DHSC – CQC external quality regulation programme

Rosebank A

Inspection report

Adult Social Care Directorate
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Our findings

Overall summary

We carried out this announced inspection on 27 July 2022. The inspection was led by a Care Quality Commission (CQC) inspector.

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

Rosebank A is a residential care home providing personal care for up to four people. The service provides support to people with a learning disability and/or autistic people. At the time of our inspection there were four people using the service. Rosebank A is located in Braddan and is a large, detached house which had shared bathrooms, kitchen and lounge facilities.

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

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted.

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 safe recruitment, maintenance of the building, provider oversight of the quality of the service and some aspects of medicines management.

The service was able to demonstrate in several areas how they were meeting the underpinning principles of culture, control and choice. Rosebank A was located in a residential area and there was no visible signage from the road or outside of the property to suggest people lived in a care home. People were involved in agreeing their support plans and goals, received person-centred support, were supported to be part of their local community and to be as independent as possible.

People were supported to have maximum choice and control of their lives. The policies and systems in the service supported this practice. People were protected from the risk of abuse. Risks were assessed and support plans were in place to manage these risks. Incidents and accidents were recorded and reviewed to reduce the risk of a reoccurrence.

There were enough staff on duty to meet people's needs; however, staffing levels were currently low as a result of staff absence. The manager was reliant on staff undertaking overtime shifts or using relief staff. Staff had received the training they needed for their roles; although some updates were needed. Staff said they felt supported by the manager, who was based on site.

People told us they were happy living at Rosebank A. Staff knew people and their needs well. Staff were able to explain how they supported people to maintain their privacy and dignity. Staff supported people to be involved in their own care and to make day to day choices.

People were supported to maintain their health and wellbeing. Nutritional needs were being met.

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

- Take action to undertake additional audits to ensure the safe management, storage and administration of medicines.
- Ensure dates of opening of bottles and creams are routinely recorded.
- Take action to ensure areas of the service used to store medicines have recorded temperature checks to demonstrate medicines are safely stored in line with the manufacturer's instructions.

- Arrange for re-grouting of the bathroom tiling. Consider kitchen replacement in future refurbishment plans for the service.

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

- The provider needs to 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 Rosebank A.
- The provider needs to take action to improve their oversight of the service through checks made at service manager level of the organisation.

The inspection

About the service

Rosebank A 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.

Rosebank A 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 three people who used the service about their experience of the care provided. We also observed interactions between staff and people living at Rosebank A.

We spoke with two members of staff including the manager and a support worker.

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

After the inspection

We received written feedback from one member of staff. This gave us further views about the service and people's experience of the care provided.

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.

Using medicines safely

People received their medicines as prescribed. We identified improvements which were needed to ensure the safe management of medicines.

Daily temperature checks were not carried out in the areas of the home where medicines were stored. This meant we could not be assured medicines were being safely stored in line with manufacturer's instructions.

The date when tubes of prescribed creams that were opened did not have the required opening date recorded on the product. We found one cream prescribing instruction stated the cream could only be used for two months after being opened. We were unable to determine when the tube had been opened to be satisfied its efficacy, was still in date and appropriate to use. These findings were discussed with the manager who told us they would address the issues raised.

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 on staff to assess competency.

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. The manager told us they were currently reliant on staff to undertake overtime shifts or relief staff to cover shifts due to ongoing staff absence. The provider was currently in the process of recruiting new staff.

Assessing risk, safety monitoring and management

Routine checks on the environment and equipment were undertaken. Certificates were in place to demonstrate this.

People's needs were appropriately assessed; support plans had been developed to minimise any risk to people's health and wellbeing.

We identified one person's support plan contained inaccurate information about dietary needs. This was raised and immediately addressed. There was no risk to the person of receiving inappropriate support.

Support plans and risk assessments were reviewed on a regular basis.

Preventing and controlling infection

People were protected from the risk of infection. Rosebank A was visibly clean; staff received training in infection, prevention and control. The provider's policy was up to date and a recent audit of practice had been completed. We did observe some environment improvements were needed. For example, the bathroom needed to be re-grouted around the bath and the kitchen would benefit from updating as it was tired in appearance. We shared our observations with the manager.

Staff wore appropriate protective personal equipment, for example facemasks and there were adequate stocks available.

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.

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

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.

People who lived at the service were able to consent to the care and support they received. When a person's capacity had been assessed it was clearly documented they had the capacity to make the decision in question.

Staff understood the importance of seeking consent before providing people with aspects of care and we observed staff seeking people's consent. One staff member told us, "Always. It demonstrates respect and develops trust."

Staff support: induction, training, skills and experience

The provider's training records were not fully up to date and a number of staff needed to undertake refresher training. Access to face-to-face training was now becoming available with easements of restrictions imposed during the COVID-19 pandemic.

We had no concerns about staff skills and knowledge to meet the needs of people who lived at the service.

New staff received an induction to the service and had the opportunity to shadow experienced staff.

Adapting service, design, decoration to meet people's needs

The living environment at Rosebank A met the needs of people living at the service. There were adequate hygiene and communal living facilities.

People were encouraged to personalise their bedrooms through décor and with photographs and personal items. People were eager to show us their personal spaces within the service.

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

People's needs had been assessed. Support plans 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 Rosebank A.

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

People's nutritional needs were assessed, and they were supported to maintain a balanced diet. Care plans reflected any preferences in meal choices and preferences.

People confirmed they were involved in making choices for their meals, supported to assist with meal preparation and spoke positively about the quality of the food. Comments included, "I go food shopping, but I can't cook" and, "I make chips and I am the best cook."

At the time of our inspection visit people were planning a choice of meal for a party that evening.

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. Records demonstrated referrals were made to medical professionals and other services when appropriate.

One person told us, "Staff would help me go to the doctors or the dentist."

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

We observed warm and friendly interactions between people and members of staff. Staff were attentive and spoke to people in a respectful manner.

People told us they liked living at Rosebank A. One person told us, "It's good living here."

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

Staff encouraged people to do as much as they could for themselves. Each person chose a dedicated task which they had responsibility for around the home. For example, emptying the bins or cleaning an area of the home. People were supported to do their own laundry.

Personal information was always kept secure and confidential.

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

People confirmed they were aware of their support plans and had been involved in making decisions. Records also demonstrated this. Where appropriate, family members were also invited to share their views. One person told us, "I recently had a review and my mum came. We talked about holiday plans."

Is the service responsive?

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

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

People told us they received personalised care and could make daily choices. Staff were familiar with people's needs and preferences and important information was recorded.

Each person had a 'key worker'. The key worker role ensured designated staff were identified to work closely with people around their needs and preferences. One staff member said, "People are aware who their keyworkers area and how they can help them."

Meeting people's communication needs

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.

The communication needs of people were assessed and understood. Support plans contained information, when appropriate, to assist staff when working with people.

Information about the service 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

During our inspection we observed activities taking place. Support plans identified people's interests and hobbies. The people living at Rosebank A had formed friendships and often chose to go out together to see shows and attend other social events such as parties.

People appeared engaged and appeared to enjoy the social interaction within the service. People also had the opportunity to go out alone with staff support. One person told us, "I went to Ramsey yesterday to the chippy." People described other activities they enjoyed and plans for the future. For example, all the people living at the service enjoyed watching motorcycle racing on the Isle of Man and were planning holidays.

People were supported to stay in touch and spend time with friends and family. One person told us they were looking forward to their family visiting for their birthday. Another person told us, "I use my iPad to talk to my family."

Improving care quality in response to complaints or concerns

A complaints policy was in place and information on how to make a complaint was available. Records were maintained.

People confirmed they knew how to raise a complaint and who they would complain to. One person told us, "I would speak to the staff if I was unhappy."

End of life care and support

The service doesn't not provide end of life care and support. However, the manager was able to describe how they would work with other agencies should a person find themselves in need of this type of care.

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 limited systems in place to monitor and review the quality of care and experiences of people living at Rosebank A. Although routine health and safety checks were undertaken by staff, medicines audits were only formally completed once a year. This meant errors and areas of improvement were not be identified in a timely manner.

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. However, the provider had little day to day involvement in the running of the service. There was a lack of auditing and monitoring at a provider level.

The manager described their line manager as 'supportive' and said they were available by phone or they could access the local office for support and advice. We were told this lack of oversight had been since the start of 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

People received a person-centred service. People told us they were happy living at 3 Rosebank and were fully involved in the way their support was delivered and supported to make their own decisions. One person said, "I wouldn't change anything." Staff told us they enjoyed working at the service and felt supported by the manager on site.

The manager was also responsible for managing another service which was located next door. They told us, "I love managing the services." One staff member expressed concern at these management arrangements as they didn't feel the manager was able to spend as much time at Rosebank A as they did at the other service. Staff had not had recent supervisions. Neither had there been routine team meetings for staff to come together to discuss any issues or share views. The manager told us the recent staffing shortages and COVID-19 pandemic had been the cause of this and was planning to address this in the coming weeks.

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 Rosebank A worked in partnership with other agencies.