DHSC – CQC external quality regulation programme

Reayrt Skyal

Inspection report

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Our findings

Overall summary

We carried out this announced inspection on 26 July 2022. The inspection was led by a Care Quality Commission (CQC) inspector and supported by an inspector from the Isle of Man Registration and Inspection Unit.

This inspection is one of a programme of inspections that the CQC is completing at the invitation of the Isle of Man Government's Department of Health and Social Care (IoMDHSC) in order to develop an ongoing approach to providing an independent regime of inspection of health and social care providers delivered or commissioned by IoMDHSC and Manx Care.

The CQC does not have statutory powers with regard to improvement action for services on the Isle of Man, and providers on the island are not subject to CQC's enforcement powers. The inspection is unrated and areas for improvement can be found in the Recommendations or 'Actions we have told the Provider to take' sections of this report.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively**.**

Service and service type

Reayrt Skyal is a residential care home providing personal care for up to 16 people. The home consists of 14 bedrooms for permanent residents who lived with dementia and two bedrooms reserved for people who stayed on a respite basis. There were 14 people using the service at the time of our inspection, with no one accessing the respite bedrooms. Reayrt Skyal is in Ramsey

and accommodates people in a single storey building. Each bedroom had an en-suite sink and toilet. Full bathing facilities were shared across adapted bathroom and shower rooms.

People's experience of using this service and what we found

To get to the heart of people's experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions form the framework for the areas we look at during the inspection.

Our key findings

We identified areas of improvement in relation to demonstrating safe recruitment, medicines management and effective provider oversight.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The physical environment of Reayrt Skyal was clean and met people's needs. Appropriate measures were in place to protect people from the risk of infections. However, there were areas of the service, including bedrooms and bathrooms which were locked when not in use. This meant people had to ask to access their bedroom if they were not able to hold their own key and only two toilets were available for use; unless being directly supported by staff. A blanket approach to these restrictions had been taken rather than based on individual needs and risks. A new policy had recently been introduced which would assist the manager to review these practices.

People received a caring service. However, some staff practices were observed to be focused on the practical care needs of people and didn't always consider people's emotional needs or offer meaningful choice to people. The manager was working with the team to review this approach and demonstrated a commitment to making improvements to the service.

Risk assessments and appropriate care plans had been developed to meet people's needs. People were involved in developing their care plans when they were able to. Family members were also involved. People were supported to maintain their physical health and wellbeing. People's nutritional needs were being met.

Staffing levels were safe although a number of appointments were needed to strengthen the number of senior social care workers at Reayrt Skyal. We were unable to access staff recruitment documents.

Staff felt supported by the manager and worked with other professionals and organisations to ensure people's needs were met.

We found areas where the service could make improvements. CQC recommends that the service:

- Take action to recruit adequate numbers of senior social care workers to the service.
- Take action to ensure any care plans for people who require medicines to be administered covertly include guidance from a pharmacist to confirm this is a safe method of administration.
- Take action to ensure appropriate guidance is in place for people who require medicines on an 'as required' basis.

- Take action to review any restrictive practices in place which could deprive a person of their liberty. This review should be undertaken with full consideration of best practice guidance in the Isle of Man in relation to assessing mental capacity.
- Take action to look at best practice guidance when working with people who live with dementia to review how staff support people's emotional needs throughout the day.

We have also identified areas we have escalated to the IOMDHSC.

- The provider should take action to ensure the manager is able to readily access staff recruitment records to demonstrate safe recruitment practices have been followed prior to offering a person employment at Reayrt Skyal.
- The provider needs to take action to improve their oversight of the service through implementing a system of effective auditing of the quality and experience of people who use the service.

The inspection

About the service

Reayrt Skyal is a 'care home'. People in care homes receive accommodation and personal care as a single package under one contractual agreement. Both were looked at during this inspection.

Reayrt Skyal had a manager in post who was not yet registered with the Inspection and Registration Unit of the IoMDHSC. It is a requirement of the IoMDHSC that all Manx Care services and managers are registered.

Notice of inspection

This inspection was announced as part of a comprehensive inspection programme which is taking place between April and September 2022.

What we did before inspection

We reviewed information received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information containing key information about their service, what they do well, and improvements they plan to make. We reviewed health and safety information provided by the manager. We used all this information to plan our inspection.

During the inspection

We spoke with eight people who used the service and two family members about their experience of the care provided. We also observed interactions between staff and people living at Reayrt Skyal.

We spoke with five members of staff including manager, a senior residential support worker and social care workers.

We reviewed a range of records. This included five people's care records and six medication records. We looked at two staff files in relation to staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Is the service safe?

We found that this service was not always safe in accordance with CQC's inspection framework.

Staffing and recruitment

Individual staff recruitment files were not available for us to view as they were held centrally by the provider's human resources team. This meant we were unable to determine if safe recruitment practices had been followed.

At the time of our inspection, there were enough staff on shift to meet people's needs. However, the service needed to recruit to fill several senior social care worker vacancies. We spoke with several staff. They described morale within the team as, "Good," however told us it could be difficult to manage their workloads during periods of being short staffed. The manager explained they were managing to cover shifts through the use of relief staff; however, it was difficult to ensure there were always enough senior staff to review and update care plans.

Assessing risk, safety monitoring and management

Routine checks on the environment and equipment were completed and certificates were in place to demonstrate this. We found routine servicing checks on the fire alarm system and emergency lighting were out of date. We raised this with the manager who immediately contacted the provider's estates department to arrange completion.

Actions had been taken in response to the latest external contractor's fire risk assessment.

People's needs were appropriately assessed; care plans had been developed to minimise any risk to people's health and wellbeing. Care plans were stored on an electronic system and paper copies were also available for staff to follow.

There was a handover system in place. This ensured important information about new admissions to the service, a person's care, or any changes were shared in a consistent and timely manner.

Using medicines safely

People received their medicines as prescribed. However, we identified a number of improvements which were needed to ensure the safe management of medicines.

A small number of medicines allergies were not consistently recorded either within care plans or on medication administration records. The senior social care worker told us they would review this and update accordingly.

Two people required their medicines to be administered covertly. Covert medicines are placed in food or drink when a person refuses to take medicines; but has been deemed to lack to capacity to understand the impact of not taking the medicines as prescribed. One care plan did not describe how this was to be administered. Some medicines cannot be altered from their original form as this can impact their effectiveness. Information in the care plans did not confirm the staff had checked they were using a safe method of administration.

Guidance was not in place for several people who required medicines administered 'when required' (PRN). This meant staff did not always have the guidance they needed to understand the circumstances PRN medicines should be offered to a person.

Systems were in place to ensure the safe management of controlled drugs. There was a medicines policy in place and staff undertook appropriate training. In addition to this training, observations of practice were made annually on staff to assess competency.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

Systems were in place to protect people from the risk of abuse. Staff received training and understood the actions they must take if they felt someone was being harmed or abused.

There was a system in place to record and monitor accidents and incidents. Accidents and incidents were reviewed on a regular basis by the manager and the provider also had oversight. This enabled an analyse of trends to be undertaken to identify any lessons learnt and to reduce the risk of incidents reoccurring.

Preventing and controlling infection

People were protected from the risk of infection. Reayrt Skyal was visibly clean and staff received training in infection, prevention and control. The service had recently undergone a deep clean. The provider's policy was up to date.

Staff wore appropriate protective personal equipment (PPE) and there were adequate stocks available.

Is the service effective?

We found that this service was effective in accordance with CQC's inspection framework.

Ensuring consent to care and treatment in line with law and guidance; Adapting service, design, decoration to meet people's needs

As far as possible, people should be enabled to make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under Manx legislation. Best practice in care homes, and some hospitals, is for example through Mental Capacity Act 2005 (MCA) application procedures called the Deprivation of Liberty Safeguards.

We checked whether the service was working within the principles of the good practice on mental capacity.

We found these principles had been followed when a person had been unable to consent to medical procedures, including vaccinations and for covert medication; however, this approach had not been taken for other decisions.

For example, the service had several environmental restrictions in place. These included locked external doors as well as locked internal doors including bedrooms and bathrooms when not being used by people. These are considered as restrictions on people's freedom of movement. We discussed this practice with the manager who explained a number of safety and security reasons for the restrictions to be in place; however, these restrictions had been placed upon everybody living at the service, regardless of whether it was a specific risk to them.

There was no evidence to demonstrate how people's capacity had been assessed to establish if they could consent to such restrictions; or whether the decision had been considered as the least restrictive option; and in people's best interest.

The provider had recently introduced a new policy and guidance for assessing capacity and gaining people's consent. The manager told us they would review these practices in line with the new policy.

The communal living environment at Reayrt Skyal met the needs of people living at the service. There were a number of different lounges and seating areas which enabled people to sit where they chose. People had the equipment they needed to be supported effectively and were encouraged to personalise their bedrooms through décor and with photographs and personal items. One person confirmed to us, "I was able to bring my own things when I moved in."

Supporting people to eat and drink enough to maintain a balanced diet

People's nutritional needs were assessed. Care plans reflected any preferences in meal choices and preferences as well as support needs.

Pictorial menus were displayed. However, we were told people chose their meal the day prior to enable the chef to prepare the correct quantities of food. People we spoke with couldn't recall what they had ordered; more than one person told us on the day they didn't like either option.

We observed the options on the day of inspection was a chicken meal with rice or fish with vegetables. Staff were not creative to mix these where people preferred. One person told us the day's meal was, "Two out of ten". Other comments about the food included, "Alright," "It's okay" and, "The food is alright. No problems. I have put some weight on which is good for me."

We discussed our observations with the manager who told us they were in the process of undertaking observations of practice at mealtimes. They also planned to raise our feedback with the staff team and discuss menu choices with the head chef.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

People's needs had been assessed and reflected advice and guidance provided by other health and social care professionals. The manager explained how they were involved in the process to ensure the service would be able to meet the needs of a person moving to Reayrt Skyal.

Staff support: induction, training, skills and experience

Staff received the training they needed to support people safely and effectively. New staff received an induction to the service and had the opportunity to shadow experienced staff. One staff member told us, "I have had a good induction and training."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

Staff worked with other agencies to ensure people received consistent, effective and timely care. Care records demonstrated referrals were made to medical professionals and other services when appropriate.

Family members also told us they were kept informed about any medical appointments for people or any changes in a person's physical health. One family member commented, "Staff would ring me with any problems."

Is the service caring?

We found that this service was caring in accordance with CQC's inspection framework.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

People told us they liked living at Reayrt Skyal. Comments included, "I love it here. No problems. Staff are here to help me" and, "I am looked after head to foot."

Family members also told us they believed people were treated respectfully. One family member commented, "The care is very good. Staff are very friendly and helpful."

We observed warm and friendly interactions between people and members of staff. However, we also observed periods in the lounge area when staff were not present unless supporting a person

with an aspect of their care, or to take medicines. For example, we sat in the lounge for an hour and a half. Whilst staff did come in and out of the room, it was over an hour before a staff member sat with residents and engaged in a meaningful way. Whilst people did not appear unhappy, some people had fallen asleep or were sat alone not engaging with other people in the room. We discussed this the manager who told us they were working with the staff team to encourage them to take a more person-centred approach to their work and focus on people's emotional support needs as much as their care needs.

Religious and cultural needs were identified when developing care plans and planning social events and activities.

Staff were able to describes how they protected people's privacy and dignity when providing care; and how they supported people to maintain their independence. One person told us, "I can get washed and dressed myself."

There was a small laundry room people could use to maintain their domestic skills.

Supporting people to express their views and be involved in making decisions about their care

People were involved in decisions about their care when they were able. Where appropriate, family members were also involved. Family members told us they were kept informed about any changes in a person's physical health or care needs.

Is the service responsive?

We found that this service was responsive in accordance with CQC's inspection framework.

Meeting people's communication needs; Planning personalised care to ensure people have choice and control and to meet their needs and preferences

Best practice in communication (for example the Accessible Information Standard) describes how to tailor communication to people with a disability or sensory loss, and in some circumstances, their carers, so that they get information in a way they can understand it. It also says that people should get the support they need in relation to help them communicate.

Staff were familiar with people's needs and preferences. Important information was recorded. This included how people communicated and any specific needs. Family members had supported people to write down their personal histories. This gave staff a greater understanding of people's family and professional life before moving to Reayrt Skyal.

People told us they received personalised care and could make daily choices. One person told us, "[Staff Name] is a lovely lady. If I need anything, I will go to her."

The manager confirmed information about Reayrt Skyal was available in different formats and languages upon request.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

The service did not employ an activity coordinator. Care staff assisted people to maintain their leisure interests and hobbies.

There was an activity planner displayed. This detailed several activities available within the service. Some people told us they chose not to participate. We also saw photographs of people

enjoying outings in the local community. People had access to the use of a vehicle which was shared with a nearby service. One person told us, “I go for walks. I like to walk up the beach.”

Information about the local community and ‘a day in history’ board was displayed. This provided information about key events or places on the Isle of Man to stimulate conversation and memories with people.

People were supported to stay in touch and spend time with friends and family. One person told us how happy she was her pet dog could visit each day.

Improving care quality in response to complaints or concerns

A complaints policy was in place and information on how to make a complaint was clearly visible within the home. Systems were in place to ensure records were maintained.

People confirmed they knew how to raise a complaint and who they would complain to.

End of life care and support

Care plans demonstrated personal wishes had been established in relation to this aspect of a person’s care.

Where appropriate, Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) orders were clearly recorded in care plans and visible to staff in the event of a medical emergency.

Is the service well-led?

We found that this service was not always well-led in accordance with CQC's inspection framework.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

There were some systems in place to monitor and review the quality of care and experiences of people living at Reayrt Skyal. Senior social care workers audited each other’s care plans and developed actions plans for their colleagues if improvements were needed. Medicines checks were also made by staff and the provider. The manager completed an annual report on the quality of the service. This was shared with the provider and the Inspection and Registration Unit on request.

A senior manager attended the service on a regular basis. However, the provider did not have current systems in place for additional auditing of the quality and experience of people using the service. This meant there was no evidence improvements we identified had been already identified by the provider or any evidence of striving for continuous improvement or improving care.

The manager told us their line manager was also available by phone or they could access the local office for support and advice. The manager also had regular supervision and attended managers meetings and felt well supported. We were told the management team across the wider older people’s services team was planning on reintroducing quality checks which had stopped during the COVID-19 pandemic.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

There was a positive culture amongst the staff team who told us they enjoyed working at Reayrt Skyal. Staff had regular one to one meetings with their line manager but told us team meetings had not been as frequent during the COVID-19 pandemic. Staff described a close working relationship. One commented, “We keep each other informed.”

Family members felt engaged and told us they could raise any issues at any time. One family member said, “[Managers Name] is very helpful, very nice. I can’t fault them at all.”

We observed occasions when the staff approach was focused on the practical needs of people. The manager told us they welcomed these observations. We were told routines had developed between staff. They added some staff felt they put pressure on other staff if they were seen to sit with people whilst other staff were busy; this was a culture they wanted to change.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

The manager demonstrated an understanding of their responsibilities under duty of candour.

Working in partnership with others

Information contained within care plans demonstrated the staff at Reayrt Skyal worked in partnership with other agencies. This included the older people’s mental health team and district nurses.