Inspection Report 2023-2024

LV Crovan Court

Adult Care Home

6 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. We looked at the overall quality of the service.

We carried out this unannounced inspection on 6th July 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
LV Crovan Court is an adult care home in the north of the island and it provides residential and nursing care for up to fifty two people.

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
The home was clean and tidy on inspection. Residents were seen to be appropriately dressed and appeared to be clean.

We found areas of improvement on the inspection relating to the following areas; submission of notification of events forms, consistency of information included in care plans and risk assessments, and the need for robust auditing informing the quality assurance process.

SECTION B The Inspection

About the service
LV Crovan Court is registered as an adult care home able to accommodate up to fifty two residents. It provides care and support to people who require both residential and nursing care.

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 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. We carried out an unannounced inspection on 6 July 2023.

What we did before the inspection
We reviewed statutory notification of events from July 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 residents, actions taken by the home following the incident and any learning identified.

During the inspection
We examined the following evidence on inspection;

- Care plans relating to specific individuals identified;
- Diagnosis for individual residents, and any appropriate staff training undertaken;
- Mobility of individuals with specific staff training identified;
- Moving and handling care plans;
- Involvement of appropriate professionals documented, with advice acted on and included in care plans;
- Care plans reviews appropriately carried out, and evidence of required changes made;
- Care records to compare notification of events forms submitted with incidences recorded.

After the inspection we discussed our findings with the duty 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 requires improvements in this area.

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

Staffing levels were generally agreed to be sufficient on the day of inspection. There were five staff on duty on each floor.

We looked at records relating to residents who had had falls. Information recorded was not always clear. For example, on initial assessments, conflicting evidence was seen as to whether additional staff assistance was needed to maintain mobility. This potentially could lead to unsafe practice.

Risk assessments were in place. However, these assessments were not always sufficiently detailed. We were not always assured that information contained in care plans was included in risk assessments. For example, a care plan was seen regarding the wearing of a helmet, but this was not included in risk assessments. This does not fully ensure all risks had been fully addressed. We also saw information which was contradictory in pre admission assessments and care plans.

Notification of Events forms were examined. From our examination of the records, we saw not all incidents had been submitted to the Inspection and Registration team. We saw several instances where incidents had taken place in the home, but no record was in place of notification of events forms being submitted. We also saw instances where falls had been recorded as "general notes" on the recording system, but again no formal notification of events forms had been submitted. Specific information contained in a notification of events form regarding safety equipment did not have an accompanying risk assessment.

Staff had received training in moving and handling practice, which incorporated dealing with falls. However, there was no specific guidance for staff regarding the procedure in the event of a fall. We were informed that various factors were considered after resident falls. As a matter of good practice it was agreed that this checklist of factors was to be incorporated into the Moving and Handling training by the deputy manager.

Action we require the provider to take

Key areas for improvement:

- Information relating to the service recipient plans must be clear and consistent.
  This improvement is required in line with Regulation 13 of the Care Services Regulations 2013 – Service recipients plan

- All incidents must be submitted promptly to the Registration and Inspection Team.
  This improvement is required in line with Regulation 10 of the Care Services Regulations 2013 - Notifications

- Specific guidance for staff in relation to falls procedure must be in place.
  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/does not require any improvements in this area.

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

Risk assessments were in place. However, these were not always detailed enough or consistent in terms of information aligned with care plans. No policy was in place regarding the need to ensure triangulation of information in pre admission assessments, care plans and risk assessments. We saw evidence of information contained in daily notes but not documented elsewhere. This could potentially impact on unsafe practice if not all necessary relevant information is documented.

Risk assessments had not all been appropriately reviewed in line with timescales.

We saw evidence of capacity and best interests decisions being made, together with family involvement, where appropriate.

We saw evidence of links with appropriate professionals in order to source additional support, and consideration of moving on where appropriate for residents.

Action we require the provider to take

Key areas for improvement:

- Risk assessments must contain detailed and accurate information, and be appropriately reviewed.
  This improvement is required in line with Regulation 23 of the Care Service Regulations 2013 – Review of quality of care

- All information must be recorded appropriately.
  This improvement is required in line with Regulation 14 of the Care Service Regulations 2013 – Records

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.

The home was welcoming on inspection. Records demonstrated that residents had contact with families. We saw interactions between staff and residents were kind and responsive to need. Staff were able to tell us about residents and their needs, and they were familiar with every day routines.

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 be responsive in line with the inspection framework.

We saw how residents' increasing need was documented. Reassessment of need was in place. However information in the care plan regarding the use of additional equipment did not have an accompanying risk assessment. We could not be assured that all staff would be aware of individuals' needs given the general disparities in information.

Family discussions were seen which discussed the use of equipment due to increasing need. We also saw evidence that people had moved into nursing care when appropriate.

No specific falls training was in place. Given the falls occurring in the home, we would consider it good practice to have specific falls training accompanied by robust procedures for staff to implement and document.

Referrals to professionals were documented. However, there was no evidence of, for example, specific information of concern being passed to professionals.

The home employs a system of risk ratings relating to falls. However, these ratings were unclear. We saw evidence of risk ratings which did not correlate to actual risk and could present an incorrect and unclear picture.

Action we require the provider to take

Key areas for improvement

- Risk assessments must be in place in line with information in care plans.
  This improvement is required in line with Regulation 14 of the Care Service Regulations 2013 – Records

- Specific falls training for staff to be considered accompanied by robust procedures.
  This improvement is required in line with Regulation 16 of the Care Service Regulations 2013 – Staffing

- All information to be shared with professionals as appropriate.
  This improvement is required in line with Regulation 15 of the Care Service Regulations 2013 - Conduct of Care Service

- The system of risk ratings relating to falls needs to be accurate and regularly updated.
  This improvement is required in line with Regulation 14 of the Care Service Regulations 2013 - Records

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.

The manager and their deputy spent time discussing the situation regarding falls in the home. A system is in place whereby audits are carried out by named nurses in the home. From our examination of records, it is clear that a more robust system needs to be in place. There needs to be a system of overall audit by the manager incorporating all home audits including risk assessments and care plans. This would then feed into the quality assurance process. Areas of learning could then be identified with best practice included to further drive improvement.

A checklist document detailing guidance for staff following a resident fall would be useful, and ensure all relevant actions were taken and documented.

Action we require the provider to take

Key areas for improvement

- A robust auditing system needs to be in place.
  This improvement is required in line with Regulation 14 of the Care Service Regulations 2013 – Records

- A checklist document containing required actions for staff to be in place.
  This improvement is required in line with Regulation 14 of the Care Service Regulations 2013 – Records

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.