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

Eastcliffe Resource Centre

Unannounced Inspection

21 & 22 August, 6 September 2018 And 20 March 2019

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

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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: Eastcliffe Resource Centre **Tel No:** (01624) 698331

Address: Victoria Avenue, Douglas, IM2 4AL

Email Address: Rachel.Berry@gov.im & Sara.Harper@gov.im

Name of Manager: Rachel Berry & Sara Harper

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

Number of individuals using or attending the service at the time of the inspection: 31

Person in charge at the time of the inspection: Rachel Berry

Name of Inspector(s): Mandy Quirk & Egle Leadley. Catriona Bradley (20 March 2019)

Part 2 - Descriptors of Performance against Standards

Inspection reports will describe how a service has performed in each of the standards inspected. Compliance statements by inspectors will follow the framework as set out below.

Compliant
Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken. In most situations this will result in an area of good practice being identified and comment being made.

Substantially compliant
Arrangements for compliance were demonstrated during the inspection yet some criteria were not yet in place. In most situations this will result in a requirement being made.

Partially compliant
Compliance could not be demonstrated by the date of the inspection. Appropriate systems for regular monitoring, review and revision were not yet in place. However, the service could demonstrate acknowledgement of this and a convincing plan for full compliance. In most situations this will result in requirements being made.

Non-compliant
Compliance could not be demonstrated by the date of the inspection. This will result in a requirement being made.

Not assessed
Assessment could not be carried out during the inspection due to certain factors not being available.

Recommendations
Based on best practice, relevant research or recognised sources may be made by the inspector. They promote current good practice and when adopted by the registered person will serve to enhance quality and service delivery.

Part 3 - Inspection information

The 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 registration visit	Met/not met
1	6.15	Service user numbers must be in line with identified needs and available space as identified in minimum standards	Not Met
2	7.5	Evidence of pre-employment checks must be available	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 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/service user guide in place for the service which covered all the required areas. Some of the information was not sufficiently specific i.e. the maximum number of service users the service can support and the information regarding complaints – no timescales are stated.
The inspector was informed that service users have the opportunity to visit the service before they or their representative have to sign a contract. However evidence of this was not 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 Complaint

Reasons for our decision:
A number of service user files were examined during the inspection and all were found to contain a skills, needs and risks assessment. However evidence that service user's needs had been assessed prior to the commencement of the service was not available.
There was also no evidence that these assessments were utilised to create the individual care support plan.

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 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:
Service user files examined contained blank copies of the service agreement/contract which covered all required areas including services and facilities, transport, charges, notice period, attendance days and review arrangements.

The contract/service agreement was presented in easy read format to support the understanding of some service users.

Contracts/service agreements were not completed at the point the service commenced. This was being completed retrospectively.

Records noted that four weeks' notice would be given regarding any changes to the contract and any increase or variation in fees

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:
Service user files contained a number of support plans which could be linked to their assessment documentation. There was limited evidence of service user involvement in their development or detail regarding the reason for this.

There was evidence that Personal Care Planning (PCP) meetings were held regularly, although some were overdue. Information regarding attendance was sometimes missing which in turn meant that there was insufficient evidence of service user and/or family involvement. The inspector made note that the service manager had responsibility for the completion of sixty PCP meetings.

Files contained personal profiles and/or snapshots of each service user giving a brief overview including preferred form of address, likes and dislikes, communication needs and so on.

Risks relating to individual service users had been assessed.

Service users were provided with copies of their weekly timetable.

Evidence Source:

Observation		**Records**	✓	**Feedback**		**Discussion**	✓

Requirements and Recommendations
Three

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: Substantially compliant

Reasons for our decision:
The service was split into three areas and each staff team developed a programme of activities aimed at meeting the needs of service users, within the limits of available resources. All service users had a weekly timetable of activities. Group and individual activities were observed to be facilitated. The groups had access to a minibus to support community activities.
Three rooms within the building had been taken out of use for service users in order to provide a meeting room. These included a large activity area, a chill out room and a health and beauty room. A further two were no longer accessed by service users for computer skills and daily living skills. This essentially meant that the range of activities available in the building were reduced.

Service users meetings were held weekly and offered the opportunity for service users to feedback on activities provided or request new ones.

Service users' files contained a copy of their weekly timetable.

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 6 Environment
The environment must be safe, well maintained and remain suitable.

Our Decision: Partially compliant

Reasons for our decision:
The day service was based on the ground floor of a large Victorian building. It was not purpose built and therefore presented a range of challenges. In order to overcome issues relating to mobility only ground floor rooms were accessible to service users.

The interior of the building was in a poor state of repair. The inspector was informed that use of the existing building was time limited as a new service and building was being developed to commence within the next twelve months.

The garden area outside the room utilised by Group C was well maintained.

The service had a fire safety policy and fire procedure in place; however the procedure was overdue review. Service users had Personal Emergency Evacuation Plans (PEEP's), however some gender references were inaccurate. There was also a range of fire safety measures in place and a variety of checks conducted. However the fire risk assessment and the annual fire safety audit checklist had no dates of completion or signatures. All staff had completed fire safety training but not all were up to date with refreshers (addressed in standard seven).

Valid public liability insurance was on display.

There was evidence of partial electrical installations checks being conducted but there was no overall electrical installations condition report (ECIR) available.

Visual checks on portable electrical appliances had been conducted. The portable electrical appliance testing was passed the identified review date.

Water temperatures had been recorded and checked monthly. The documentation identifies the outlet tested and water temperatures recorded. Six monthly water monitoring checks had been completed.

The boiler service documentation was up to date.

There was a basic range of recreational and craft equipment available for service users.

Furniture, fixtures and fittings were mostly tired. Some efforts to address this had been made, however the outcomes have not always been successful. One example being recently purchased chairs did not seem to be fit for purpose, especially in the dining room as the back legs were sloping and stuck out, presenting a falls risk. When endeavouring to assist service users to sit at and get up from the table the chair legs were not stable. Also the dining tables were not all at a suitable height limiting service user choice regarding where they could sit. In one area of the day centre there was a significant amount of mobility aids and equipment, taking up a lot of space in the room. This was observed to create difficulties for staff members in terms of keeping all service users safe.

The kitchen area was clean and well maintained. There was evidence of good cleaning routines in place. The service was registered as a food business with the Department for the Environment, Food and Agriculture (DEFA). There were two differing opinions regarding the need for an additional fire extinguisher in this area. A third opinion should be sought to reach a final decision in this regard.

There were separate male and female toilets with suitable hand washing and drying facilities. There were also two unisex disabled access toilets. However feedback from staff indicated that this was inadequate at times given the number of service users with mobility issues requiring support with personal care. Additionally, unsuitable arrangements were in place for one service user which raised hygiene and moving and handling concerns.

Rooms had been measured and a number of issues identified both at the point of registration and during the inspection that the service did not have sufficient useable space available for the number of service users accessing the service on a daily basis. Group C was found to have too many service users attending on four days each week. Then the inspectors became aware that the larger groups A and B were limited in terms of the area available to them given the challenging nature of some service users support needs. Three rooms had been withdrawn from use by service users to create a meeting room. There was also two further rooms, used by service users previously, for computer sessions and daily living skills, likewise these were no longer in use. Feedback from staff indicated that this has created problems with regard to having limited space to reduce the group numbers at any one time and manage issues such as challenging behaviour. The other consequence was a more limited choice of activities.

Transport to and from the service, as well as for trips out was now provided by Bus Vannin. Responsibility for undertaking vehicle maintenance, checks of driving licences and ensuring that suitable insurance was in place, was the responsibility of Bus Vannin. Evidence had been provided

to confirm that these checks have been conducted. The service also had their own minibuses driven by staff from the day centre. Staff files provided evidence that relevant staff members' driving licences had been checked. There was also evidence of suitable insurance being in place.

Service users and staff members had access to lockable storage space for personal items.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements and Recommendations
Six

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 Quality Care Framework (QCF) level five.

In the absence of the service manager, no deputy was identified.

All but one member of the staff team were qualified to QCF level two or equivalent.

A number of staff files were examined and found not to contain evidence of all required pre employment checks. All files contained job descriptions but not all had copies of their contract including terms and conditions of employment. There was evidence that the manager had been making efforts to gather this information from Human Resources.

Only one staff file examined contained evidence of an induction programme being completed.

Staff rotas, staff and service user attendance registers and room sizes were examined alongside service users' needs and inspector's observations during the inspection. It was clear that staffing levels and service user numbers did not always meet the required levels. This must be reassessed to ensure that the safety and wellbeing of service users and staff members was being appropriately addressed.

There was a training policy in place for the service which identified required and additional training along with timescales for training to be refreshed. The training matrix was examined and showed that not all staff members were up to date with mandatory training and refresher training.

Staff files contained evidence of formal 1-1 supervisions. However not all staff members received the minimum required number of supervisions a year. Only one file examined contained evidence of an annual appraisal

A risk management policy was available and a range of internal and external environmental risk assessments had been completed.

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 not all staff members were

up to date with refresher training. Personal intervention plans (PIP's) were in place to identify support requirements for service users where required.

There was a detailed medication policy in place. The day service was split into three groups and each had their own medication records. Medication received into and returned from the service was recorded. Competency assessments sheets had been recently introduced for staff but the process had not yet been completed. One MAR sheet had not been fully completed. Good practice guidance was being followed by having photographs of each service user at the front of their medication records. Self administration risk assessments had been completed. Protocols regarding one specific medication were in place for a number of service users however some were overdue review or not signed and dated.

All financial transactions within the service were well documented. Any monies received into the service were logged. A financial compliance audit was held annually to ensure that the departments' financial policy and procedures were being followed.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
Eight Requirements and Two Recommendations

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 and procedure in place, to guide and inform staff practice.

All required information was contained within the procedure.

The induction programme for new staff included safeguarding within the first week. The training matrix showed that all staff had safeguarding training, however not all staff were up to date with refresher training. (Requirement made under standard 7)

Appropriate records had been maintained for any safeguarding issues raised and included all required information.

A daily attendance register was in place. It included the arrival and departure time of service users and staff.

Discussion with service users confirmed that they felt safe whilst at the day centre.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements
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: Compliant

Reasons for our decision:
There was a 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.

A suggestion and complaints box was located in the reception area.

Complaints records were held electronically. One complaint was recorded and had been resolved in line with the complaints procedure timescales.

Evidence Source:

Observation	✓	Records	✓	Feedback		Discussion	✓

Requirements
None

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 service.

Our Decision: Compliant

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.

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: Partially compliant

Reasons for our decision:
The service had a number of quality assurance measures in place including accident and incident reports, complaints and compliments, service user and staff meetings. In addition, fire safety and health and safety audits were undertaken; however not all were up to date.

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

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

Paperwork was well organised and stored securely. Some documentation was out of date but has been addressed elsewhere in this report.

Evidence Source:

Observation	✓	Records	✓	Feedback	✓	Discussion	✓

Requirements and Recommendations
Two

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: Mandy Quirk and Catriona Bradley **Date:** 26/3/19

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 and Recommendations
Standard: 1.1
The statement of purpose must be amended.
Timescale: 31 May 2019

Standard: 1.3
Written evidence of visits to the service prior to commencement of the service must be maintained.
Timescale: 31 May 2019

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: 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 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 4.4
Person Centred Planning meetings must be held every six months with attendance sheets maintained and details of 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. They must also have access to a copy.
Timescale: Immediate

Recommendation
Consideration must be given to reducing the number of PCP's which the service manager has responsibility for completing.

Standard 5.1 & 5.2
Greater service user choice must be facilitated through bringing back rooms into service user use
Timescale: 31 May 2019

Standard 6.2 & 6.12
Any furniture in the dining room which presents a health and safety risk must be replaced
Timescale: Immediate

Standard 6.3
The premises must be well maintained, in a suitable state of repair and decoration.
Timescale: 30 September 2019

Standard: 6.4
The fire risk assessment must be signed and dated upon completion.
Timescale: Immediate

Standard: 6.9
A full ECIR report must be available for inspection and portable electrical appliance tests must be carried out within the recorded review date
Timescale: 31 May 2019

Standard 6.14
There must be sufficient wheelchair accessible toilets to meet service user needs.
Timescale: 30 September 2019

Standard 6.15
Room sizes and service user number must be in line with service user needs and minimum space requirements as identified in the minimum standards
Timescale: Immediate
Carried forward May2019

Standard: 7.3
In the absence of the manager, a deputy must be identified.
Timescale: Immediate

Standard: 7.5
Evidence of all required pre employment checks must be provided
Timescale: Immediate
Carried forward May 2019

Standard 7.7
Evidence of staff contracts must be available for inspection.
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
Staffing levels must be sufficient to meet service users needs
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

Timescale: 31 May 2019

Standard 7.11
Environmental risk assessments must be reviewed.
Timescale: 31 May 2019

Standard: 7.13
- MAR sheets must be fully completed
- Medication protocols in service user files must be regularly reviewed, signed and dated.
- Staff competency assessments must be completed
- Staff signature sheets must be fully completed
- Medication allergy information must be clearly noted.

Timescale: Immediate

Recommendation
Consideration should be given to reducing the number of supervisions and annual appraisals for which the manager has responsibility.

Recommendation
Consideration should be given to reviewing the managers' job description to ensure that it is relevant to the current role

Standard: 11.1
Audits undertaken must be reviewed within identified timescales.
Timescale: 31 May 2019

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

Provider's Action Plan
Standard 1.1 -Statement of purpose has now been amended and sent to R&I
Standard 1.3 –There has been no new service users in the last 12 months. Documentation and procedure are in place to ensure transition of new service users meets all standards including visits to the service
Standard 2.1- There has been no new service users in the last 12 months. Documentation and prodecure are in place to ensure transition of new service users meets all standards including written assessment of their needs prior ro offering a place to ensure their needs can be met by the provision
Standard 2.2- New assessment document is being rolled out and will involve service users, their family/carers and other professional when appropriate
Standard 3.2 – Service user's contract signed by senior and service user/ their representative is in place for all service users
Standard 4.2 – Following new assessment document, support plans will be reviewed and will involve service users whenever they are able to contribute. If this is not possible the reasons will be recorded
Standard 4.4 – service exceeds the minimum requirement of 1 PCP meeting per year by holding 2 per year. Attendance sheets will be included as part of the document required for PCP meeting.

Standard 4.5- As in 4.2 new paper work with signing sheet now in place this will be completed for all service users.
Standard 5.1 & 5.2- Greater service users choice is met by developing activities outside of the building through community based activities. Not concerns or requests have been raised at PCP meetings regarding internal changes of room use.
Standard 6.2. & 6.12- Service provision is moving to a new building in August 2019- New equipment is being ordered including new dining room furniture. No evidence of health and safety concerns that require immediate replacement of furniture.
Standard 6.3-Service provision is moving to a purpose built facilities in Aug 2019. In the meantime current premised are all maintained.
Standard 6.4 – The fire risk assessment has been signed and review and copy forwarded to R&I
Standard 6.9-Request for full ECIR sent to estates and it was completed on 5th & 6th April- no report sent as yet.
Standard 6.14- noted addressed within the new premises
Standard 6.15- - noted and addressed within new building
Standard 7.3- protocol in place when senior is not on site, copy sent to R&I April 2019
Standard 7.5- Pre- employment checks: this matter remains under discussion between social care management and registration and inspection unit in order to clarify how regulatory and data protection obligation can both be met
Standard 7.7- HR contacted to provided missing information
Standard 7.8- Generic Induction to ALDS will be used for new starters as well as induction to specific area and where suitable Care certificate will be used.
Standard 7.9- Staffing level have been reviewed and meet needs of service users who currently access day services.
Standard 7.10- Mandatory policy is currently being amended, where possible and where training is available, staff have been booked to attend training. Planning is in place to ensure minimum of 4 supervisions are schedules for the next 12 months. Annual appraisal is not a requirement; it is one of the tool that mat be used by senior to support staff on a case by case.
Standard 7.11- Environmental risk assessments have been reviewed and signed; they are kept in Health & Safety file.
Standard 7.13- all information in medication files are being reviewed, senior is completing staff competency assessments and ensuring all documentation is completed.
Standard 11.1- Outsanding audits have been reviewed and reminders in place to ensure reviews are done within identified timescales in the future
Standard 11.2- Annual report has been amended to include audits and outcomes from audits to be part of development plan. Updated copy forwarded to R&I

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

From:

I / we have read the inspection report for the unannounced inspection carried out on **21 & 22 August and 6 September and the 20th March 2019** at the establishment known as **Eastcliffe Day Service**, 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 Pascale Despringre
Date 7/05/2019

Signed Sara Harper
Registered Manager
Date 7/05/2019

Action plan/provider's response noted and approved by Inspector:
Date: 07/05/2019 Signature/initials: PD