Isle of Man Government
Reiltys Ellan Vannin

Department of Health and Social Care
Rheynn Slaynt as Kiarail y Theay

Regulation of Care Act 2013

Adult Care Homes

3 Rosebank

Unannounced Inspection

28 & 30 November 2018

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

Contents

Completing and returning your report

To complete your report form, enter text by clicking on the box, use the tab key to move to the next box.

1. Provider's action plan and response
    a. Add details of your actions to complete the requirements/recommendations (if applicable)
    b. Confirm you have read and agree/disagree the contents of the report by clicking on the appropriate box
    c. Sign (type name when returning electronically) and date

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

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

Part 1: **Service information**

Part 2: **Descriptors of performance against Standards**

Part 3: **Inspection Information**

Part 4: **Inspection Outcomes and Evidence and Requirements**

Part 5: **Provider's action plan and response**

Part 1 - Service Information for non-Registered Service

Name of Service:
3 Rosebank

Tel No: (01624) 656077

Address:
Vicarage Road
Farmhill
Braddan
Isle of Man
IM2 2QW

Email Address:
Julia.murat@gov.im

Name of Manager:
Julia Murat – Senior Residential Support Worker (SRSW)

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

Date of previous inspection:
22, 25, 26 September 2017 & 3 October 2017

Number of individuals using or attending the service at the time of the inspection:
Four (4)

Person in charge at the time of the inspection:
Anita Lewthwaite – Residential Support Worker (RSW) 28/11/18 & Julia Murat – SRSW 30/11/18

Name of Inspector(s):
Kevin West

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 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.

Inspections are generally themed, concentrating 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, safe and compassionate.

No	Standard	Requirements/recommendations from previous inspection	Met/not met
1.	**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**	**Met** **Met** **Not met** **Met**
2.	**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**	**Not met**
3.	**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**	**Not met**
4.	**Standard 4.3**	• Detailed records must be made and retained on issues raised around safeguarding • 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 **Timescale: With immediate effect**	**Met** **Not met**
5.	**Standard 4.4**	• Safeguarding must form part of the induction process for new staff members and be discussed within	**Met**

		their first week of employment. • All staff members must be up to date with adult protection refresher training **Timescale: With immediate effect**	**Met**
6.	**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**	**Met**
7.	**Standard 4.9**	Details of all complaints and their outcomes must be recorded in the log book **Timescale: With immediate effect**	**Not met**
8.	**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 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**	**Met** **Met** **Met** **Met** **Not met** **Met** **Not met**
9.	**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**	**Met**
10.	**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**	**Met** **Met**
11.	**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**	**Met** **Met**
12.	**Standard 4.14**	A COSHH risk assessment must be completed and reviewed regularly **Timescale: 31 December 2017**	**Met**
13.	**Standard 4.16**	• A valid electrical installations condition report must be available for	**Met**

		inspection • PAT testing records other than visual must be available for inspection. **Timescale: 31 March 2018**	**Met**
14.	**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**	**Met** **Met**
15.	**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**	**Not met**
16.	**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**	**Met**
17.	**Standard 6.5**	The induction pack must be amended to cover all aspects of the care certificate standards **Timescale: 31 March 2018**	**Met**
18.	**Standard 6.8**	Regular supervision sessions must be conducted for all staff members **Timescale: With immediate effect** **Carried forward October 2017**	**Met**
19.	**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**	**Not met** **Not met** **Met**
20.	**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**	**Met**
21.	**Standard 6.12**	Individual training needs must be identified as part of a regular programme of one to one supervision **Timescale: With immediate effect**	**Met**
22.	**Standard 6.13**	An annual appraisal must be completed for all staff members. **Timescale: 31 May 2018**	**Met**

23.	**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**	**Met**
24.	**Standard 6.18**	All training is evaluated to ensure that it is fit for purpose **Timescale: 31 March 2018**	**Met**
25.	**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**	**Met**
26.	**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**	**Not met**
27.	**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**	**Met** **Met** **Met**
28.	**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**	**Met**
29.	**Standard 7.1**	The must be a robust support plan developed to assist and support the development of the new manager and the service.	**Met**

		Timescale: With immediate effect	
30.	**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**	**Not met**
31.	**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**	**Met** **Met**
32.	**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**	**Not met**
33.	**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**	**Not met** **Met** **Met**
34.	**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**	**Not met** **Not met**
35.	**Standard 3.11**	Contact with friends and relatives must be encouraged, supported and recorded **Timescale: With immediate effect**	**Not met**
36.	**Standard 3.13**	Personal Emergency Evacuation Plans (PEEPs) documentation must be reviewed	**Met**

		Timescale: 31 December 2017	
37.	**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**	**Not met** **Met** **Not met** **Met**
38.	**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**	**Not met** **Not met**
39.	**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**	**Met** **Met** **Met**
40.	**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**	**Met** **Met** **Met**
41.	**Standard 2.10**	Residents' getting up and going to bed times – morning/evening routine should be recorded. **Timescale: June 2017** **Carried forward October 2017**	**Met**
42.	**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**	**Not met**

Part 4 - Inspection Outcomes, Evidence and Requirements

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 2 - Daily Living
People are supported to set and carry out their activities and routines in suitable surroundings. The environment is conducive to people's well-being and safety. People live in a home that is safe, warm clean and comfortable. People have access to the aids, equipment and facilities they need.
2.10, 2.11, 2.12, 2.13, 2.14, 2.15

Our Decision: Compliant

Reasons for our decision:
Resident getting up and going to bed routines were recorded. Support at mealtimes was recorded. Staff members informed the inspector that residents could choose where they had their meals and at a time that suited them. Personal hygiene and bathing/showering support was recorded. If gender specific support was required than this was identified in an individual's skills, needs risk assessment.

A three week rolling menu was used by the home. Meals on offer appeared nutritious. Staff members confirmed that meal choices were on offer. Minutes evidenced that menus were discussed in resident house chats / meetings.

Residents were encouraged to assist with grocery shopping and with making their own drinks.

Drinks and snacks were available through the day / evening.

Equipment for activities, such as electronic tablets, dvd's and music was provided in the home. Resident activity planners evidenced that individuals attended day centres and social activities throughout the week.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 3 – Daily Support
People are confident that the staff will support them to maintain their health and to support their social and welfare requirements.

Our Decision: Partially compliant

Reasons for our decision:
One person had moved into 3 Rosebank in September 2018. A comprehensive compatibility assessment had been completed. An assessment of needs must be completed prior to / during admission. A skills, needs risk assessment for this resident was on file. This document had been completed by the resident's previous residential home and was dated May 2018. This assessment

must be reviewed by the SRSW of 3 Rosebank to reflect that this document was considered pre-admission.

Nutritional needs formed part of the needs assessments.

Three of the residents had detailed support plans written on known medical conditions. One resident had medical conditions identified in their needs assessment but no associated support plans. Individual health action plans / health passports were regularly reviewed, but two health check assessments had not been reviewed for over a year.

Records confirmed that residents had access to healthcare professionals / specialists when required.

Residents received annual health checks with their GP.

Where required, residents had an emotional and mental well-being support plan.

One resident attended church on a Sunday. The support required must be detailed in a support plan.

Communication support plans were in place. One resident's communication assessment and communication passport had gone past their review date and must be reviewed / updated every six months or when required.

Behaviours that challenged and how they could be managed were documented in individual Personal Intervention Plans (PIP's). Two residents' PIP were overdue a review. Staff members had received training on Managing Actual & Potential Aggression (MAPA).

Leisure interests and hobbies had been identified. Leisure activity support plans must include information on how the activity should be maintained / encouraged. Contact with family members is supported and encouraged and support plans must detail how this can be facilitated.

The home did not have any specialist furniture / equipment but two residents were currently being assessed for the use of a bath seat.

Each resident had a Personal Emergency Evacuation Plan (PEEP) which identified the level of support the person required to evacuate the building in the event of a fire.

Support plans were regularly reviewed but one resident's morning and evening routine had last been reviewed in January 2018. Another resident's support plan on a specific health condition contained out of date information. One resident's skills, needs risk assessment had just gone past its review date at the time of the inspection.

The inspector was informed by the SRSW that residents had access to advocacy services.

The majority of the residents had risk assessments in place that were regularly reviewed. One resident did not have a risk assessment regarding a specific medical condition, and another risk assessment contained out of date information and must be updated.

Staff supported residents with their finances. Benefits were paid directly into individual's bank accounts and staff assisted each person with withdrawing money when required. The money was then kept in individual locked tins. Records were kept of any monies held on behalf of the

residents. Two staff signed in an individual's cash ledger book to record monies in and out. Residents had a client financial risk assessment on file.

Each resident had a medication risk assessment and agreement form which identified if an individual was able to self-administer their own medication. All of the residents were deemed not able to store and administer medication.

Support plans for three residents detailed how they liked to take their medication. This information was not in place for one resident.

Medication was administered following prescription instructions and stored correctly.

The medication was regularly audited by the home's dispensing chemist.

Staff members were up to date with training on basic medication administration. Staff member competency to administer medication must be assessed in-house on an annual basis. Staff received this check just over a year ago but there was no record of the SRSW having their competency assessed.

A first aid box was located in the home's utility area. Staff members had received training on first aid.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements
Eleven

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 4 - Environmental and Personal Safety and Comfort
Systems, checks, policies, procedures and staff training ensure that people's dignity, well-being and safety is promoted and protected.
4.1, 4.2, 4.3, 4.4, 4.8, 4.9, 4.10, 4.16, 4.17

Our Decision: Partially compliant

Reasons for our decision:
Risk assessments had been written in respect of the environment and were regularly reviewed.

Staff had access to a whistleblowing policy and safeguarding adult procedures. A copy of the current Isle of Man adult safeguarding procedures was located in a policy file. Only the SRSW had signed to indicate that they had read and understood the policy and procedure. Staff on duty on the day of the inspection informed the inspector that they were confident in dealing with a safeguarding / adult protection concern.

Safeguarding formed part of the induction process. Staff members were up to date with safeguarding adult training.

At the time of the inspection the complaints procedure was not displayed. Information on complaints was located in a file in the hallway.

A complaints book evidenced that when complaints were made they were recorded. One complaint that was examined by the inspector did not include the outcome. This must be recorded.

A fire risk assessment had been written and was reviewed on 1/12/17. Staff members had received annual fire safety training. On the day of the inspection two large boxes were located in the hallway. These must be removed so that all means of escape in the event of a fire are kept free from hazards. One weekly alarm test had not taken place in November 2018 and the fire extinguishers had not been checked in June, August and September 2018. All other fire safety checks had taken place at the required frequency.

An electrical installation condition report had been completed on 3/7/18. Portable Electrical Appliance Tests (PAT) had been carried out by Estates on 10/8/18. Monthly visual checks were also taking place.

Water temperature checks were carried out by staff weekly and recorded. Staff also checked the temperature of the water prior to assisting a resident with a bath / shower. The wording on the recording sheets must be changed as it stated that hot water should be 44°c or below. For shower temperature recording it should state that hot water should not exceed 41°c. The thermostatic mixer valves had been checked twice since the last inspection. A water report that tested for e-coli bacteria had been carried out on 25/4/17. This test must be carried out annually.

The gas combi boiler was serviced on 18/4/18.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements
Six

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 6 - Staffing
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.
6.3, 6.20, 6.21, 6.22, 6.23

Our Decision: Partially compliant

Reasons for our decision:
Staff member pre-employment checks must be available for scrutiny on inspection. These were not available.

The inspector was informed that generally there was enough staff on duty, with additional staffing provided for outings / social activities etc. Feedback from family members also confirmed that they believed that there was sufficient staff on duty to meet the needs of their relative.

Staff rotas were accurate and reflective of actual persons and hours worked on each day. Shift leaders were not identified on the rota and a requirement has been made.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements
Two

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 7 – Management Quality and Improvement
People have confidence that the systems in place support the smooth running of the home. The registered manager is qualified and competent to manage the home. People are consulted about how the home is run and their opinions are taken into account. The home has an annual development plan that makes provision for the home to develop and improve.
7.9

Our Decision: Compliant

Reasons for our decision:
The SRSW had written an annual report and plan 2018. This included a development / improvement plan based on the outcomes of the quality assessment exercise, as well as service achievements in the past year and future plans for the next twelve months.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	

Requirements and Recommendations
None

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Other areas identified during this inspection / Or previous requirements which have not been met.

Other areas identified during this inspection
A resident did not have a wardrobe in her bedroom and so had to put clothes on the floor. A wardrobe had been delivered to the home but this required assembling by Estates and had not been put together at the time of the inspection.

Evidence Source:

Observation	✓	Records		Feedback		Discussion	✓

Requirements
One

Previous requirements which have not been met.

The statement of purpose still required the experience and qualifications of the SRSW adding.

The new resident's skills, needs risk assessment must be reviewed by the SRSW of 3 Rosebank to reflect that this document was considered pre-admission.

The newest resident must be provided with a written contract for 3 Rosebank.

Not all staff members had accessed mandatory training on communication, health and safety, nutrition, values based training and food hygiene.

Some policies and procedures needed reviewing.

The SRSW had not received confirmation that two staff members were enrolled on a QCF level 3 Diploma in Health and Social Care. Shift leaders must be qualified to, or enrolled on a QCF level 3.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements
Six

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 identify any inaccuracies, please do not hesitate to contact the Registration and Inspection Unit.

Inspector: Kevin West **Date:** 20/12/18

Part 5 - Provider's action plan and response.

The provider must complete this page in respect of all the requirements made within the report.

Requirements

1. Standard 3.3 – Daily Support
   Known medical conditions must have a support plan that instructs the reader how to support / maintain / improve the medical condition.
   Not met
   Carried over 30 November 2018
   Timescale: Immediate

2. Standard 3.3 – Daily Support
   Health check assessments must be regularly reviewed.
   Timescale: Immediate

3. Standard 3.7 – Daily Support
   A support plan must be written on one resident's church attendance.
   Timescale: Immediate
4. Standard 3.8 – Daily Support

Communication assessments & communication passports must be reviewed and updated every six months.
Not met
Carried over 30 November 2018
Timescale: Immediate

5. Standard 3.9 – Daily Support
   Individual PIP's must be regularly reviewed.
   Timescale: Immediate

6. Standard 3.11 – Daily Support
   Leisure activity support plans must include information on how leisure interests and hobbies should be maintained / encouraged.
   Timescale: Immediate

7. Standard 3.11 – Daily Support
   Contact with family members is supported and encouraged and support plans should detail how this can be facilitated.
   Not met
   Carried over 30 November 2018
   Timescale: Immediate

8. Standard 3.16 – Daily Support
   - Support plans / routines must be reviewed every six months / updated where required.
   - Needs assessments must be reviewed every six months.

   Not met
   Carried over 30 November 2018
   Timescale: Immediate

9. Standard 3.19 – Daily Support
   - Risk assessments must be in place.
   - Risk assessments must be reviewed every six months or sooner if required.

   Not met
   Carried over 30 November 2018
   Timescale: Immediate

10. Standard 3.24 – Daily Support
    Support plans must detail how a resident took their medication and the level of support required from a staff member.
    Not met
    Carried over 30 November 2018
    Timescale: Immediate

11. Standard 3.26 – Daily Support
    The competency of all staff who administer medication must be assessed on an annual basis and appropriate records maintained.
    Not met
    Carried over 30 November 2018
    Timescale: Immediate

12. Standard 4.3 – Environmental and Personal Safety and Comfort

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
Not met
Carried over 30 November 2018
Timescale: 7 January 2019

13. Standard 4.8 - Environmental and Personal Safety and Comfort
    The complaints procedure must be displayed.
    Timescale: Immediate

14. Standard 4.9 - Environmental and Personal Safety and Comfort
    Details of all complaints and their outcomes must be recorded in the log book.
    Not met
    Carried over 30 November 2018
    Timescale: Immediate

15. Standard 4.10 - Environmental and Personal Safety and Comfort
    Large boxes in the hallway must be removed so that all means of escape in the event of a fire are kept free from hazards.
    Timescale: Immediate

16. Standard 4.10 - Environmental and Personal Safety and Comfort
    - Weekly fire alarm tests must be conducted
    - Monthly fire extinguisher checks must be completed

    Not met
    Carried over twice
    Timescale: Immediate

17. Standard 4.17 - Environmental and Personal Safety and Comfort
    - Water recording sheets must be changed to state that hot water must not exceed 41°c for showers.
    - Water reports that test for bacteria must be carried out annually.

    Timescale: Immediate

18. Standard 6.3 – Staffing
    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.
    Not met
    Carried over 30 November 2018
    Timescale: 28 January 2019

19. Standard 6.23 – Staffing
    Shift leaders must be clearly identified on the rota.
    Timescale: Immediate

20. Standard 2.1 – Daily Living
    A wardrobe must be provided for a resident.
    Timescale: 30 December 2018

21. Standard 1.1 – Introduction, Assessment and Admission
    The statement of purpose must include the experience and qualifications of the SRSW.

Not met
Carried over 30 November 2018
Timescale: 30 December 2018

22. Standard 1.2 - Introduction, Assessment and Admission
    A pre admission assessment of needs must be completed by the SRSW for any new resident.
    Not met
    Carried over 30 November 2018
    Timescale: Immediate

23. Standard 1.6 - Introduction, Assessment and Admission
    During the admission process, the person being admitted and/or their representative are provided with a written contract.
    Carried over three times
    Timescale: Immediate

24. Standard 6.9 – Staffing
    All staff members must access mandatory training in:
    - Communication
    - Health & safety
    - Nutrition
    - Values based training

    Not met
    Carried over 30 November 2018
    Timescale: 28 February 2019

25. Standard 7.3 – Management Quality and Improvement
    Policies and procedures must be dated on completion, have a review date identified and followed up with a timely review.
    Not met
    Carried over twice
    Timescale: 28 February 2019

26. Standard 7.2 - Management Quality and Improvement
    Shift leaders should be qualified to, or are enrolled on a QCF level 3 Diploma in Health and Social Care.
    Not met
    Carried over twice
    Timescale: 1 April 2019

Provider's Action Plan
Requirements:

1. All medical conditions for all the service users have got support plans. The one missing was for a Choclea Implant and requires no support form staff was put in place on the 03.12.18
2. All Health Check Assessments have now been reviewed and are being updated regularly. 04.12.18
3. A support plan is now in place for the attendance at Church of one of the Service Users. 03.12.18
4. The one Communication Assessment/passport out of date has now been reviewed with no Changes.04.12.18
5. All PIP's were within date for review. One was due at the time of the Inspection and completed

0n th 04.12.18

6. One service users interest in going on the Tram and Train was not documented in a support Plan. A support plan for this avtivity is now in place. 03.12.18
7. Contact with family has been actively encouraged for all the service users and a support plan for each of them is now in place. 04.12.18
8. All support plans and risk assessments have been reviewed. One Service Users support plans were in date for the previous house, and were in the process of being updated as we became accustomed to how her support has changed since her move to 3 Rosebank.
9. All risk assessments were up todate at the time of the inspection, however one was missing regarding a medical condition of a service user although the support plan was in place. This has been rectified and a risk assessment completed. 04.12.18
10. This had been completed for all service users except the resident who had recently joined the household. A Support plan is now in place. 03.12.18
11. All staff have undertaken competency checks for medication and this has now been recorded.
12. Staff have now all signed the read and understood sheets to confirm they have read the Safeguarding policy and procedures.
13. The complaints procedure was held in a clearly marked file in the entry to the house. As advised this has now been more prominently displayed.
14. The outcome of the complaint mentioned has now been updated in the complaints record book.
15. All boxes have been removed form the hallway. Completed within two days of the inspection.
16. The Senior will double check that these checks are being completed as these have been missed due to use of relief staff.
17. The water log sheets for the shower has now been amended to state 41 degrees instead of 44 degrees. The temperatures recorded for the shower did not exceed the 41 degrees.

Completed on a separate piece of paper.

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

From:
3 Rosebank
I / we have read the inspection report for the unannounced inspection carried out on 28 & 30 November 2018 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. ☒

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) ☐

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.

Signed
Responsible Person Julia Murat
Date 11.01.19

Signed Fams Camara
Registered Manager
Date 11.01.19

Action plan/provider's response noted and approved by Inspector: Kevin West
Date: 16/1/19 **Signature/initials:** K.W.