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

Hutchinson Square

Unannounced Inspection

22 January 2019

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

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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.

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    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

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Part 1 - Service Information for non-Registered Service

Name of Service:
Hutchinson Square

Tel No: (01624) 675513

Address:
11 Hutchinson Square,
Douglas,
Isle of Man, IM2 4HT

Email Address:
Kristina.Neagle@gov.im

Name of Manager:
Kristina Neagle – 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:
14 March 2018

Number of individuals using or attending the service at the time of the inspection:
Three (3)

Person in charge at the time of the inspection:
Kristina Neagle - SRSW

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 should be amended to include: • The SRSW's relevant experience qualifications. • The age range of the residents that the service intends to meet. • The room sizes. • Correct details in the complaints section. • The arrangements for meeting the residents' health needs. • How the service intends to respect privacy, dignity and promote independence and choice. **Timescale: June 2018**	**Not met**
2.	**Standard 1.1**	An easy read version of the statement of purpose should be developed. **Timescale: June 2018**	**Met**
3.	**Standard 1.6**	All residents should be provided with a written contract. **Timescale: June 2018**	**Met**
4.	**Standard 4.5**	Staff should attend MAPA training at the required frequency identified by the service. **Timescale: June 2018**	**Not met**
5.	**Standard 4.6**	Personal intervention plans must be reviewed every six months as a minimum. **Timescale: Immediate**	**Not met**
6.	**Standard 4.7**	Any restrictions around freedom of movement for the residents should be recorded. **Timescale: Immediate**	**Met**
7.	**Standard 4.10**	Fire alarm testing should take place weekly. **Not met** **Carried over March 2018** **Timescale: Immediate**	**Met**

8.	**Standard 4.10**	Fire extinguishers should be checked monthly. **Timescale: Immediate**	**Not met**
9.	**Standard 4.13**	Food put in the fridge should be dated when opened / cooked. **Timescale: Immediate**	**Met**
10.	**Standard 4.16**	A record should be maintained of when a full PAT test by an electrician has been carried out. **Timescale: June 2018**	**Met**
11.	**Standard 4.17**	The blenders / thermostatic mixer valves should be checked at the departments own frequency of twice a year. **Timescale: Immediate**	**Not met**
12.	**Standard 6.3**	Staff files should be made available so that the inspector can verify that all relevant pre-employment checks are in place. **Timescale: Immediate**	**On-going**
13.	**Standard 6.9**	Staff members should receive refresher training at the required frequency identified by the service, for example moving and handling training every two years. **Timescale: Immediate**	**Not met**
14.	**Standard 6.9**	All staff should receive training on autism awareness. **Not met** **Carried over March 2018** **Timescale: June 2018**	**Met**
15.	**Standard 6.9**	All relief staff that are assigned to work at Hutchinson Square must receive diabetes / insulin training. **Timescale: August 2018**	**Not met**
16.	**Standard 6.13**	Staff members should receive an annual PDR. **Timescale: June 2018**	**Met**
17.	**Standard 7.9**	An annual report should be completed yearly. **Timescale: June 2018**	**Met**
18.	**Standard 7.2**	Shift leaders must be registered for or qualified to QCF level 3. **Not met** **Carried over March 2018** **Timescale: June 2018**	**On-going**
19.	**Standard 3.19**	Risk Assessments must be reviewed on a six monthly basis. **Not met** **Carried over March 2018** **Timescale: Immediate**	**Not met**
20.	**Standard 3.16**	Support Plans must be reviewed on a six monthly basis, as a minimum. **Not met** **Carried over March 2018**	**Not met**

		Timescale: Immediate	
21.	**Standard 3.16**	PCP meetings must be conducted on a six monthly basis **Not met** **Carried over March 2018** **Timescale: Immediate**	**Not met**
22.	**Standard 2.10**	Resident getting up and going to bed routines should be recorded. **Timescale: Immediate**	**Not met**
23.	**Standard 3.4**	Health check assessments should be reviewed and updated regularly. **Timescale: Immediate**	**Not met**
24.	**Standard 3.19**	Skills/needs risk assessments must be completed fully. **Timescale: Immediate**	**Not met**
1.	**Recommendations**	It is recommended that the home provide feedback questionnaires to family members once / twice a year.	**Met**
2.	**Recommendations**	• It is recommended that the home make available the Health and Social Care Act 2008 code of practice on the prevention and control of infections and related guidance, as well as the Healthcare associated infections – prevention and control in primary and community care (NICE) guidelines. • It is recommended that the home use the Safer Food Better Business food safety management procedures, including the kitchen opening and closing checks.	**Carried over**

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: Substantially compliant

Reasons for our decision:
People living in the home should set their own daily living routines and these routines must be recorded. Two service users did not have their getting up and going to bed routines recorded.

Mealtime preferences and the support individuals required were recorded. The kitchen was kept locked at night due to the actions of one service user and the reason for this must be recorded in that individual's support plan.

Individuals had support plans written on personal hygiene, bathing and oral hygiene.

Meals and menus were based on individual likes.

Where appropriate, service users were encouraged to make their own snacks and drinks.

Weekly planners evidenced that service users accessed a variety of activities. Equipment for activities was provided in the home.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements
Two

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:
Each service user had a skills, needs risk assessment document written. Only one service user's summary of needs and risks section had been completed.

Nutritional needs formed part of the skills, needs risk assessment document.

Known medical conditions had been identified in individual's needs assessment, but not all of the medical conditions then had a support plan that instructed the reader how to support, maintain improve the condition.

Service users accessed healthcare specialists / professionals and this input was recorded. This included a yearly health check and medication review.

Emotional well-being must be factored into support plans and this was in place for one service user. One service user was on medication for anxiety but there was no associated support plan.

Individual's faith had been recorded.

Communication support plans had been written.

Personal intervention plans identified any behaviour that challenged the service, as well as how the behaviour could be managed. One service user's plan had gone past the review date. Staff members had received training on Managing Actual & Potential Aggression (MAPA), but one relief staff had not received refresher training at the frequency identified by the service.

Service user leisure interests and hobbies had been identified. Support plans must be written on family contact and any support required.

The inspector was informed that no specialist furniture / equipment were required in the home.

Each service user had a personal fire safety risk assessment and emergency evacuation plan.

Where appropriate, individual's last wishes were recorded.

Two service user's support plans had been regularly reviewed but several of one person's support plans had gone past their review date. For two service users, Person Centred Planning (PCP) meetings had taken place every six months. One service user had a gap of more than six months between meetings. The inspector was informed that this was because the family had asked for a delay in this meeting taking place. The reasons must be recorded to evidence why the PCP was delayed.

Access to an advocacy service was available.

Risk assessments for individuals had been written on daily activities that constituted or suggested a risk. These must be reviewed when a person's needs change or at least every six months. One person's risk assessments had gone past their review date while all three service users' client financial risk assessments were last reviewed in May 2018.

If a service user was able to look after their own finances, this was identified in their skills, needs risk assessment. Money support plans were in place where required. Records were kept of any monies held on behalf of service users. These records were signed and witnessed as being accurate by two members of staff.

Medication was listed on individual Medication Administration Record (MAR) sheets.

Each service user had a medication risk assessment and agreement form which identified if they could manage and administer their own medication.

How each service user took their medication and the staff support required was recorded.

MAR sheets were examined and staff had signed to indicate that medication had been administered.

Staff members had received training on basic medication, but two relief staff had not received refresher training at the frequency identified by the service.

Staff competency to administer medication was assessed annually.

First aid training formed part of the home's training programme, but one relief member of staff had not received refresher training at the frequency of every three years. First aid boxes were located in the home and kept stocked.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements
Nine

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 on the environment and had been recently reviewed.

Staff members were able to access a whistleblowing policy and the current Isle of Man Adult Safeguarding procedures on the home's computer.

Staff members had received training on adult protection but one person had not undertaken annual refresher training.

Information on the complaints procedure was displayed in the home.

Two complaints had been made and recorded fully since the last inspection.

The home had a written fire risk assessment that was reviewed in April 2018.

Staff members had received training on fire safety which was updated yearly. On the day of the inspection, all means of escape were free from hazards. Records confirmed that weekly alarm testing only took place twice in September 2018. The SRSW explained that all of the service users were on holiday, along with staff on the missing dates. This should be clearly recorded in the fire log book. Fire extinguishers must be checked monthly. These were not checked in July 2018. All other fire safety checks had taken place.

The home had an electrical installation condition report dated 6/9/17. A full check of the Portable Electrical Appliance Test (PAT) equipment had taken place in October 2018. Monthly visual checks were also taking place.

A water report that tested for bacteria had last taken place on 13/9/17. Testing should take place yearly. Staff members were checking and recording water temperatures in the home. The thermostatic mixer valves / blenders had been checked on 14/4/18. This must take place at the departments own frequency of twice a year. Records produced subsequent to the inspection evidenced that a further check took place on 11/9/18.

An oil firing servicing and commissioning report had been completed on 8/11/18.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements
Four

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: Substantially compliant

Reasons for our decision:
The inspector was informed that no new staff members had started in the home since the previous inspection. Evidence of staff pre-employment checks was not available for scrutiny.

Generally, two members of staff were on duty from 8am-5pm.

Staff rotas were accurate and reflective of actual persons and hours worked. The shift leader / key holder was identified on the rota.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements
One

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: Substantially compliant

Reasons for our decision:
An annual report and plan 2018 was examined. The annual report still contained descriptors in each section and some sections had not been completed or contained very little information.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements
One

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
There were several areas around the home that needed to be fixed / redecorated, such as mould in bathrooms and ripped wallpaper.

Evidence Source:

Observation	✓	Records		Feedback		Discussion	✓

Requirements
One

Previous requirements which have not been met.
The statement of purpose still needed additional information adding.

Some staff had not received training on health and safety or diabetes / insulin.

Shift leaders must be registered for or qualified to QCF level 3.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements
Three

Recommendations
It is recommended that the home use the Safer Food Better Business food safety management procedures, including the kitchen opening and closing checks.

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:** 15/2/19

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 2.10 – Daily Living
   Service user getting up and going to bed routines must be recorded.
   Not met
   Carried over 22 January 2019
   Timescale: 11 March 2019

2. Standard 2.10 – Daily Living
   Support around accessing the kitchen must be recorded in the relevant service user's support plan.
   Timescale: 11 March 2019

3. Standard 3.1 – Daily Support
   Skills, needs risk assessment document must be completed fully.
   Not met
   Carried over 22 January 2019
   Timescale: 11 March 2019

4. Standard 3.3 – Daily Support
   Known medical conditions must have an associated support plan that instructs the reader how to support, maintain improve the condition.
   Timescale: 11 March 2019

5. Standard 3.6 – Daily Support
   Emotional well-being must have an associated support plan.
   Timescale: 11 March 2019

6. Standard 3.9 – Daily Support
   Personal intervention plans must be reviewed every six months as a minimum.
   Not met
   Carried over 22 January 2019
   Timescale: 11 March 2019

7. Standard 3.9 – Daily Support
   Staff must attend MAPA training at the required frequency identified by the service.
   Not met
   Carried over 22 January 2019
   Timescale: 1 May 2019

8. Standard 3.11 – Daily Support
   Support plans must be written on family contact and any support required.
   Timescale: 11 March 2019

9. Standard 3.16 – Daily Support
   Support Plans must be reviewed on a six monthly basis, as a minimum.
   Not met
   Carried over twice
   Timescale: Immediate

10. Standard 3.16 – Daily Support
    PCP meetings must be conducted on a six monthly basis.
    Not met
    Carried over twice
    Timescale: 1 May 2019

11. Standard 3.19 – Daily Support
    Risk Assessments must be reviewed at least every six months.
    Not met
    Carried over twice
    Timescale: 11 March 2019

12. Standard 4.10 – Environmental and Personal Safety and Comfort
    If fire checks are not completed due to service users and staff on holiday then this must be recorded in the fire log book.
    Timescale: Immediate

13. Standard 4.10 - Environmental and Personal Safety and Comfort
    Fire extinguishers must be checked monthly.
    Not met
    Carried over 22 January 2019
    Timescale: Immediate

14. Standard 4.17 - Environmental and Personal Safety and Comfort
    A water report that tests for bacteria must take place yearly.
    Timescale: Immediate

15. Standard 4.17 - Environmental and Personal Safety and Comfort
    The blenders / thermostatic mixer valves must be checked at the departments own frequency of twice a year.
    Not met
    Carried over 22 January 2019
    Timescale: Records of these checks were produced subsequent to the inspection

16. Standard 6.3 - Staffing

Staff files should be made available so that the inspector can verify that all relevant pre-employment checks are in place.
Not met
Carried over 22 January 2019
Timescale: 3 June 2019

17. Standard 7.9 – Management Quality and Improvement
The annual report and plan must contain information based on the outcomes of the quality assessment exercise.
Timescale: 1 April 2019

18. Standard 2.1 – Daily Living
The following areas must be remedied:

- Mould present on the edge of the bath and sink edge in top floor bathroom.
- Ripped / discoloured wallpaper in top floor bathroom.
- Dent in bedroom wall.

Timescale: 1 May 2019

19. Standard 1.1 – Introduction, Assessment and Admission
The statement of purpose should be amended to include:

- The SRSW's relevant experience qualifications.
- The room sizes.
- Correct details in the complaints section.
- The arrangements for meeting the residents' health needs.

Not met
Carried over 22 January 2019
Timescale: 11 March 2019

20. Standard 6.9 - Staffing
Staff members must receive refresher training at the required frequency identified by the service, for example moving and handling training every two years.
Not met
Carried over 22 January 2019
Timescale: 1 May 2019

21. Standard 6.9 - Staffing
All relief staff that are assigned to work at Hutchinson Square must receive diabetes / insulin training.
Not met
Carried over 22 January 2019
Timescale: 1 May 2019

Recommendations

1. It is recommended that the home use the Safer Food Better Business food safety management procedures, including the kitchen opening and closing checks.

Provider's Action Plan

1. All service user's getting up and going to bed routines have been recorded now in their Skills, Needs Risk assessments, so all daily living information is easily located. (11.03.19)
2. Support needs around kitchen have been recorded in separate support plans for all service users. (11.03.19)
3. Skills, Needs and Risk assessments have been completed for all service users (11.03.19)
4. Service user's medical conditions and support required will be recorded in separate support plans for each service user (25.03.19) .
5. Emotional well-being and support required have been recorded in Skills, Needs and Risk assessment (11.03.19)
6. All Personal Intervention Plans have been updated (13.03.19)
7. Staff member who's MAPA training is out of date is on list for next available training.
8. Service user's family contacts and support required to maintain relationships with family and Friends have been recorded in Skills, Needs and Risk Assessments (11.03.19).
9. All support plans have been reviewed and up to date. (13.03.19)
10. The reasons why the PCP meeting was delayed have been recorded and can be found in Service user's file. It will be made sure all PCP meetings are held every 6 month.
11. Most of the risk assessment have been updated and up to date (13.03.19). Financial Risk Assessments are going to be updated on PCP meetings (which are scaduled in next couple of month) and will become as a part of PCP agenda in order to keep them reviewed and up to date.
12. Reason why couple of Fire alarm cheks have been missing in September is recorded now in the Fire File.
13. It will be made sure that Fire extinguisher checks are completed monthly.
14. Bacteriological water tests has been requested on 6.02.19.
15. Thermostatic mixer valves have been checked and evidence has been provided. It will be made sure that evry checks get recorded in House Log Book in the future.
16. Pre-employment checks - This matter remains under discussion between social care management and the Registration and Inspection Unit in order to clarify how both regulatory and data protection obligations can be met.
17. Annual Report and Plan will be completed by 01.04.19
18. Dent in the bedroom wall has been fixed now. Issues in the bathroom have been raised with Estates (08.02.19).
19. Statement of Purpose has been updated (11.03.19)
20. All contracted staff are up to date with their mandatory training. Relief staff is in the process of having their training up to date.
21. All staff team is diabetes and insulin trained. Diabetes Nurses have been contacted about extra training and refreshers.

To:

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

From:

Hutchinson Square

I / we have read the inspection report for the unannounced inspection carried out on 22 January 2019 at the establishment known as Hutchinson Square, 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 Dale Lowey
Date 12.03.19

Signed Kristine Neagle
Registered Manager
Date 13.03.19

Action plan/provider's response noted and approved by Inspector: Kevin West
Date: 19/3/19 **Signature/initials:** K.W.