DHSC – CQC external quality regulation programme

Salisbury Street Adult Care Home with Nursing

Inspection report

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Our findings

Overall summary

We carried out this announced inspection on 28 and 29 June 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

Salisbury Street Adult Care Home with Nursing is a residential care home providing nursing and personal care for up to 68 people. The service provides support to older people, a number of whom lived with dementia. At the time of our inspection there were 67 people using the service.

Salisbury Street Adult Care Home with Nursing is located in Douglas and accommodates people across three separate floors, each of which has separate adapted facilities.

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 auditing the quality of the service, improving care plans and some aspects of medicines management.

Staff knew people and their needs well. People were happy with the support they received. People told us they were treated with respect and staff upheld their dignity during care. Risks were assessed. However, a number of care plans needed to be reviewed to ensure current care needs were accurately reflected.

Although staff sought consent on a day-to-day basis and people told us they were offered choice, the service did not always demonstrate how it was working within best practice guidance for assessing mental capacity. The policies, documentation and systems in the service did not always support this.

People were supported to maintain their health and wellbeing. People's nutritional needs were being met. However, some areas of medicines management needed to be more robust.

The physical environment of Salisbury Street Adult Care Home with Nursing was clean and met people's needs. People had the opportunity to access a range of activities, however some people gave us feedback these could be improved.

People were protected from the risk of abuse. Incidents and accidents were recorded and reviewed to reduce the risk of a reoccurrence.

There were enough staff employed to meet people's needs. Staff were recruited safely. Staff had received the necessary induction and training they needed for their roles and felt well supported by the management team.

The provider also worked with other professionals and organisations to ensure positive outcomes were achieved for people.

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

- Take action to review existing processes and implement documentation to demonstrate how the service gives full consideration of best practice guidance in the Isle of Man in relation to assessing mental capacity.
- Seeks feedback from people and reviews the activities on offer to reduce the risk of social isolation.

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

- The provider must ensure thickening products prescribed for people at risk of choking are securely stored. The registered manager must also ensure records are maintained to demonstrate such products have been administered as prescribed.
- The registered manager must ensure recording systems are introduced to demonstrate people have received topical medicines based upon prescriber instructions.
- The registered manager must ensure a review is undertaken of risk assessments and care plans to ensure they accurately reflect current needs.
- Care plan auditing systems need to be improved. This is to ensure there is a clearer process for identifying when a person's needs have changed to check appropriate risk assessments and care plan have been updated in a timely manner.

The inspection

About the service

Salisbury Street Adult Care Home with Nursing 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.

Salisbury Street Adult Care Home with Nursing had a manager in post who was registered with the Inspection and Registration Unit of the IoMDHSC.

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 registered manager. We used all this information to plan our inspection.

During the inspection

We spoke with thirteen people who used the service and six family members about their experience of the care provided; and received written feedback from one family member. We spoke with two professionals who regularly visit the service.

We also observed interactions between staff and people living at Salisbury Street Adult Care Home with Nursing and we used the Short Observational Framework for Inspection (SOFI) to support this. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with nineteen members of staff including the registered manager, deputy manager, nurses, care staff and ancillary staff. We also spoke with the head cook and activity workers.

We reviewed a range of records. This included eight people's care records and eight medication records. We looked at five staff files in relation to recruitment and 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.

Assessing risk, safety monitoring and management

People had risk assessments to identify risks including moving and handling, epilepsy, diabetes, falls and nutritional needs. This included where people needed nutritional support via a percutaneous endoscopic gastrostomy (PEG). Care plans were in place to mitigate risk. However, we found a number of improvements were needed to ensure people received safe care and treatment.

A number of care plans needed to be updated to reflect people's current care needs. This was to ensure staff have the most accurate information when proving care to people. For example, one person's mobility needs were inaccurate. One person's continence care plan did not reflect their catheter was not now in place. Another person had a recent change in nutritional care needs which had not been updated in all areas of the care plan or handover information.

Risk assessments in place to determine if a person needed bed rails to reduce the risk of falling out of bed were not always fully completed. This meant we were unable to determine whether the risk of people becoming trapped in the bedrails or whether people may attempt to climb over them had always been considered.

Thickening products prescribed to people at risk of choking were left unattended on drinks trolleys on each floor of the home. This created a risk people could access this product which could cause them physical harm.

We raised all these issues with the registered manager and nursing team who took immediate action to ensure the thickening products were securely stored and told us risk assessments and care plans would be reviewed. After the inspection we were informed an improved storage solution for thickening products had been put in place.

Care plans were reviewed using recognised monitoring tools to assess ongoing risks to a person's physical health.

Routine checks on the environment and equipment were up to date and certificates were in place to demonstrate this. This included checks to ensure the home was safe in the event of a fire. Actions from a recent fire inspection had been addressed.

Using medicines safely

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, regular observations of practice were made on staff to assess ongoing competency.

People also told us staff discussed their medicines with them. However, we identified a number of improvements which were needed to ensure the safe management of medicines.

One person required their medicines, which were not available in a liquid form, to be crushed so they could be taken in a thickened drink. Some medicines cannot be altered form their original form as this can impact their effectiveness. Information in the care plans did not confirm the

nursing staff had checked this was a safe method of administration. Following our inspection, we received assurance this had been checked and was safe to administer in this way.

A number of people were prescribed creams and medicated shampoo products. Prescribed creams are applied to protect people against the risk of developing pressure sores. The administration of these creams was not recorded. Therefore, we could not establish if people were receiving their creams as prescribed. The administration of thickening products in drinks was also not recorded. Staff were able to confirm the correct dosage of thickening product for people, however we were unable to see recorded evidence.

We discussed these recording issues with the nursing staff and registered manager. We were told this would be addressed through the implementation of improved documentation.

Staffing and recruitment

Staff were safely recruited. Appropriate checks had been made before being offered employment.

At the time of our inspection there were enough staff rostered to meet people's needs. The registered manager told us they had experienced periods when they struggled to recruit staff. In response to this, the provider had recently recruited a number of overseas workers. The home was now fully staffed. Most staff told us there were enough staff to meet people's needs. One person commented this could be affected when staff were absent, for example taking annual leave.

People told us staff were responsive to call bells. One told us, "Staff do come quickly if I ring the bell." We also observed appropriate numbers of staff present in communal areas of the service throughout our inspection.

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 registered manager; 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. Salisbury Street Adult Care Home with Nursing was visibly clean; staff received training in infection, prevention and control. One family member commented, "The home is kept beautifully clean." Regular audits were undertaken, and the provider's policy was up to date.

Staff wore appropriate protective personal equipment (PPE) and there were adequate stocks available. Staff also completed regular testing for COVID-19 in line with guidance.

Is the service effective?

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

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; 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's needs had been assessed. Care plans had been developed based on these assessments, as well as advice and guidance provided by other health and social care professionals. Wherever possible, people's consent to the care had been obtained and recorded through the care plan.

However, when a person was unable to express their consent, documentation was not always consistently in place to demonstrate their capacity had been assessed. Family members had been consulted, however there was also a lack of consistent documentation to demonstrate how decisions had been made in a person's 'best interests'. Although there was no evidence people were being restricted unnecessarily, we could not be assured decisions which may restrict people's movement, for example through the use of bed rails, were the least restrictive option for the person. We discussed this with the nursing staff who told us they would review the current documentation in place.

Staff understood the importance of seeking consent before providing people with aspects of care. One staff member told us, "I would encourage but respect decision."

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

People gave positive feedback about the food available and confirmed they were offered choices at mealtimes.

Menus were displayed. The head cook was knowledgeable about the dietary needs of people and their preferences. Systems were in place to ensure people received the correct diet based on their needs.

Staff support: induction, training, skills and experience

Staff received the training they needed to support people effectively. Staff spoke positively about the training they received. New staff received an induction to the service. At the time of our inspection, the service had a number of new staff undergoing induction training.

Staff also received support through supervision and observations of their practice.

People told us staff received the training they needed to support people appropriately. One person said, "Yes, I think so. I find them champion."

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

Salisbury Street Adult Care Home with Nursing is a large, modern property. Each bedroom had facilities such as en-suite shower rooms. The environment met the needs of people living at the service. However, we did observe there was limited storage space. This meant areas which could be used for additional small seating areas were utilised for practical storage, such as charging stations for electric hoists. Some bathrooms had also been taken out of use to provide additional storage. We discussed this with the registered manager however we agreed there were no easily identifiable solutions to this arrangement. We were assured this didn't have an impact on facilities people needed on a day-to-day basis.

People also had the equipment they needed to be supported effectively and were encouraged to personalise their bedrooms with photographs and personal items.

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 when appropriate. People confirmed they were supported to access their GP and other health services when required. One person told us, “I see the doctor now and again. Appointments are made if needed.”

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

People spoke positively about the care they received. Comments included, “Its smashing” and “Staff are really brilliant”. One person described the home as a, “Mini heaven.”

Family members also told us they believed people were treated respectfully. One told us, “The staff are helpful and polite. [Name] is given a bath every day and is always clean and tidy.”

We observed warm and friendly interactions between people. Staff spoke to people in a respectful manner. We did observe one occasion when a staff member was standing over a person when having a drink, with little verbal communication. We shared this observation with the registered manager who told us they would increase observations of staff practice.

Religious and cultural needs were identified when developing care plans.

Respecting and promoting people’s privacy, dignity and independence

Staff encouraged people to do as much as they could for themselves. This was reflected in care plans.

People’s privacy and dignity was also respected. People confirmed staff knocked before entering their bedrooms and family members gave examples of ways in which people’s privacy and dignity were promoted. One family member told us, “Since [name] has been in the home they have always been treated with dignity and respect. [The staff team] have shown they take individual needs into consideration.”

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

People were involved in decisions about their care. Where appropriate, family members were also involved. Most 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.

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

A plan of activities was available for people. We observed one to one activity take place during our inspection. However, some people told us they chose not to participate and preferred to spend time alone in their bedroom to watch television and read.

Feedback on the range of activities was mixed. Comments included, “Not that many to do. I join in sometimes. I do get asked what I would like to do” and, “Activities are boring. I don’t get a say.” Other people however spoke positively about what was available. We were told, “I enjoy the karaoke and bingo” and, “I find the activities interesting.” One family member told us, “Activities are not very good. Not very interactive. [Name] had a hand massage yesterday. First time in ages.”

We discussed activities with the registered manager and staff. We were told the COVID-19 pandemic had continued to impact on the range of activities on offer. For example, some outside entertainers and faith groups had not returned to provide their previous services. In addition, the lead activity worker was currently absent. We discussed the importance of reviewing the feedback received with the registered manager.

People were supported to go out of the home to visit and spend time with friends and family.

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. For example, staff described how they adapted their approach to communicating including using picture prompts with one person and white boards to write information on.

Most people confirmed they were supported in a way they preferred. This feedback was also confirmed by most family members. One commented, “Staff give [Name] their meals at the time they want them and get ice for [Name’s] drinks.”

The manager confirmed information about Salisbury Street Adult Care Home with Nursing was available in different formats and languages upon request.

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. 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 handover information. Documentation was available 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

Systems were in place to monitor and review the quality of care and experiences of people living at Salisbury Street Adult Care Home with Nursing. Regular audits were completed. The registered manager completed an annual report on the quality of the service. The provider also undertook regular visits. These visits were documented, and action plans developed to reflect any areas of improvement.

However, these systems were not always fully effective. For example, existing systems did not identify the improvements we found in relation to care plans and medicines management. When we raised concerns, we did find the registered manager and nursing team were responsive and updated governance systems in response to our findings.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

People living at Salisbury Street Adult Care Home with Nursing told us they were happy and received person-centred care. Most family members also spoke positively about the home. One told us, “I would highly recommend the home to other people.”

Staff told us they enjoyed working at the home. All staff told they felt morale was good and there was a good level of team working.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; 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 provider sought the views of staff, residents and family members through questionnaires and regular meetings. Staff confirmed they had team meetings and felt they could raise issues. Records were maintained of feedback received and actions taken in response.

Not everyone said they knew who the registered manager was or that they saw them often around the home. However, this feedback was received mainly from people who had recently moved into the home and was not the experience shared by everybody.

The manager demonstrated an understanding of their responsibilities under duty of candour. Most family members told us they felt listened to and the management team responded to any concerns.

Working in partnership with others

Information contained within care plans demonstrated the staff at Salisbury Street Adult Care Home with Nursing worked in partnership with other agencies.

Professionals were positive about the relationships they had. One told us working with the staff team and manager was, “very good”. We were told communication was good and staff were responsive. They also told us felt confident their professional advice would be followed.