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 Day Care Services

Greenfield Park

Unannounced Inspection

8 & 11 February 2019

DRAFT

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

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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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    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

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Part 1 - Service Information for non-Registered Service

Name of Service: Greenfield Park **Tel No:** **(01624)** 698327/642965

Address: Ballamona Farmhouse, Strang, Braddan, IM4 4TE

Email Address: Marie.Spencer@gov.im

Name of Manager: Marie Spencer

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

Date of previous inspection: First inspection of new premises as the service has relocated. Requirements were made on visit to service at previous locations.

Number of individuals using or attending the service at the time of the inspection:

Person in charge at the time of the inspection: Marie Spencer

Name of Inspector(s): Mandy Quirk

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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.

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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		Medication records must be up to date and complete	Met
2		MARS sheets must be complete	Met
3		At least two emergency evacuation drills must be completed per year	Partially Met
4		There must be an identified person in charge of the service in the absence of the manager.	Not Met

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

Our Decision: Partially compliant

Reasons for our decision:
There was a statement of purpose in place which had recently been updated. The document provided information about the service as required in the minimum standards and registration regulations.

The service user handbook contained a range of useful information however information regarding transport costs and service users rights and responsibilities was missing.

Information about the process of accessing day services explained that service users would have the right to visit services prior to being offered a place and signing a contract. However there was no written evidence of this available.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
Two

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

Our Decision: Partially compliant

Reasons for our decision:
Service user files were examined with content found to be variable. There was no evidence to confirm that assessments had been undertaken prior to service users being offered a place at the service. The manager explained that work had recently been undertaken to ensure that the assessment documentation was suitable for the service provided and in place for any new starters.

There was limited evidence of the involvement of service users, families and other relevant professionals in the assessment process.

Assessment documentation was available but not always utilised to create service users' support plans.

Evidence Source:

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Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
Three

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

Our Decision: Substantially compliant

Reasons for our decision:
A service user agreement/contract had been devised and was in the process of being implemented. Service user files examined contained a blank copy which the manager explained was planned to be completed at service users' next person centred planning meetings. Service users must sign the document where possible and identify where service users are unable or choose not to.

The document contained information regarding fees, facilities, transport, review arrangements and required notice period for termination of the service.

There was no evidence that contracts were in place prior to service users commencing the service. However paperwork had now been designed to utilise for any new service users.

Fees or charges were found to be reviewed annually.

Evidence Source:

Observation		Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
One

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

Our Decision: Partially compliant

Reasons for our decision:
Most service user files contained a number of support plans. There was limited evidence of service user involvement in their development or detail regarding the reason for this.

Files contained a range of documents including personal profiles and/or snapshots of each service user, information regarding any specialist equipment required and communication needs. Risks relating to individual service users had been assessed but were not always linked to identified needs or were generic in content.

There was evidence that Personal Care Planning (PCP) meetings had been held, although most were overdue. There was variable evidence of service user and/or family involvement.

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Service users were provided with copies of their weekly timetable.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
Five

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 5 Activities
The day care service must offer a structured programme of varied activities and events related to its statement of purpose.

Our Decision: Compliant

Reasons for our decision:
The service offers a range of work related experience for service users linked to service user choice. This included woodwork, metal work, craft, gardening, shop work and café including serving and kitchen skills. The overall aim of all the activities was noted as offering service user the opportunity to learn new skills and be actively involved in all aspects of service delivery. The focus was on meeting service user needs, maximising abilities, skills and potential and aiming to minimise any potential barriers to work and employment.

Being a new facility the resources available for each area of activity were appropriate to the activities being undertaken. The shop, café and gardens all encouraged community inclusion.

All activities were provided by existing staff members. There were no contracted services.

Information was displayed in each area of the service to identify the activities each service user was engaged in that day and the staff members that would be supporting them.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
None

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

Our Decision: Partially compliant

Reasons for our decision:
As this was a new service the buildings and external areas of the service were all in good condition.

The design of the buildings internally supported service users' independence. Externally most areas were well maintained with good accessibility. However since taking possession a number of

issues have been identified, that were not initially anticipated. This included the need for some form of protection at the sides of the gardens sales area. The manager had already raised these issues for action with the building contractor and/or Estates.

Cleaning schedules were noted to be in pace in all areas of the site and no issues in this regard were noted. Most areas were in a good state of repair but there were some outstanding jobs which had been reported to Estates.

There was a written fire risk assessment in place which had an identified review date. However There was no mention of risks associated with tumble dryers.

Fire notices and signs were on display throughout the buildings. All staff had access to a fire safety policy and procedure. Since moving to the new site work was completed to raise awareness of fire safety issues and one fire evacuation drill had been conducted.

All staff had attended a fire safety talk but the refresher was now overdue (already addressed in standard seven).

Weekly fire alarm, monthly fire extinguisher and emergency lighting checks had been completed regularly and were up to date.

Valid public liability insurance was on display.

An electrical installations certificate was in place. Visual portable electrical appliance (PAT) checks had been conducted monthly and an inspection was in process during the inspection.

Water temperature checks were completed and recorded. Six monthly water monitoring checks had been completed. An issue with a cold water outlet had been identified and was awaiting further action.

The new boiler had been commissioned.

There was sufficient and appropriate equipment available, internally and externally, to facilitate service users engaging in work related activities.

The furnishings and fittings had been purchased to ensure that they met the needs of those using the service. The space available supported the mobility needs of service users.

The service was registered with the Department of Environment, Food and Agriculture (DEFA) as a food business. There was appropriate labelling of food items that had been opened. Fridge and Freezer temperatures were checked and recorded daily. Staff members complete food hygiene training as part of mandatory training. Work had been completed with regard to awareness and understanding of the fourteen allergens.

There were eight toilets including separate male, female and disabled access toilets, available in all areas except for the shop. Staff and service users working in the shop must access an external toilet. There was a fully equipped disabled bathroom which was not utilised fully. The manager discussed plans to make this a community resource.

There was sufficient overall space to accommodate the maximum identified number of service users. However the facilities for service users working in the café could be improved. The area could be expanded to include a changing area and a lunch area for service users. Additional

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storage would also be beneficial. This could be accommodated by releasing the space between the shop and the café currently used for records storage.

The service does have a truck with an automated tailgate which was serviced by Estates. Staff driving licences are checked annually by the service manager. Many service users travel independently but some have transport provided by Bus Vannin. All required vehicle and driver checks had been completed by Bus Vannin.

Staff members and service users had lockers for storage of personal items. There was a staff room, a manager's office and a meeting room available, in addition to activity areas.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
Three requirements and one recommendation

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) **Standard 7 Management and staffing** Good quality support and care must be provided by management and staff whose professional training, qualifications and expertise enable them to meet the service users' needs.

Our Decision: Partially Compliant

Reasons for our decision:
The service manager had recently achieved her Quality Care Framework (QCF) level five.

In the absence of the manager, no on site deputy was identified. There was also no administration support on site.

Over fifty per cent of the staff team were qualified to QCF level two/three or equivalent.

The recruitment process was outlined in a policy. A number of staff files were examined and found not to contain evidence of all required pre-employment checks. Job descriptions and contracts were also not available. There was evidence that the manager had been making efforts to gather this information from Human Resources. However the manager explained that these were all long standing staff members. There had been no new starters in recent years. Job descriptions may need to be reviewed in light of the changing work responsibilities and skill requirements.

The service had one volunteer, at present, whose expertise in weaving was being shared. A DBS check had been undertaken.

Only one staff file examined contained evidence of an induction programme being completed. However the manager had all the paperwork ready for any new starters.

Staff rotas were examined and showed that all areas of the service were covered. However, although on paper the maximum staff to service user ratio appears appropriate, it does not take account of the layout of the service, activities being undertaken and the risks involved. The manager has at this point taken the decision to halt any future placements due to the difficulties being experienced with current staffing levels.

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There was a training policy in place for the service which identified mandatory and additional training along with timescales for training to be refreshed. Training records were examined and showed that not all staff members were up to date with mandatory training and refresher training. It would be beneficial if all staff training was recorded on a training matrix and included timescales for refresher training. Additional training may need to be considered to expand the range of staff members with relevant specialist skills.

Staff files contained evidence of 1-1 supervisions. However not all staff members had received the minimum required number of supervisions over the year and annual appraisals had not been completed. The inspector acknowledged that the manager's workload during this period had been excessive with project managing the setting up of the new service whilst maintaining responsibility for managing the old services.

A risk management policy was available and a range of internal and external environmental risk assessments had been completed. The risk assessments had been recently reviewed however, they did not cover all required areas.

There was a policy in place regarding behaviours that challenge the service and the staff team were trained in Management of Actual or Potential Aggression (MAPA). However one file examined did not contain a copy of the Personal intervention plan (PIP) referred to in the assessment.

There was a detailed medication policy in place and all staff access basic medication awareness training. In addition to this some staff had training in relation to specific conditions and their treatment. All medication to be administered by staff was stored in a metal cabinet, fixed to the staff room wall. Medication received into and returned from the service was recorded. Good practice guidance was being followed by having photographs of each service user at the front of their medication records. Medication risk assessments had been completed. Protocols for individual service users regarding a specific medication were in place however some were overdue review. Assessments of staff competence to administer medication were not available.

A financial policy was in place for guidance. The manager explained that the service does not handle service users' finances. Fees are invoiced and monies for lunch are handled by service users themselves. There was a clear process in place for dealing with any monies collected from the sale of goods produced.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
Eight requirements and one recommendation

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9) **Standard 8 Safeguarding** Service users must be safeguarded from abuse.

Our Decision: Compliant

Reasons for our decision:
There was a detailed safeguarding policy in place to guide and inform staff practice.

Safeguarding was included as part of the first week of the induction programme for new staff. This was followed by attendance at a classroom based adult protection training course; followed by

annual refresher training. Most staff members were not up to date with refresher training (Requirement made under standard 7).

There was evidence that appropriate action and recording had taken place with regard to any identified safeguarding concerns.

A daily attendance register was held in all areas and completed daily, including arrival and departure times.

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 9 Complaints
All complaints must be treated seriously and responded to promptly and effectively.

Our Decision: Substantially compliant

Reasons for our decision:
The service had an identified complaints policy and procedure in place. All required information was contained within the procedure. Additionally there was a comments, complaints and compliments leaflet available.

The complaints procedure outlined the process, relevant timescales and contact details for Registration and Inspection and the independent advocacy service.

Service users were given information about the complaints procedure within the service user guide and the statement of purpose.

A complaints and compliments log book was located in the reception area along with copies of the complaints, compliments and suggestions leaflet.

No formal complaints had been received at the service since the arrival of the current manager. Only one complaint had been recorded in the log book three years ago but there was no information to confirm whether the matter had been resolved in line with the complaints procedure timescales. This was discussed with the manager to ensure that she was aware of the requirements should any further complaints be received.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
One

Regulation of Care Act 2013, Part 2 (37) and Care Services Regulations Part 3 (9)
Standard 10 Policies and Procedures
The service must have policies and procedures in place which ensure the quality of care and

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service.

Our Decision: Complaint

Reasons for our decision:
All staff members had access to a wide range of policies and procedures. All required areas, identified in appendix one, were found to be covered. All policies were either in date or undergoing an identified period of review.

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 11 Quality and Improvement
The service must have systems in place to assess the quality of the service and makes provision for improvement and development.

Our Decision: Substantially complaint

Reasons for our decision:
The service had a number of quality assurance measures in place including accident and incident reports, complaints and compliments log book, service user and staff meetings. In addition, fire safety and health and safety audits were undertaken. The manager had also implemented a feedback questionnaire for users of the new café. The inspector viewed a wealth of completed forms, all of which were overwhelmingly positive in their response. The manager discussed the difficulties of gaining feedback from families and options to overcome this were considered.

An annual report had been completed for the service and contained information about the successes of the service. There was also a development plan for the year ahead. However there was no clear evidence that this was linked to the outcomes of any quality assurance measures.

The manager utilised a range of methods to determine staff compliance with the terms and conditions of their employment and the services policies and procedures. This included staff supervision, team meetings and observation of staff practice.

Paperwork was well organised and stored securely. Staff files were stored in a locked cabinet in the manager's office. The lock to the manager's door was faulty and had been reported to Estates for action. Not all documentation was up to date but this has been addressed elsewhere in the report.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
One

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

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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: Mandy Quirk **Date:** 25/02/19

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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 and Recommendations
Standard: 1.2
The service user handbook must contain information regarding transport costs and service users rights and responsibilities.
Timescale: 31 March 2019

Standard: 1.3
There must be written evidence of visits to the service, prior to commencement.
Timescale: Immediate

Standard 2.1
The service must undertake a written assessment of the individual service user's needs prior to offering a place to ensure their needs can be met by the provision.
Timescale: Immediate

Standard 2.2
The service user, their family and other professionals (as appropriate) must be involved in assessment process.
Timescale: Immediate

Standard 2.3
Assessment outcomes must be utilised to develop support plans
Timescale: Immediate

Standard: 3.2
There must be a contract in place for each service user, signed by the service manager and the service user themselves or their representative
Timescale: Immediate

Standard: 3.3
Contracts must be in place for each service user, prior to commencement of service.
Timescale: Immediate

Standard 4.1
All service users must have support plans in place.
Timescale: Immediate

Standard 4.2
Service users must be involved in the creation of their support plans. Where the service user chooses not to be involved or is unable to, this must be recorded.
Timescale: Immediate

Standard 4.3
Risk assessments must be linked to service users' identified needs and reviewed regularly.
Timescale: Immediate

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Standard 4.4
Person Centred Planning meetings must be held every six months with attendance sheets maintained and details recorded regarding reasons for any service users not being involved.
Timescale: Immediate

Standard 4.5
Support plans must be signed and dated by service user or their representative. If this is not achievable the reasons must be recorded.
Timescale: Immediate

Standard 6.3
All outstanding jobs must be completed, including broken tap and the installation of new doors to improve security.
Timescale: 30 June 2019

Standard 6.4
The fire risk assessment must be amended to include tumble dryers
Timescale: Immediate

Standard 6.7
Two fire drills per year must be conducted.
Timescale: Immediate
Carried forward from Registration visit

Recommendation
Consideration should be given to improving facilities for service users working in the care through provision of include a changing area and a lunch area for service users. Additional storage would also be beneficial.

Standard 7.3
In the absence of the manager, a deputy must be identified.
Timescale: Immediate
Carried forward from Registration visit

Standard 7.5
Evidence of all required pre-employment checks must be provided
Timescale: Immediate

Standard 7.8
All new staff members must have an induction to the service and there must be records confirming this Signed and dated by both the inductor and inductee.
Timescale: Immediate

Standard 7.9
Maximum staff and service user ratios must be reviewed to take into consideration the needs of service users, the layout of the buildings and the activities being undertaken.
Timescale: Immediate

Standard 7.10
- All staff members must be up to date with mandatory training and refresher training.
- All staff members must have four supervisions per year
- All staff members must have an annual appraisal

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Timescale: 31 August 2019

Standard 7.11
Environmental risk assessments must be expanded to cover all required areas.
Timescale: 31 March 2019

Standard 7.12
Personal intervention plans must be in place, where required.
Timescale: Immediate

Standard 7.13
- Medication protocols in service user files must be regularly reviewed, signed and dated.
- Staff competency assessments must be completed

Timescale: Immediate

Recommendation
Job descriptions for the manager and staff would benefit from review to ensure that they are relevant to the current roles and responsibilities.

Standard 9.4
The complaints log must include details of the complaint, investigation and any action taken
Timescale: Immediate

Standard: 11.2
The development plan, within the annual report, must be clearly linked to the outcomes of any quality assurance measures
Timescale: 31 March 2019

Provider's Action Plan Click here to enter text.

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

From: Greenfield Park

I / we have read the inspection report for the unannounced inspection carried out on **8 & 11 February 2019** at the establishment known as **Greenfield Park**, 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) ☐

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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 Click here to enter text.
Date Click here to enter text.

Signed Click here to enter text.
Registered Manager
Date Click here to enter text.

Action plan/provider's response noted and approved by Inspector: **Date:** **Signature/initials:**

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