Regulation of Care Act 2013

Adult Day Care

Nunnery Howe Resource Centre

Announced Inspection

16 & 21 June 2021

The provider did not return their response within the specified time scale and consequently it has been placed on the website without their comments

Contents

Part 1 - Service Information for Registered Service

Name of Service:
Nunnery Howe Resource Centre

Telephone No:
(01624) 674826

Care Service Number:
ROCA/P/0138I

Conditions of Registration:
No more than 21 service users at any one session.

Registered company name:
Autism Initiative (IOM)

Name of Responsible Person:
Paul Ormond-Smith

Name of Registered Manager:
Andrea Gaskell

Manager Registration number:
ROCA/M/0162

Date of latest registration certificate:
6 November 2018

Date of any additional regulatory action in the last inspection year (ie improvement measures or additional monitoring):
None

Date of previous inspection:
28 August 2019

Person in charge at the time of the inspection:
Andrea Gaskell

Name of Inspector:
William Kelly

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.

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.

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.

Part 3 - Inspection information

The Inspection report is based on the information provided as part of the pre inspection desk top analysis and the findings of the inspection visit.

The purpose of this inspection is to check the service against the service specific minimum standards – Section 37 of The Regulation of Care Act 2013 and The Regulation of Care (Care Services) Regulations 2013 part 3, regulation 9.

Inspections concentrate on specific areas on a rotational basis and for most services are unannounced.

The inspector is looking to ensure that the service is well led, effective and safe.

Summary from the last inspection

Number of requirements from last inspection:
Four

Number met:
Two

Number not met:
Two

All requirements not met will be addressed within this inspection report

This was an announced annual inspection, covering a number of standards within the Adult Day Care Minimum Standards 2017.

Nunnery Howe Resource Centre is an adult day service for people with a diagnosis of an autistic spectrum condition. The Centre provides adults with opportunities to engage in a range of activities to support and develop their social, emotional and educational skills.

The Centre had a large amount of indoor space, which included a workshop facility, kitchen area, an area for desktop activities and a soft-seated 'lounge' area. Outdoor space catered for ball games and an area dedicated to gardening.

During the inspection, service user' care plans and records were reviewed and measured against the standards. Other areas looked at during this inspection included the environment, management and staffing, safeguarding and policies and procedures.

The inspector also had an opportunity to gather feedback from several service users and staff members. The manager was unavailable during the inspection; however, the Area Manager provided feedback throughout the inspection.

Part 4 - Inspection Outcomes, Evidence and Requirements

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 1 – Informing and Deciding
Outcome

Prospective users of the day service have all the information needed to help make a decision about using the service.

Our Decision:
Substantially Compliant

Reasons for our decision:
The inspector had an opportunity to review the most recent Statement of Purpose, which had been reviewed in January 2021; however, this was found not to include all of the information set out in Schedule 3 of the registration regulations.

The service user Handbook contained all the information required to meet the criteria of this standard.

Records and feedback from the service users confirmed that they had an opportunity to visit the day centre prior to agreeing to receive a service.

Evidence Source:

Observation		Records	✓	Feedback	✓	Discussion	✓

Requirements:
One

Recommendations:
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) **Standard 2 – Assessment of Need** Outcome Each service user must have an up-to-date assessment of their needs with regard to the service provided.

Our Decision:
Non-Compliant

Reasons for our decision:
The inspector had an opportunity to review several service user's files. The Day Service had produced their own formal assessment paperwork, which had been completed with the prospective service user prior to them receiving a service; however, one service user file did not contain an assessment of needs.

For several service users, there was no evidence to determine if they had been involved in the assessment process. The assessment paperwork did not include signatures for either the service users or their representatives.

There were several service user's files that did not contain formal assessment paperwork; therefore, there was insufficient evidence to determine how the support plans had been developed, taking the service user's needs into consideration.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
Three

Recommendations:
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 3 – Contract/Agreement
Outcome
Each service user must have a contract/agreement detailing the services to be provided.

Our Decision:
Substantially Compliant

Reasons for our decision:
Each service user had received a 'service summary' which had the same function as a contract; however, this document did not contain all of the criteria of the standard. The service summaries did not include a start date or inform when the summaries were to be reviewed.

The service summaries stored within the service user's files were not signed by the service user, evidencing that the service user had agreed with the level of support being offered.

The service summary for one service user was dated more than five days after the service had been taken up by the service user.

There was sufficient evidence to determine that the service summaries had been reviewed annually.

Information regarding the annual reviewing of services was included in the service user's handbook.

People attending the day centre did not pay for the services they had received.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
Three

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 4 – Service User Plan
Outcome
Each service user must have an up-to-date comprehensive care support plan.

Our Decision:
Partially Compliant

Reasons for our decision:
Each service user had support plans in place that appeared comprehensive to their needs; however, the support plans had not been signed by the service user, or their representative; therefore, it could not be evidenced who had been involved in the development of the support plans. There was no information in the service user's file to indicate if they had chosen not to be involved with developing their support plans, nor the reasons why their representatives had not signed them.

For one service user, their most recent review identified several support needs and actions; however, there were no support plans within their file, identifying how the service was going to provide the required support to meet the service user's outcomes.

For several service user's, their support plans had not been reviewed on a regular basis. The support plans did not record when they were due to be review.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
Four

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 6 - Environment
Outcome
The Environment must be safe, well maintained and remain suitable.

Our Decision:
Substantially Compliant

Reasons for our decision:
The grounds outside of the building were well maintained and areas were designated for various activities, including gardening and ball games.

The interior of the premises was designed purposefully to meet the individual needs of the service uses. Several activities were catered for, including arts and crafts, a workshop area, a kitchen and an indoor games room.

The premises were found to be well maintained, clean, very tidy and in a good state of repair and decoration throughout.

The service had an up-to-date fire risk assessment, which had been reviewed in November 2020.

The service also had a fire safety policy, which had been reviewed in June 2019. Discussions with staff members confirmed their awareness on what to do in the event of an emergency. There was appropriate fire safety signage throughout the premises.

Staff training records confirmed that all staff had completed an on-line fire marshal training course.

The service user' files contained a Personal Emergency Evacuation Plan for each of the service users.

Records confirmed that the fire alarms within the building had been tested weekly; staff members had visually examined the firefighting equipment monthly and the emergency lighting had also been checked on a monthly basis.

Records demonstrated that fire evacuation drills had been carried out twice in the last twelve months.

The service had sufficient public and employer liability insurance, which was due to expire on 29 June 2021.

The service did not provided an up-to-date electrical conformity certificate. There was no evidence to support that the electrical installation had been inspected by a qualified electrician recently.

Records of the most recent Portable Electrical Testing (PAT) was available for inspection, which had been carried out in September 2020. These records showed that two items of electrical equipment had failed the test. Further inspection determined that at least one of these items of equipment was still being used in the premises.

The inspector had an opportunity to measure the temperatures of the hot water outlets, which were found to be within tolerances identified within the standard.

The service had produced several environmental risk assessments; however, there was no risk assessment identifying the need to regularly monitor and record the hot water temperatures. The service did not produce any historical records of hot water temperatures.

The service did not produce a Legionella risk assessment and there were no records demonstrating that samples of water had been tested for the presence of the Legionella bacteria, on an annual basis.

There was a range of recreational and craft equipment available to the service users, specific to meeting the needs and outcomes of their support plans. Activities based around the 'ASDAN' programme, and the 'John Muir 4 Principles' had been adopted by the service. Resources and materials had been provided to the service users, to maximise their abilities and support positive outcomes. Areas within the grounds were also used to good effect, such as the gardening area.

There was a copy of the weekly activity planner available to the service users and a copy was stored within their personal file.

Furniture and fittings had been in keeping with the supported activities. The inspector observed sufficient staffing to support the service users and maximise the space and resources available.

The inspector had an opportunity to inspect the kitchen area. Fridge temperatures had been recorded daily; however, this evidenced that the fridge had been running too warm for the safe storage of food. For the three weeks prior to the inspection the fridge had been, on average, between 8-9°C.

Food stored in the fridge was appropriately labelled with the open date and the use by date.

Training records evidenced that all staff had completed their food safety and first aid training.

The premises had separate toilets for both genders and each toilet had sufficient space for wheelchair access. The facilities were clearly marked and had sufficient hand-washing and drying facilities. Each toilet could be locked from the inside and opened from the outside, if necessary, in case of emergency.

The sizes of the rooms used by the service users were found to meet the criteria of the standard.

The service had a vehicle used specifically for transporting the service users on activities; however, there was no evidence that this had been serviced on a regular basis.

There were lockers available for service users and staff to use, to store their personal belongings. There was an office available for staff members and the manager to use.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements:
Four

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 7 – Management and Staffing
Outcome
Good quality support and care must be provided by management and staff whose professional training, qualifications and expertise enables them to meet the service users' needs.
7.2, 7.4, 7.8, 7.9, 7.10, 7.11, 7.13, 7.14.

Our Decision:

Substantially Compliant

Reasons for our decision:
Training records confirmed that the manager had attained the QCF level 5 Diploma in Leadership for Health and Social Care.

Training records also verified that all staff working at the Day Centre had attended 'Understanding Autism, Keeping Safe' training, which was specific to the people using the service.

Records established that all staff had undergone an induction programme, which included completing a 'Shadow Shift' record sheet; however, for one staff member, their records showed that they had not completed the 'Staff New on Shift' checklist within their probation period.

Staffing rotas demonstrated a staff deployment of 3:1 service users to staff on shift; however, the rotas did not show staff members' full names or their role and the manager's hours were not identified on the rotas.

The rotas also displayed the hours constituting an 'early' shift, as 0800 – 15.30; however, the inspector was informed that staff at the day centre work to 16.30 hours. The rota also shows hours that constitute a 'late' shift, as 1300 – 2030 hours; however, the staff at the day centre do not work a late shift.

Records and staff feedback determined that all staff within the service had received 1-1 supervision with their line manager at least four times per year. Records of supervision meeting were kept within the staff member's personal file. The manager of the service had not been present for several weeks. In their absence, the Area Manager had been conducting the supervision meetings on a regular basis.

The service had produced several environmental risk assessments, which appeared comprehensive and had been reviewed on a regular basis. The risk assessments identified when the next review date was due.

The service had produced a medication policy, which had been reviewed in November 2019 and was scheduled to be reviewed again in November 2021.

Staff training records demonstrated that all staff had attended 'Safe Administration of Medication' training, which had been refreshed every two years. Also, staff had been trained in administering Midazolam.

Discussions with staff determined that they had supported the service users in spending their petty cash. Records of transactions included a 'Petty Cash Control Sheet', which had been completed after every transaction. There were also petty cash vouchers for every transaction, which were individually numbered. Each voucher had been countersigned by a second member of staff.

Evidence Source:

Observation		Records	✓	Feedback	✓	Discussion	✓

Requirements:
Two

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 8 - Safeguarding
Outcome
Service users must be safeguarded from abuse.
8.1, 8.2, 8.3, 8.4, 8.6.

Our Decision:
Partially Compliant

Reasons for our decision:
The service had produced a safeguarding policy which had been reviewed in January 2020 and was scheduled to be reviewed again in January 2022. The policy had included the contact details for the Isle of Man Registration and Inspection team and the Adult Protection team; however, the policy refers to UK legislation throughout and not Manx safeguarding legislation.

The policy referred to safeguarding liaison arrangements via the protection officer; however, the policy did not identify and name appropriately trained members of staff with whom concerns should be discussed.

Staffing records determined that the procedures for safeguarding vulnerable adults was covered in the induction programme.

Training records showed that safeguarding refresher training had lapsed for some staff members; however, the Area Manager explained that the service' responses to the recent COVID pandemic lockdown had a detrimental effect of providing training.

Two staff members had not attended any safeguarding training.

There were no reported safeguarding concerns or alerts raised since the last inspection.

The inspector had an opportunity to review the daily attendance register. There were two registers, one for staff members and visitors, and another for service users. Both registers had only recorded the first name of the person entering the building, not their surname. On the day of the inspection, one entry used only the initials of the visitor. Discussions with staff members at the time could not identify the person to whom the entry was referring to.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
Four

Recommendations:
None

Regulation of Care Act 2013 Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 10 – Policies and Procedures
Outcome
The service must have systems in place to assess the quality of the service and makes provision to improvement and development.

Our Decision:
Non-Compliant

Reasons for our decision:
The service did not provide the inspector with a comprehensive list of all policies and procedures, available to staff, in line with Appendix A of the Minimum Standards (covered in Standard 7.1)

The Area Manager informed the inspector that all policies and procedures were available to staff electronically and staff had to sign a sheet confirming they had read the policy; however, only two members of staff had signed the sheets at the time of the inspection. There were an insufficient number of signing sheets to cover all the policies and procedures identified in Appendix A of the Minimum Standards.

Review dates for some policies were identified on the staff signing sheets; however, these dates showed that some policies and procedures had lapsed their review dates. The service did not provide the inspector with a list of all their policies and their review dates.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
Two

Recommendations:
None

Other areas identified during this inspection /or previous requirements which have not been met.

Standard 7.1
The Area Manager did not provide sufficient evidence that all policies and procedures, identified in appendix A of the Minimum Standards, was available to staff members (carried from previous inspection).

Standard 7.13
There was no evidence to support that staff members, trained to administer medication, were regularly monitored and assessed on their competency (carried from previous inspection).

Regulation 11 of the Regulation of Care (Care Services) Regulations 2013
The service had failed to submit a Regulation 10 Notification of Event form, informing the Registration and Inspection Team that the manager had been absent for over four weeks, at the time of the inspection.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements:
Three

Recommendations:
None

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 or have identified any inaccuracies, please do not hesitate to contact the Registration and Inspection Team.

Inspector: William Kelly **Date:** 15 July 2021

Provider's Response

From: Autism Initiatives IOM

I / we have read the inspection report for the inspection carried out on **16 & 21 June 2021** at the establishment known as **Nunnery Howe Adult Day Centre** and confirm that there are no factual inaccuracies in this report. ☐

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

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
Registered Manager
Date

The provider did not return their response within the specified time scale and consequently it has been placed on the website without their comments