Inspection Report 2023-2024

Sunnydale Residential Home

Adult Care Home

22 & 24 November 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 announced inspection on the 22 & 24 November 2023. An inspector from the Registration and Inspection team carried out the inspection.

Service and service type
Sunnydale is an adult care home based in Douglas. People in care homes receive support and accommodation as a single package under a contractual agreement. Both were looked at during this inspection.

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
Areas for improvement are required in relation to the environment, training, care records, supervisions and appraisals and twice-yearly responsible person audits.

Systems were in place to protect people from harm or abuse. Risks were assessed and guidance in place to manage those risks. Staff had been recruited safely.

Detailed pre-admission assessments were being completed. People were involved in the reviewing of their care plans, which were reviewed regularly. Regular staff meetings were taking place.

Staff knew people and their individual needs well. Positive interactions between people and staff members were observed on inspection. Staff were attentive to peoples' needs.

Individualised support was provided to meet peoples' needs. People were supported to maintain relationships that were important to them.

Staff confirmed that the home had a clear set of values which were discussed and put into practice. Staff confirmed that they received the support and training to meet the needs of the people in the home.

At this inspection, we found four areas for improvement had not been met from the last inspection. These have been addressed in this inspection report.

SECTION B The Inspection

About the service
Sunnydale is a residential care home. Sunnydale is in Douglas and is registered for up to forty-three people aged thirty and above. At the time of our inspection, forty-two people were living at the home.

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 part of our annual inspection programme which took place between April 2023 and March 2024.

Inspection activity started on 16 November 2023. We visited the service on the 22 and 24 November 2023

What we did before the inspection
We reviewed information we received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR), notifications, complaints/compliments and any safeguarding issues. 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 several people who lived in the home and observed staff support being provided.

We spoke with four members of staff, the registered manager and the head chef.

A tour of the home was carried out.

We reviewed a range of records, including people's care records, staff supervision records and a variety of records relating to health and safety and the management of the service.

After the inspection
Three family members provided feedback by telephone and one family member responded by email.

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 to be safe.

Assessing risk, safety monitoring and management
A range of safety checks had been completed throughout the building, including electrical, fire and gas safety. The passenger lift had recently been serviced.

Each service user had a Personal Emergency Evacuation Procedure (PEEP) written and stored on file. An easy reference guide relating to individual PEEP's was readily available for staff to refer to in an emergency. Training records showed that one staff member had not received training on fire safety.

A fire risk consultant had completed a fire risk assessment on the home and several areas required action being taken. These either had all been actioned or were in the process of being completed.

A Legionella risk assessment had been reviewed in June 2023. An external agency had tested the water for the presence of Legionella bacteria in the water system. No bacteria was present. Staff were checking water temperatures and thermostatic mixer valves were inspected and serviced annually. Showerheads were cleaned and disinfected monthly.

Some areas of the skirting board in one of the lounges required redecoration. The inside of the lift was in need of attention / decoration. The home was in the process of decoration and renovation, with showers in people's en-suites being upgraded.

Staffing and recruitment
The provider had recruited safely. The files of six staff were examined and these evidenced that all required pre-employment checks had been completed.

Disclosure and Barring Service (DBS) checks for the staff team were up to date and reviewed within a three-year period.

Staff rotas were clear and legible with shift leaders clearly identified.

Peoples' level of dependency was assessed monthly and an easy read chart identified how many people were of a low, medium or high dependency.

Staff felt that for the majority of the time there were enough staff on duty to support the needs of the people living in the home.

Several staff members had come to work in Sunnydale when another nearby residential home, run by the provider, had closed and they had moved over. The people from this home had also moved into Sunnydale.

The home had a business continuity plan, which the manager had reviewed in September 2023.

Preventing and controlling infection
The home was clean throughout. Domestic staff were observed carrying out cleaning tasks and cleaning schedules were being completed. Personal Protective Equipment (PPE) was available for staff use. Staff had completed training on infection prevention and control. Monthly infection control audits were taking place and mattress checks formed part of this audit.

The home's infection control policy was reviewed in August 2023.

COSHH products were kept in a lockable cupboard. Safety data sheets on these products were available.

Staff had received food safety training. Fridge and freezer temperatures were being recorded three times a day. Food was being stored appropriately and a system was in place regarding when to use by once opened.

Learning lessons when things go wrong
The manager was completing monthly audits of accidents and incidents and safeguarding concerns. Audits identified any actions to be completed and any learning to be had. There was evidence that the manager had responded to incidents and changed practice accordingly.

Generally the regulator had been informed of all notifiable events, but two falls had not been reported.

Staff knew their responsibilities in preventing and responding to incidents or near misses.

The manager said that they had signed up to relevant external safety alerts.

Action we require the provider to take

Key areas for improvement:

- Action must be taken to repair / redecorate areas in a lounge and the passenger lift.
  This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Fitness of premises: Health and Safety.

- Action must be taken to inform the regulator of all notifiable events.
  This improvement is required in line with Regulation 10 of the Care Services Regulations 2013 – Notifications.

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.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
Detailed pre-admission assessments had been completed on people prior to their move into the home. The assessments recorded who was involved in the meeting. A person's transition into the home was also documented. Gender preferences for personal care were identified.

Care plans and risk assessments were not always written on individual's identified needs. Greater detail was required in some care plans to further inform and guide the reader. A new assessment of needs was taking place every six months or following a change in needs. There was evidence of involvement of the service user / representative in the review process. The involvement of other health professionals in a person's care was included in care / support plans.

Not all people had their ability to self-medicate assessed via completion of a risk assessment.

Staff support; induction, training, skills and experience
Generally staff had received training to meet people's needs. Mandatory training consisted of many courses, which the manager was aiming to add to. Where staff were in need of refreshing a training course, there was evidence of the management reminding staff to complete the training. One staff member had not received training on fire safety and safeguarding adults.

Staff confirmed that they received the training and support needed to provide excellent care. One staff member said that they had spoken to the manager about the possibility of receiving specific training.

Staff members had received at least one supervision with the manager, but this did not meet the standard of having a minimum of four formal supervisions. The majority of the staff had not received an annual appraisal of their performance.

Regular staff meetings were taking place, with the manager wanting to increase the frequency to monthly. Staff felt supported by their manager. Comments made included, 'the manager is very supportive and listens', and 'the manager has a presence on the floor'.

Staff responsible for medication were having their competency to administer medication assessed annually.

Supporting people to eat and drink enough to maintain a balanced diet
People's dietary / nutritional needs were being assessed on admission, with eating and drinking care plans written where required and risks of malnutrition assessed. Allergies were recorded. A discussion was had with the head chef as to how the kitchen were informed of a new

person's dietary needs and likes and dislikes. Food and drink preferences were displayed in the kitchen with special diets highlighted.

Where required, guidance was sought from external agencies such as the speech and language team, with care plans developed from this input.

A menu was displayed in the dining area. People confirmed that choices were available. Meals and menus were discussed in resident meetings. A mealtime was observed on the inspection. The dining experience was relaxed and one person requiring assistance with feeding was being supported in an unhurried caring manner.

Prior to the inspection we had been informed that desserts were no longer being served at lunchtimes, just at teatime, and that this had upset some of the people living in the home. This was discussed with some people on inspection, but it no longer appeared to be an issue. We were also informed, pre-inspection, that people were being given very small portions at mealtimes. The manager explained that she was revisiting peoples' likes and dislikes, as well as what size portion of food they wanted. There were no concerns over portion size witnessed on inspection.

Action we require the provider to take

Key areas for improvement

- Action is needed to write support plans and risk assessments on any identified need.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records.

- Action is required to include greater detail in support plans and risk assessments.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records.

- Action is required to ensure that people's ability to self-medicate is assessed through the completion of a risk assessment.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records.

- Action is needed to ensure that all staff receive mandatory training on induction and refresher training at the frequency identified by the provider.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure all staff receive regular supervision.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure that staff annual appraisals be undertaken.
  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 not require any improvements in this area.

This service was found to be caring.

Ensuring people are well treated and supported; respecting equality and diversity
We observed warm and friendly interactions between people and staff members on inspection. Staff were observed listening to people and responding in a way that was attentive and understanding. Staff knew people and their individual needs well. People appeared relaxed with staff.

Individual communication needs were addressed.

The home had consulted with relevant professionals to support people with their mental health needs.

Religious and cultural needs were identified on admission and care plans developed. People in the home were supported to be involved in social activities. People were supported to maintain important relationships with family and friends.

Supporting people to express their views and be involved in making decisions about their care
People and their relative / representative were involved in the admission process, as well as in contributing to care plans.

Staff confirmed that they had opportunities to spend quality time with people. The manager spoke about the difficulty in people wanting to be part of resident meetings, but formal meetings had taken place with minutes recorded. Menus and activities formed part of the agenda.

Questionnaires were given to people and their relative / representative as part of the homes quality assurance process.

Staff had received training to meet the needs of the people living in the home and health professionals had been consulted to support people with any specific need.

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 an improvement in this area.

This service was found to be responsive.

Planning personalised care to ensure people have choice and control to meet their needs and preferences
People received individualised care / support to meet their needs. Generally, person-centred care plans identified people's needs and provided guidance for staff on how to meet these needs. These included levels of independence, communication needs, physical and emotional needs and hobbies and interests. Peoples' support needs were reviewed every six months, or when required, with the person and / or family member, representative. Staff were familiar with peoples' needs.

People were supported to develop and maintain relationships.

People had access to a 'resident user's guide' and the statement of purpose was available by the front door of the home.

A calendar clock was located in the dining room to reduce confusion over the date and time.

Where staff were carrying out nighttime checks on people, agreement had been sought from individuals and evidenced. Several people had pressure mats in their rooms. The home need to evidence that their use has been discussed with the person and an agreement reached.

Improving care quality in response to complaints and concerns
The provider had a complaints policy that had been reviewed in May 2023. The complaints procedure was displayed in the home, as well as easy read and large print versions. Leaflets on the complaints process were available. We were informed that when a person moved into Sunnydale they were given a copy of the residents' guide – containing information on complaints, and the complaints procedure.

The manager and staff dealt with most concerns informally. Family members said that they would speak with staff on duty if they had a concern or complaint. A complaints section formed part of the home's annual report. This outlined concerns raised by family members and how the home responded to the concern.

Action we require the provider to take

Key areas for improvement

- Action is required to evidence that the service user, taking into account capacity and best interest decision-making, has agreed to the use of a pressure alarm mat.
  This improvement is required in line with Regulation 13 of the Care Services Regulations 2013 – Service recipients plan.

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 an improvement in this area.

This service was found to be well-led.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
Staff confirmed that the home had a clear set of values which were discussed and put into practice. The manager said that she was instilling a person-centred culture in the home and gave the following examples - through regular staff meetings, in handovers and by having a meeting with staff each day at 2pm whereby the shift progression and service user wellbeing was discussed. A new keyworker system had been introduced so that staff worked on different floors of the home and became familiar with the needs of more people.

The manager was present, visible and accessible to the staff team and staff felt supported by their manager.

The manager had a current up to date job description.

Service users and family members had been given questionnaires to complete as part of the home's quality assurance exercise.

The manager had attained a Level 5 Diploma in Leadership and Management for Adult Care qualification. The manager received and updated their mandatory training. The manager felt supported, with weekly video conference call meetings with the provider and regular supervisions with the responsible person.

In order to keep up to date with their skills and knowledge, the manager said that they did self-directed reading, which had resulted in putting together a learning pack on mental health for the home. We were also informed that the manager received updates from an adult care development and planning body.

How does the service continuously learn, improve, innovate and ensure sustainability
Staff received on-going training. Staff confirmed that they received the support and training to meet the needs of the people in the home. Staff responsible for medication administration were having their competency to administer assessed annually.

The manager regularly observed staff practice.

The manager had received training on how to provide staff with supervisions.

The home had recently introduced a computerised care record system and staff carried electronic devices which accessed peoples' care records.

Monthly auditing was taking place on a variety of areas, including clinical audits, kitchen, medication and accident analysis. Learning from these audits was used to improve service provision.

Twice yearly, the responsible person, or agreed nominee, must make twice-yearly visits to the home and produce a report in respect of each visit and include assessments on the premises, staffing levels and skills, service user and family satisfaction and record keeping. This had not taken place.

Staff were not receiving regular supervision or annual appraisals.

The home had formal systems for seeking feedback from service users, family members and staff.

An annual report had been written in August 2023, covering areas such as quality assurance, achievements from the past year and future development plans.

Action we require the provider to take

Key areas for improvement

- Action is required for the responsible person, or agreed nominee, to carry out twice-yearly audits of the home.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

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.