Inspection Report 2023-2024

Salisbury Street Nursing Home

Adult Care Home

4th July 2023

Isle of Man Government

DHSC

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

SECTION A Overall Summary

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.

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.

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 lived in the care home and were subject to falls.

The care home was clean and the physical layout of the building is conducive to people's mobility needs.

There were systems in place to underpin falls management and prevention within the care home, this included accident and incident recording and a falls management policy.

The service is compliant with statutory notifications as required under the Regulation of Care Act 2013.

We found daily records, care plans, risk assessments, accident and incident recordings were not always aligned or up to date.

SECTION B The Inspection

About the service

Salisbury Street Nursing Home is registered as an adult care home able to accommodate up to 68 residents across three floors in a purpose built building. It provides care and support to people who require nursing care.

At the time of our inspection there were 64 residents

The building is a large modern property with car park, a garden for resident's use, lounges, en-suite facilities and the home has equipment for the specific needs of people who live there.

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.

The registered manager has recently returned to this post from a role within the same organisation.

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 4th July 2023.

What we did before the inspection

We reviewed statutory notification of events forms from May 2022. 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
- Relevant care home policies and procedures

After the inspection

After the inspection we discussed our findings with the registered manager.

SECTION C Inspection Findings

C1 Is the service safe?

Our findings:
Safe – this means we looked for evidence that people were protected from abuse and avoidable harm. The service does require improvements in this area.

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

We were told by the manager the service was sufficiently staffed to meet people's needs and current recruitment was in relation to anticipatory staffing needs.

There were systems and policies in place which helped to support people's safety and protect them from avoidable harm. This included daily records, pre assessments, care plans, risk assessments, accident and incident recording and a falls management policy. Despite this, in the small number of cases reviewed, we found recording was not always accurate, consistent or aligned.

We found the impact of specific conditions such as cognitive impairment, dementia or head injury were not adequately considered in the management of risk.

A care plan and risk assessment had not been updated since April 2023 yet we could see from daily records there had been a significant change of need.

Risk assessments and preventative actions were not always adequately detailed or updated.

Appropriate domains were not always completed in the care plans we looked at, for example cognition.

When we spoke with the registered manager about our documentation findings we were informed the incongruence of care plans and risk assessments had previously been identified. We were advised a plan to respond to this was in formulation which included a corresponding change to staff responsibilities.

We note the Care Quality Commission (CQC) identified similar themes during their external quality regulation programme of inspections in June 2022.

The service also uses an assessment tool FRASE (Falls Risk Assessment Scale for the Elderly) which identifies if an individual is low, medium or high risk of falls. The tool is a prebuilt template incorporated in to the digital case management platform used by the care home. We found this tool (FRASE) did not adequately cover information which is now considered relevant in nationally recognised falls management and prevention approaches. The questions asked within the tool were open to interpretation, did not take in to account multiple risk factors and the outcomes did not always match the level of risk represented in care plans or notifications we received.

The care home has a system in place to monitor accidents and incidents. This could be very effective in identifying trends and falls analysis within the care home if consistently and appropriately used.

We found accidents and injuries were not consistently recorded when compared to our notifications and we found incidents logged under the wrong category.

Action we require the provider to take

Key areas for improvement:

- Ensure care plans and risk assessments are consistent, up to date and comprehensive to be assured risks are managed appropriately and to protect people from avoidable harm.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of care service

- Ensure staff use systems appropriately to record incidents and accidents according to care home policies and provide access to training on this if required.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 - Staffing

- To consider if the systems and policies in place, including the FRASE tool are comprehensive and effective in managing and responding to falls 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.

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 to not always be effective in accordance with the inspection framework.

The physical layout of the building is conducive to people's mobility needs. All passage ways were wide and we observed they were clear and free from trip hazards during the inspection.

We found the care home to be clean throughout.

The manager reported there were sufficient staff working within the home. In addition there is a recruitment process ongoing and three overseas staff are expected to commence employment in the near future.

We found there were systems in place to support and promote best practice for falls management and prevention but they were not always used effectively.

All of the case files we looked at were complete with initial assessments, care plans, risk assessments and reviews. Documentation was holistic however we found that important information did not always correspond, carry forward through the records or was variable in quality.

Records did evidence the use of technology such as sensor mats in the management of falls.

Recorded actions and steps taken in the immediate response to falls did not consistently evidence that best practice or the care home policy, "Falls – care of someone who has fallen 2022", had been followed.

The case management system does support recording of mental capacity information and best interests within care plans and daily records. We found records did not always evidence mental capacity and best interest decision making had been considered in relation to specific care decisions. We also found the mental capacity care plan was sometimes used as an emotional wellbeing domain.

The care home has a high level of compliance with submitting statutory notifications however when matched with the recording of accidents and incidents we could see the events had not always been recorded internally as per the care homes policy.

We acknowledge the FRASE tool is part and parcel of the current case management system however we cannot be assured of its efficacy given it is not in line with current evidence based guidance and best practice. The tool does not take in to account sufficient information in relation to multiple risk factors.

The care home provides care and support to some individuals with very complex health conditions and needs. We could not be assured from the records we looked at, that the impact of their health condition on falls risk and ability to manage own safety needs was fully understood. We found this was not always reflected in care plans and risk assessments.

Action we require the provider to take

Key areas for improvement

- To arrange guidance for staff in relation to specific needs and processes as identified. 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.

- Review processes for recording mental capacity and best interest decisions. Ensure processes are aligned to best practice guidance, are fully considered in care plans, risk assessments and staff are familiar with the principles.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

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 not require any improvements in this area.

This service was found to be caring in line with the inspection framework.

We found the care home to be welcoming to our unexpected arrival.

We observed positive interactions between staff and residents as we walked around the building.

We saw people being assisted appropriately with daily living tasks, meals and drinks.

The records we viewed demonstrated people were supported and encouraged to be as independent as possible according to their limitations. There was a positive risk taking culture with consideration to least restrictive practice and respecting people's freedom and choices.

We saw evidence of significant other contact in relation to falls incidents and general welfare.

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 not always responsive in line with the inspection framework.

Overall there was good evidence of seeking involvement from external professionals in response to a change of need and to ensure better outcomes for residents.

We found one situation in which initiating earlier involvement from other professionals may have been beneficial in the context of preventative action and collaborative risk management for an individual with complex needs.

In discussing this case, the manager highlighted barriers to accessing appropriate information, ongoing support and guidance from other professionals, particularly where there were complex health and specific behaviour needs with individuals.

It is acknowledged that aspects of care coordination for people who have complex needs in care homes may be out of the care provider's control, however care homes must do what they can to evidence they have been proactive to involve multiagency involvement where it is needed.

We could not be assured the support provided to people in the care home was responsive to people's needs due to the lack of alignment in daily records, care plans, risk assessments and incident logs.

It was evident significant others were informed appropriately when falls occurred however we could not see that review meetings were held in response to people who were falling regularly and at increased risk of harm as a result of this. Such meetings would provide opportunity to specifically focus on falls management, explore possible interventions, involvement from other disciplines and formally acknowledge ongoing risk factors if all options have been exhausted.

Action we require the provider to take

Key areas for improvement

- To implement a formal review system in response to people who are falling regularly, with involvement from the person supported, and/or significant other as appropriate. This will ensure changes of need and risks are fully understood, recorded, aligned to best practice approaches and responded to in a timely manner.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

- To ensure all staff understand their responsibilities in using, reviewing and updating care plans and risk assessments.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

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 any improvements in this area.

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

We found there was a positive atmosphere in the care home during the inspection.

The manager was open, honest and transparent during the inspection. The manager genuinely welcomed feedback, acknowledged our findings and made a commitment to take the necessary improvement actions.

The care home is highly compliant with submitting statutory notifications.

There was evidence of Salisbury Street working well alongside other stakeholders and professionals. Access to multidisciplinary input has improved at the care home due to their unique participation in a frailty team project which is attended by senior health professionals. Whilst this project is small scale, and has a specific remit we discussed if this could be expanded to include individuals identified as being at high risk of falls. This was something we were told the manager would need to discuss with the project members.

We were not assured the quality assurance systems in place at Salisbury Street were adequately identifying gaps and inconsistencies in practice and recording or in finding care plans and risk assessments which were not up to date. We were also not certain the existing quality assurance systems in place were being used to analyse trends in falls and incidents to deliver better outcomes for people, service improvements and organisational learning.

From our conversations with the manager it did not appear that staff had access to specific training in relation to managing falls in a care home environment, common themes, risk factors and interventions to consider. This may help to underpin and embed the care homes falls, accidents and incidents policies.

It may be beneficial to consider staff taking on special interests in this area so they can participate in the improvement process.

Action we require the provider to take

Key areas for improvement

- To ensure quality assurance data is triangulated with daily records to ensure it accurately reflects what is happening on the ground, people's needs and the management of risk.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

- Build on existing policies, incident and quality assurance systems to support a structured approach to falls management and prevention which is underpinned by best practice, and improves the service response.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

- To arrange specific training for staff in relation to falls management and prevention in a care home environment.
  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.