

Inspection Report

2023-2024

Ellan Vannin Residential Home

Adult Care Home

16th June 2023

**Under the Regulation of Care Act 2013 and
Regulation of Care (Care Services) Regulations 2013**



DHSC

We carried out this inspection under Part 4 of the Regulation of Care Act 2013 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements, regulations and standards associated with the Act.

We carried out this unannounced inspection on 16th June 2023.

The inspection was carried out as part of a series of focussed inspections on services where we identified a number of unwitnessed falls or serious injuries over the last year.

The aim is to confirm if this is due to an increase in appropriate notification and/or an indication that actions need to be taken to improve the service in the area of falls.

In the cohort of older people the presence of multiple risk factors increases the likelihood of a fall or fracture. Research tell us that older people in care homes are three times more likely to fall than people of a similar age in the community, often these incidents are preventable. There are a number of approaches that can prevent some falls and fractures.

<https://doi.org/10.1136/bmj-2021-066991>

<https://evidence.nihr.ac.uk/alert/falls-prevention-programme-effective-care-homes/>

The inspection was led by members of the Registration and Inspection team.

Service and service type

Ellan Vannin is registered as an adult care home able to accommodate up to thirty-seven people across two floors. It provides care and support to people who require residential care.

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

Whilst we acknowledge there is no established Falls Pathway at this time on the Isle of Man the provider did not have a robust process internally to support people who were subject to falls.

Assessments, care plans and risk assessments were detailed, person centred and promoted independence.

We observed and found evidence of a relaxed atmosphere within the home and positive relationships between staff and residents.

We found care plans and risk assessments were not always up to date and accurate.

We recommend a review of existing arrangements in relation to falls and near miss incidents to ensure best practice guidance is being followed.

About the service

Ellan Vannin is registered as an adult care home able to accommodate up to thirty-seven people across two floors. It provides care and support to people who require residential care.

At the time of the inspection there were twenty seven residents.

Registered manager status

The service has a registered manager. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of Inspection

This unannounced inspection was undertaken as part of a number of themed inspections where there were a concerning number of incidents notified to the Registration and Inspection team. The focus of this report was to review specific residents care files against the inspection framework

We carried out an unannounced inspection on the 16th June 2023.

What we did before the inspection

We reviewed statutory notification of events forms from May 2023. We specifically concentrated on those notifications detailing unwitnessed falls or serious injuries during that period. Where there was a significant number of incidents, we analysed these in terms of frequency of falls for the same resident, actions taken by the home following the incident and any learning identified.

During the inspection

We examined the following evidence on inspection;

- A sample of electronic resident daily records
- Assessments and care plans relating to specific individuals
- Risk assessments relating to specific individuals
- Professional and other agency involvement

We also undertook a general walk around the home as part of the inspection.

After the inspection we discussed our findings with the duty manger.

Our findings:

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. The service requires improvements in this area.

This service was found not always safe in accordance with the inspection framework.

Assessments, care plans and risk assessments did outline people's choices and were respectful of their freedom. It was also clear individuals' independence were being promoted. The duty manager we spoke to was keen to stress this balance between freedom, independence and not being risk averse.

We were not assured residents were being kept safe from avoidable harm due to care plans and risk assessments not containing the most accurate information in the small sample we viewed. This resulted in there being limited evidence in how changes were being made as to how care and support was being delivered to people.

There was no evidence of involvement from individuals or significant others in reviews and risk assessments. This lack of involvement means there may have been missed opportunities to robustly address and explore strategies in falls prevention or discuss anticipated future needs.

There was evidence in the notifications to the Registration and Inspections Team people had been offered moves to rooms on the ground floor to increase their observation and mitigate falls risk for their own safety.

Falls intervention practices did not appear to be in line with current good practice and we were told staff had not received specific training on this subject outside of mandatory moving and handling.

The majority of the falls notifications received by the registration and inspections team from the care home typically state falls have occurred inside people's rooms.

The premises were clean, hygienic and communal walkways and areas were uncluttered and free from hazards.

There are four current staff vacancies. The duty manager stated there were sufficient staff to meet current needs and dependency levels as the home is currently carrying vacant rooms. The care home are making use of agency staff to cover staff vacancies. Whilst we were told agency staff were closely supported by permanent staff, if reading care plans they may not be correctly informed on how to support people due to the lack of up-to-date information. There may be a risk of people receiving disjointed care.

There is a system for considering dependency levels and staffing. However, if care plans and risk assessments are not always up to date this may affect the dependency score within the home.

Action we require the provider to take

Key areas for improvement:

- There was a lack of evidence staff receive relevant support and training for them to be able to support people to stay safe from avoidable harm (in the areas focussed on in this report).
[This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing](#)
- There was a lack of evidence of formal evaluation to ensure people's needs were being met and risks managed beyond the initial assessments. The care home must ensure the assessment and care planning process is dynamic capturing up to date and accurate information to evidence staff are informed and risks are managed.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)
- Ensure care plans and reviews are up to date and accurate to be assured dependency levels, workload and number of staff deployed are safe.
[This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of care service](#)

Inspection Findings

C2 Is the service effective?

Our findings

Effective – this means we looked for evidence that people’s care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence. The service does require improvements in this area.

This service was found not always effective in accordance with the inspection framework.

Initial assessments were person centred, strength based, and holistic. They contained good quality information to ensure resident’s needs could be met. This included likes, dislikes, preferences and who else was to be involved in an individual’s care and review.

Assessments and care plans outlined what people could do for themselves and what they needed help with. This promoted peoples independence.

Information held within the initial assessment considered peoples involvement in decision making, consent and mental capacity.

We could see evidence people were assumed to have mental capacity to make their own decisions and consent sought appropriately.

Information in the initial assessments in relation to mobility needs were clear.

Reviews of care plans were automatically generated every six months. We could not see evidence people who lived in the care home or their significant others were routinely involved in this process.

In the records we looked at, care plans and risk assessments did not appear to be significantly adjusted during or in between reviews. This resulted in inaccurate information being held on the care plans and risk assessment relating to falls history and current abilities. There was a lack of clear information contained in mobility risk assessments and care plans as to falls that had occurred, what new risk factors had been identified, what else had been considered and what action had been taken.

We found the impact of other features such as cognitive problems, dementia, pain or vision changes on a person’s ability to manage their own safety were not consistently considered. These factors were not always carried forward in to care plans, falls prevention and action plans.

In the event of a fall/near miss, internal procedures were followed in the files we viewed. This included completion of an internal accident/incident /near miss form which contains some relevant prompts around falls interventions.

It would be beneficial to review this procedure with a view to implementing current best practice responses to falls prevention and interventions.

There was evidence of involvement from and proactive referrals to other professionals and agencies. Due to a lack of evidence in relation to dynamic care plans, formal reviews and

people's involvement we could not be assured referrals to other agencies and professionals were timely.

There was no evidence staff were being provided with specific training or knowledge on good practice in managing falls in a care home environment.

Whilst we were told staff knew residents needs well, the impact of care plans and risk assessments not being up to date and providing relevant information to staff on mobility, risk factors and mitigations needs to be considered.

Action we require the provider to take

Key areas for improvement

- To evidence involvement of individuals and their significant others in reviews, care plans and risk assessment discussions aligned with good practice guidance.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)
- To review existing arrangements in relation to falls and near miss incidents ensuring interventions are based on current guidance.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)
- Provide staff with access to training to ensure they have the relevant skills and knowledge to understand common themes and risk issues to meet specific resident need; relevant to the client group and setting.
[This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.](#)

Inspection Findings

C3 Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect. The service does require improvements in this area.

This service was caring in line with the inspection framework.

We found the care home to be a very welcoming and warm environment. We observed interactions between staff and residents during our visit and they seemed to be natural, spontaneous and caring. We could hear laughing and joking between staff and residents.

We found evidence people were being treated with compassion and kindness in their day to day care.

It was obvious from speaking to the duty manager there was a genuine fondness, compassion and care for the people supported within the home which aims to promote a family atmosphere and caring culture. The duty manager knew the residents needs very well but this further illuminated care plans and risk assessments were not accurate.

The duty manager told us priority was being given to spending quality time with residents. Consideration needs to be given as to how this can be balanced against staff being given time to be trained and gain knowledge to meet specific needs and risks. Giving time to maintain effective systems and formally involve people regularly in their care plan, review and risk assessment practices within the care home may contribute to overall improvements and the wellbeing of people who live there.

Action we require the provider to take

Key areas for improvement

- To involve people and their significant others in reviews, risk assessments and care planning. This will ensure and evidence people are actively involved in their care and support.

[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)

Inspection Findings

C4 Is the service responsive?

Our findings:

Responsive – this means we looked for evidence that the service met people’s needs. The service does require improvements in this area.

This service was found to not always be responsive in line with the inspection framework.

We found evidence in files of involvement from other professionals and agencies in response to a change of needs.

Initial assessments and care plans did reflect what was important to people and how they should be involved in their care.

There was evidence that people had moved on to nursing homes recently due to an increase in their health and care needs.

We could not be assured the care home is delivering care which is responsive to people’s needs given care plans and risk assessments were not up to date or adjusted. In addition we saw no evidence regular reviews and reassessments were undertaken robustly with involvement of people supported or their significant others. One of the files we looked at included a hospital admission and a number of falls in a relatively short period of time. There was no evidence of these events triggering a formal new assessment of need or review. There is also a lack of current good practice in approaches to falls prevention and interventions within the setting or clear procedures to follow to mitigate risk.

There was no evidence of assistive technology (such as room sensors/sensor mats) being used to support better outcomes for residents.

There were external challenges which impact on the care home being responsive highlighted by the duty manager. These included

- Access to GPs
- Delays in social work involvement to support people with moving on when care needs exceeded that which the care home could provide.
- Difficulty filling staffing vacancies

Action we require the provider to take

Key areas for improvement

- To consider how technology can be used in a way that benefits people.
[This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service](#)
- Involve people and their significant others in the review process to evidence care and support delivery is person centred and meeting their needs.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)

- Evidence ongoing assessment and risk assessments are being adjusted and/ or undertaken six monthly or as required. This will ensure changes of need or reviews are responsive and linked to changes to care delivery.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)

Inspection Findings

C5 Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture. The service does require improvements in this area.

This service was found to not always be well led in accordance with the inspection framework.

There appeared to be an open and relaxed atmosphere within the care home. The duty manager was extremely candid during inspection for which we were grateful.

The duty manager informed us there was a small staff team in the care home. There were opportunities to disseminate information through staff meetings, handovers and ad-hoc as needed.

An example was provided by the duty manager in relation to lessons learned from an incident (unrelated to falls) and we found evidence the care home had followed guidance given by the inspector following a falls notification.

The care home is proactive in submitting notifications in accordance to statutory requirements hence an awareness of the number of falls within the home.

We were informed of current challenges in relation to recruitment as there are four staff vacancies. We were told this is placing additional pressure on the existing small staff team. The care home are using agency care staff to relieve some of this pressure and actively working on recruitment. One new member of staff has been appointed however they are coming from overseas and this is taking additional time to complete.

We were not assured quality assurance systems were in place in relation to falls, care plans and reviews. There was no evidence provided of auditing, systems to establish areas of learning or proactively seeking out best practice.

It was evident from the duty manager that leaders of the home are keen to take on information which will help them to raise standards within the home and benefit the people who live there.

There was no evidence the management had provided staff with specific training and knowledge on good practice in managing falls in a care home environment.

There was no evidence of involving care staff or keyworkers in taking on some responsibility in adjusting care plans. It is acknowledged current staffing issues may be impacting on this.

It may be helpful to consider encouraging staff to take on more responsibility or develop special interests in areas such as falls interventions and becoming a falls champion going forward.

We heard how residents were very engaged in the running of the home however improvement is needed to ensure people are involved in their review meetings, care plans and risk assessments as appropriate.

Action we require the provider to take

Key areas for improvement

- To arrange training and guidance for staff in relation to specific needs as they arise. Staff will become knowledgeable and confident to adjust care plans, risk assessments and contribute to quality improvements as a result.
[This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing](#)
- To consider implementation of a governance framework ensuring care plans, reviews are completed in line with best practice.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)
- To implement a systems for recording and reviewing incidents of falls/ near miss, share and evidence learning and improvements made.
[This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.](#)
- Service to ensure that staff are involved in any learning outcomes to help inform day to day care.
[This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing](#)

If areas of improvement have been identified the provider will be required to produce an action plan detailing how the areas of improvement will be rectified within the timescales identified. The R&I team will follow up and monitor any actions undertaken.