home but no suggestions for improving the service had been received. There was limited evidence of opportunities for staff members and relatives to share their views on the service as supervision sessions and team meetings had not happened since May 2016. There had also been one audit of all areas covered within the minimum standards undertaken in August 2016. However the standards require two such visits and reports to be completed. The inspector noted that only one area noted for action had subsequently been addressed.

All evidence considered ought to support the service to measure the quality of care provided and
feed into the compilation of the annual report, informing plans for the year ahead.

**Requirements and recommendations**  
**Standard 7.13**

- Two visits to the home per year must be conducted by a nominated person in order to assess in relation to a range of areas. After which a report must be produced and shared with the home manager for consideration when compiling the annual report for the service.
- Any quality assurance measures in place must be appropriately completed in order for the information to be considered when a development plan for the service is being devised.
- Opportunities to gather feedback on the quality of the service from staff members and relatives must be provided.

**Timescale:** February 2017  
**Carried forward:** October 2017

**Provider’s action plan**  
7.13-Access has been difficult for RC due to arrival of new S/U. HC to liaise with RC to ensure audit is effected. RC quality audit to be used in conjunction with updating annual plan for Service. JAN 2018  
Questionnaires have been sent to family members and staff to give feedback ref.Service. Findings will be actioned as required.DEC2 2017

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**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**

Non complaint
### Reason for our decision
There was no annual report available within the home.

### Requirements and recommendations
#### Standard 7.9
An annual report must be completed for the service which describes the details the achievements of the service over the previous year and offers a development plan for the year ahead. The plan must be based on the outcomes of a range of quality assurance measures. The document must be displayed within the home and available to all.

**Timescale:** August 2017  
**Carried Forward October 2017**

### Provider’s action plan
7.9-SRSW to locate details from RC as to when she last visited the property. Access has been difficult due to transition of new S/U but time can be arranged to ensure audit can be done. DEC 2017  
Annual report to be updated in new year. JAN 2018

### Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
#### Other Areas Identified during this inspection
#### Standard 7.1

### Our decision
Partially compliant

### Reasons for our decision
Examination of a variety of service user and service records, showed that there are a wide range of areas for action within the service, details of which are recorded elsewhere within this report. The extent of the work required to address all issues raised, has highlighted the need for additional support for the new manager in order to facilitate effective action.

### Requirements and recommendations
#### Standard 7.1
The must be a robust support plan developed to assist and support the development of the new manager and the service.

**Timescale:** With immediate effect

### Provider’s action plan
7.1 HC to work with FC. It has been agreed that HC will work 9-5 Monday to Friday to allow for time to get this huge workload under control. As it is difficult to work at the House without interruption, it has been agreed that HC can use a computer at the office to allow for support from SNR MGMT Team and to work without distraction. Documented evidence of supervision will be recorded. MET
### Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)

**Other Areas Identified during this inspection**

**Standard 3.24, 3.35 & 3.26 - Medication**

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<th>Our decision</th>
<th>Partially compliant</th>
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**Reasons for our decision**

The home had a detailed medication policy available for staff guidance. Medication in the home was found to be stored within two metal cabinets, one large and one small. A recent audit of the contents of the cabinet, by the local pharmacy, found a range of items there which, were either out of date, overstock or were no longer required and, ought to have been returned to the pharmacy. A full audit report was awaited at the time of the inspection. The medication file was found to contain medication administration record (MAR) sheets, examination of which showed that on occasion staff members had not signed sheets to confirm that medication had been administered. There was also one sheet where staff members had signed to confirm that they had administered medication but there was no detail of what they had administered. In conclusion the records had not been fully completed and were not being stored in the standardised format that has been rolled out across learning disability community houses. However the new manager, who had only just started, had already put together a new file, in the standardised format, to be implemented as soon as possible.

**Requirements and recommendations**

**Standard 3.24**

Support plans must contain detail regarding why a service user does not manage their own medication and detail what support staff are required to provide in this regard.

**Timescale:** With immediate effect

**Standard 3.25**

- Medication must be stored in line with the Royal Pharmaceutical Society of Great Britain: The handling of Medicines in Social Care (2007) and the NICE guidelines: Medicines management in Care Homes. Therefore any medication that is out of date or no longer required must be returned to pharmacy and new prescription orders must only be completed as required to avoid any build-up of stock.

- Any medication administered must be detailed on a MAR sheet, including name of medication, strength of medication, dose of medication and frequency of administration

**Timescale:** With immediate effect

**Standard 3.26**

The competency of all staff who administer medication must be assessed on an annual basis and appropriate records maintained.

**Timescale:** With immediate effect

**Carried forward October 2017**

**Provider’s action plan**

3.24-Full review of Medication risk assessments and assessment of administering of medication to be done. DEC 2017

Medication file to be brought in line with Standardisation visits and all paperwork updated.
## Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Other Areas Identified during this inspection

## Standard 3 Daily Support

### Our decision

**Partially compliant**

### Reasons for our decision

Two service users’ files were examined in detail whilst two files were examined in relation to dates of documentation such as person centred planning meeting records. Records showed that person centred planning meetings for service users had not been held every six months and were all overdue. This had impacted on the relationship between the service and at least one relative who felt that contact with the home was less positive, which had led to them having less contact. The service manager had agreed to address this with immediate effect. A variety of documents including weekly planners, medication profiles, health passports, communication passports, support plans and risk assessments were found to be overdue review. Support plans were found to have multiple issues recorded on one document, with no associated risk assessment documents having been completed. Medication risk assessments had been completed but the outcome was not detailed in support plans or the health passports viewed. Records for one service user requiring daily checks for a health condition were incomplete and failed to offer staff members clear guidance regarding how often to complete the task. In addition to this the paperwork being used did not have a sign off section for staff members to complete. This could be detrimental for the health and wellbeing of the service user and must be addressed immediately.

The staff team, for reasons beyond the full control of the service, suffered a loss of knowledge and expertise in relation to managing behaviours that challenged the service recently. The difficulties that this presented have been acknowledged by senior management and a new staff team has been put together comprising of people with relevant skills and a motivation to work within the service.

### Requirements and recommendations

#### Standard 3.3
- There must be clear support plans relating to any medical conditions which advise staff members about how support must be provided.
- Health action plans updated every six months or as required.
- Health passports must be reviewed and update every six months or sooner if required

**Timescale: With immediate effect**

#### Standard 3.8
- Communication assessments must be reviewed and updated every six months
- Communication passports must be reviewed and updated every six months

**Timescale: With immediate effect**

#### Standard 3.11
Contact with friends and relatives must be encouraged, supported and recorded

**Timescale: With immediate effect**

**Standard 3.13**  
Personal Emergency Evacuation Plans (PEEPs) documentation must be reviewed  
**Timescale: 31 December 2017**

**Standard 3.16**  
- Support plans must be reviewed every six months  
  **Timescale: 31 December 2017**  
- Support plans must be clearly written to support staff knowledge and understanding  
  **Timescale: With immediate effect**  
- Needs assessments must be reviewed every six months  
  **Timescale: 31 December 2017**  
- Person centred planning meetings must take place every six months  
  **Timescale: 31 December 2017**

**Standard 3.19**  
- Risk assessments must be in place.  
- Risk assessments must be reviewed every six months or sooner if required.  
  **Timescale: With immediate effect**

**Provider’s action plan**

3.3-Support plans to be updated and medical need documented accordingly.DEC2017
3.8-MAR 2018
3.11-Families and friends have been actively encouraged to come to visit the Home. Family members who cannot drive have been offered the opportunity to meet in a mutually acceptable venue. Xmas get-together has been arranged for between xmas and new year to welcome all to meet the new team. Invites will go out shortly. Visits are recorded on RIO reorting system.DEC 2017.MET
3.13-All PEEPS have been updated.MET
3.16-Support plans have been fully updated for DK as of the 10/11/17. Support plans for SN, MT and SC are currently being updated.DEC 2017

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

**Other Areas Identified during this inspection**

**Carried forward from previous inspection**

**Requirements and recommendations**

**Standard 2.1**  
The home should be kept in a good state of repair. The following should be remedied:  
- Paint bubbling / peeling in several areas of the home.  
- Marks on upstairs walls should be cleaned / redecorated.  
- Mark on wall in the lounge should be repaired.  
**Timescale: June 2017**
Carried forward October 2017

Standard 2.1
- The recliner chair in the lounge needs cleaning
- Lounge and corridor paintwork needs refreshing
- Photographs in the lounge must reflect all service users in equal measure

Timescale: 31 March 2017

Standard 2.10
Residents’ getting up and going to bed times – morning/evening routine should be recorded.

Timescale: June 2017
Carried forward October 2017

Standard 7.2
Shift leaders should be qualified to, or are enrolled on a QCF level 3 Diploma in Health and Social Care.

Timescale: October 2017
Carried forward October 2017

Provider’s action plan
2.1-HC/FC to meet to list all repairs required. HC to report to estates with list.NOV 2017
Recliner chair to be quoted for price to be cleaned.NOV 2017
Photographs in lounge reflect all S/U and are current. House camera has been sourced and everyone is encouraged to use this.MET
2.10-Morning/evening routines to be documented.HC to raise in Team meeting on 28/11/17.JAN 2018
7.2-3 staff in the Home are qualified to level 3 QCF or equivalent .Others are QCF 2.1 staff is currently requesting QCF 3 and 1 staff is on induction but has requested QCF 2.

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 co-operation 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: Mandy Quirk Date: 26/10/17
To: The Registration and Inspection Unit, Ground Floor, St George’s Court, Hill Street, Douglas IM1 1EF

From: 3 Rosebank

I / we have read the inspection report for the unannounced inspection carried out on 22, 25 & 26 September and 3 October 2017 at the establishment known as 3 Rosebank 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)

☐

Click here to enter text.

Signed
Responsible Person  Fams Camara
Date  04/12/17

Signed
Registered Manager  Hilary Coulthard
Date  04/12/17

Action plan/provider’s response noted and approved by Inspector:
Date:  07/12/17  Signature/initials: MQ