# Inspection Report 2023-2024

# Cushag House

Adult Care Home

27 October 2023 &

2 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 27 October 2023 and 2 November 2023. The inspection was led by an inspector from the Registration and Inspection team.

**Service and service type**
Cushag House is an adult care home, operated by Manx Care and based in Port St. Mary, providing care and support to adults with a learning disability. The home is registered to look after a maximum of five people. People in care homes receive support and accommodation as a single package under a contractual agreement. At the time of the inspection there were six people using the service.

**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 for improvement in relation to fire safety, the recruitment, supervision and training of staff, residents accessing advocacy services and updating policies and procedures.

Systems were in place to protect the residents from harm or abuse. Risks were assessed and guidelines were in place to manage these risks. Incidents were reviewed to reduce the risk of occurrence.

Staff sought guidance from other professionals to ensure the residents' day-to-day health and wellbeing needs were met.

Staff knew the residents and their needs well. Staff ensure that the care they provide protects the residents' privacy and respects their choices and rights.

Care plans reflected the residents' physical, mental, emotional and social needs. The residents were supported to participate in social activities and maintain relationships that were important to them.

The manager understood their role and responsibilities to deliver what is required.

At this inspection, we found six areas for improvement from the previous inspection had been met and two still outstanding. The outstanding areas for improvement have been addressed in this inspection report.

## SECTION B The Inspection

### About the service
Cushag is a large, spacious bungalow located in Port St. Mary with local shops and bus stops close by. Each resident had their own bedroom, shared access to a lounge and dining area, kitchen and bathrooms and there is a garden at the rear of the home, accessible to the residents.

### Registered manager status
The service did not have a registered manager. This means that the provider is 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 26 October 2023. We visited the service on 27 October 2023 and 2 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). This contained information about their service, what they do well, and improvements they plan to make. We reviewed notifications, complaints, compliments and any safeguarding issues. The inspector also reviewed a number of policies and procedures. We e-mailed staff members for their views and feedback regarding working at the service.

### During the inspection
We reviewed a range of records. This included the resident's care records and a variety of records relating to the management of the service and a number of staff files. We spoke with two members of staff and one resident and observed interactions between staff and the residents living at the home. We spoke with the service manager during the inspection on the 27 October 2023. The manager was available when concluding the inspection on 2 November 2023.

### After the inspection
We e-mailed a number of staff members for their views and feedback, regarding working at the service; however, none responded. We contacted three family members of service user's for feedback. We also received further information from the manager to support the inspection process.

## 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.

**Assessing risk, safety monitoring and management**
The service has completed a number of safety checks throughout the building. These checks included an inspection of the fire safety systems, emergency lighting, electrical installations and portable appliance testing (PAT). Water safety checks were carried out for the detection of legionella bacteria.

An independent, qualified person had completed a fire risk assessment, which had identified one area of concern regarding regular inspections of the fire doors.

Staff had completed fire safety training and 'safer people handling'; however, refresher training had lapsed for a number of staff. We recommend that all staff complete their refresher training prior to it lapsing and the manager has a system in place to inform them when training is due to lapse.

Qualified engineers had completed the inspection and maintenance of the heating system in January 2023.

Each resident had a Personal Emergency Evacuation Plan (PEEP's) and a copy of his or her plan was stored in the 'Fire' file. The PEEP's had been reviewed every six months.

**Staffing and recruitment**
Recruitment files were not available for us to view. This meant we could not ascertain if the provider had recruited staff safely. The service manager informed us that managers had been notified of a new process for accessing recruitment information, held in a 'secure manager's folder'; however, this file could not be accessed at the time of the inspection and we were not assured that all staff had been recruited safely. This is an area for improvement carried from the previous inspection.

Evidence of Disclosure and Barring Service (DBS) checks for five staff determined they were out of date.

Staffing rotas appeared legible with some colour coding, the meaning of which was unclear. We recommend if colour is used as a reference, there is a key to explain the relevance. The staffing rotas identified the shift leader with a 'K' (key holder); however, not all staff taking responsibility for the shift, in the absence of the manager, had attained the Regulated Qualifications Framework (RQF) level three, or equivalent.

A number of staff told us that the home was often short-staffed and were unable to support the residents with all of the planned activities. On the day of the inspection, the service manager reported that five staff were unavailable for work due to contracting COVID. The service manager spent a considerable amount of time seeking staff to cover the late shift.

The home had completed an assessment of the resident's needs using a 'Skills, Needs and Risks Assessment', to determine the level of support for the people residing at the home.

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

**Preventing and controlling infection**
The provider had an infection, prevention control policy; however, the review date was 27 September 2020 and the policy was headed 'Department of Health and social Care'. This will be an area for improvement in the 'Well Led' domain.

The home was very clean and tidy throughout. A cleaning rota was in place, including for the carpets. Staff members had completed a mattress audit in October 2023. Cleaning tasks had been identified in the diary for the year ahead.

The inspector observed staff members using the appropriate Personal Protective Equipment (PPE) to the task they were performing.

Staff members had completed infection control training; however, for some staff, refresher training had lapsed. We recommend all staff complete refresher training prior to it lapsing. For one member of staff, their infection control training had lapsed by two years. This will be an area for improvement under the 'Effective' domain.

One staff member had not completed 'safer food' training. This will be an area for improvement under the 'Effective' domain.

The manager completed the infection, prevention, control self-audit and toolkit every six months; the last was completed on 5 May 2023.

The laundry room was clean and tidy. Cleaning products falling within the Control of Substances Hazardous to Health (COSHH) were stored in a cupboard in the laundry room. Safety information sheets were present for all cleaning products hazardous to health.

The home had recorded fridge temperatures on a daily basis.

**Learning lessons when things go wrong**
Staff recorded incidents, accidents and safeguarding concerns involving the residents on an internal system called 'Datix'. The Datix system automatically informed the manager, and their line manager, of the incident. The system also informed a data controller, via e-mail.

The manager reviewed all accidents, incident and safeguarding concerns, to ensure that processes, policies and procedures were followed, investigated and closed the incident, when necessary. The manager also made referrals to other services, when required.

The Manx Care Quality Services and the data controller also collated information regarding incidents, accidents and safeguarding concerns, to identify any trends and make recommendations to support the staff team and the service users.

The manager had not submitted notifications of all significant events to the Registration and Inspection team in line with regulatory requirements. This will be an area for improvement under the 'well led' domain.

The home had consulted with a number of health care professionals, when necessary, to maintain the health and wellbeing of the residents and had recently purchased a 'raiser chair' in response to one resident experiencing a fall.

## Action we require the provider to take

Key areas for improvement:

- Action is required to complete the recommendations from the fire risk assessment and provide the Registration and Inspection Team with an action plan, identifying a timeframe to complete the work.
  This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 – Fitness of Premises: Health and Safety.

- Action is needed by the provider to ensure the manager is able to access recruitment records to demonstrate safe recruitment practices have been followed prior to offering a person employment (carried from previous inspection).
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is required by the manager to ensure the Disclosure Barring Service (DBS) checks for all staff are current and up-to-date.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure all senior support care workers, deputising for the manager are qualified to a RQF level three in Health and Social Care.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

## Inspection Findings

## C2 Is the service effective?

**Our findings**
Effective – 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 effective in accordance with the inspection framework.

**Assessing people's needs and choices; delivering care in line with standards, guidance and the law**
The home had completed a 'Skills, Needs and Risks Assessment' for the residents, upon admission, to develop person-centred support plans and risk assessments for the residents.

The home had employed staff of either gender, to address the preferences of the residents. The Skills, Needs and Risks Assessment asked 'Is there any need for gender specific support'.

The home had conducted review meetings (Person-Centred Planning meetings) every six months; however, we noted that some review meetings were due a number of weeks prior to the inspection. We recommend the home conduct these as soon as possible. Family members had attended the review meetings. One family member told us, "Yes, I attend all of [name] PCP meetings, except the last one, but I was told what was discussed. I get to see [name] support plans, as well."

The home has a Statement of Purpose that acknowledges it is a five-bedded residential home and has five bedrooms that conform, in size, to current legislation. The statement of Purpose also informs that, presently, there are six residents at Cushag House.

One resident had moved into the home in September 2022 on a temporary basis; however, it had been determined in May 2022 that the room they had moved into was too small to conform to current regulations. The provider is required to ensure the resident is re-located to another room that conforms to current legislation, as soon as possible.

The home had consulted with other medical professionals, to support the health and wellbeing of the residents. Support plans included information in meeting the resident's individual needs, containing guidance for staff from other health and social care professionals, as necessary.

The manager had registered with the Alzheimer's Society and accessed their website for information, to address the individual needs of their residents, demonstrating how they kept themselves informed of evidence-based research. We recommend that the manager and staff also register to receive newsletters and information from organisations, such as the National Institute for Health and Care Excellence (NICE), or the Social Care Institute for Excellence (SCIE) and BILD.

**Staff support; induction, training, skills and experience**
An administrative officer generated training records centrally and updated them regularly; however, some staff had not attended mandatory training in a number of subjects. Other staff needed to undertake refresher training. We recommend that staff attend refresher training before it has lapsed.

Staff 1:1 supervisions were not up-to-date; however, staff were working towards completing an annual appraisal of their performance (Performance Development Review).

A number of staff had received a bespoke training session in dementia, to meet the individual needs of the service users; however, we were not assured that this training was accredited and had extended to all members of staff, including relief staff used to cover the home, at times. The manager reported that the provider no longer arranged for staff to receive accredited dementia training. Submitted training records for the home did not include information relating to dementia training.

The manager had conducted team meetings regularly. The minutes to the meetings identified the attendees and discussions regarding the residents and the running of the home.

All staff had their competency in administering medication assessed at least annually.

**Supporting people to eat and drink enough to maintain a balanced diet**
Residents' Skills, Needs and Risks Assessment included a section identifying their dietary requirements. Support plans provided guidance for staff to meet the individual needs of the residents.

The home had consulted with healthcare professionals, as necessary. Information relating to supporting residents with special dietary requirements was stored in their 'My Health Passport'.

We had an opportunity to observe lunch with the residents, which was relaxed and unrushed. Staff were attentive and supported the residents needs throughout. The residents had a choice of sitting at a large dining table or a number of smaller, satellite tables. They appeared to sit at their preferred places to eat. One staff member said, "Mealtimes can be unrushed as long as we have enough staff on, which isn't always the case."

The home did not have a weekly menu on display; however, staff told us that the home planned the menu around the residents' preferred choices and usually has the menu in the kitchen. We recommend that there is a menu available for the benefit of the staff and residents.

## Action we require the provider to take

Key areas for improvement:

- Action is required to ensure that each resident accommodated at the home has a bedroom of sufficient size to conform to the Regulation of Care Act 2013.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

- Action is necessary to ensure all staff have completed, and are up-to-date with, all mandatory training.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- Action is needed to ensure that staff receive a minimum of four supervisions per annum.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- Action is required by the provider to source suitable training to enable staff to support the individual needs of the residents, particularly in relation to dementia and communications.
  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 requires one improvement in this area.

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

**Ensuring people are well treated and supported; respecting equality and diversity**
Staff knew the residents and their individual needs well and appeared relaxed and communicated well with the residents, showing dignity and respect. Staff listened and responded with warm and friendly interactions throughout the inspection. Residents appeared relaxed and comfortable with the staff.

Staff showed a comprehensive understanding of the residents' communication needs and offered choices throughout. Staff had consulted with relevant professionals to support the residents with their communication needs, when necessary. Records showed that one resident used Makaton to communicate; however, staff had not received this training, to meet the individual needs of this resident. The manager informed us that one member of staff knew Makaton and had spent time teaching the rest of the staff team; however, this does not constitute learning from a qualified instructor. The manager reported that the provider no longer arranged for staff to receive this training. This will be an area for improvement under the 'Effective' domain.

One family member told us, "I think [name] is getting a great service. I'm really happy with the staff there and think they're doing a great job looking after [name]. I couldn't be happier."

Staff told us they could only spend some quality time with the residents if there were sufficient number of staff on shift. We were told that it was increasingly common for there to be only two staff on shift, especially during the late shift.

The residents' initial assessments had identified their individual needs and the manager and staff, together with the residents and their family, had developed appropriate care plans to support the planning of social events and activities, as necessary.

Family members felt that the staff supported the residents to maintain important relationships with them.

**Supporting people to express their views and be involved in making decisions about their care**
Residents had received reviews (person-centred planning meetings) of their care and support approximately every six months. Records showed that family members were involved with the reviews, where possible. Staff also kept in touch with the residents' family members on a regular basis.

Most of the residents had family members supporting them with making informed decisions about their on-going care. The manager assured us through the inspection process that staff worked closely with residents with no family members, supporting them in making informed decisions; however, there was no independent advocacy service available to support those

residents without capacity, or family members to support them with decisions about their on-going care.

We were informed that the home had 'informal' residents meetings, called 'house chats', to discuss meals, menus and activities. Staff supported the residents with attending activities and social events.

Staff had received training in communication awareness but have not received formal training in Makaton. Staff told us that all of the residents have the ability to communicate and they had sufficient time to get to know the residents and develop good relationships with them all.

## Action we require the provider to take

Key areas for improvement:

- The provider is required to support residents to access independent support and/or an advocacy service, where they lack the capacity to make informed decisions regarding their on-going care.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service.

## 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 requires one improvements in this area.

This service was found to be responsive in accordance with the inspection framework.

**Planning personalised care to ensure people have choice and control to meet their needs and preferences**
The residents received individualized support that met all of their needs. Person-centred plans identified their support needs, and provided guidance for staff on how to meet those needs. Support plans identified their family members and what support the residents required to maintain contact with their family.

The resident's Skills, Needs, and Risks Assessments and My Health Passport identified their physical, emotional communication and social needs, as well as their preferences in the foods they liked, their preferred daily routines, activities and pastimes. Support plans identified personal goals and objectives, designed to increase the resident's independence.

The home had followed best practice principles in relation to some capacity assessments, regarding COVID inoculations and Lateral Flow Testing (LFT's), the outside doors remaining locked and independent control of their heating, lighting and ventilation. Best interest decision making had also been in consultation with medical professionals; however, capacity assessments and best interest decision making did not extend to other areas of the resident's life, including their medication.

The home had introduced a Restrictive Practice Audit Tool, to support forming capacity assessments and best interests decisions; however, the forms were generic and included all residents, not individualised, and the resident or their representative had not signed the audits. Some areas identified as restrictive were not included with the audit tool. This is an area of improvement carried from the previous inspection.

**Improving care quality in response to complaints and concerns**
The provider (Manx Care) had a complaints policy, which was effective from October 2022. A copy of the complaints procedure, or an easy-read version was not on display, or available for the benefit of the residents. We recommend that both versions are available and on display for residents and visitors.

The home had an 'easy read' version of the resident's guide, which was on display in the foyer.

The provider had not received any complaints since the last inspection.

The home's statement of purpose contained information on how to make a complaint, ensuring people knew what to expect from the complaints process.

Family members told us they had not seen a copy of the complaints policy; however, they all said they would talk to the manager if they were not happy about something and wanted to make a complaint.

Reporting on complaints also formed part of the home's annual plan.

## Action we require the provider to take

Key areas for improvement:

- Action is needed to review any restrictive practices in place, which could deprive a person of their liberty. This review should be undertaken with full consideration of best practice guidance in the Isle of Man in relation to assessing mental capacity (carried from the previous inspection).
  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 requires improvements in this area.

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

**Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people**
The provider had a set of principles and values staff were expected to implement in their daily work. The manager shared these principles with the staff team during staff supervisions and this year's Performance Development Review (PDR).

All staff members were aware of the shared values. One staff member told us, "Care values are part of our supervisions and PDR's now [the manager] discusses with us during meetings".

The manager had 'office days' and worked alongside the staff team, on shift. This provided an opportunity to gather informal feedback from the staff members and family members of the residents.

The manager was qualified and attained the QCF level five diploma in leadership in health and social care. The manager informed us that they kept up-to-date with their skills and knowledge by attending mandatory training and attending managers meetings. We recommend that the manager be registered to receive newsletters and information from organisations, such as the National Institute for Health and Care Excellence (NICE), or the Social Care Institute for Excellence (SCIE) or the British Institute for Learning Disabilities (BILD).

The manager received regular supervision, had a job description and received an annual appraisal of their performance; however, the provider is required to update the manager's job description to include that they have to be registered under the Regulation of Care Act 2013, to manage the service.

All staff members have opportunities to attend team meetings and staff were offered the opportunity to cover vacant shifts.

The majority of staff who provided us with feedback felt that the manager was not supporting or listening to them. A dispute had arisen between the manager and the staff team; however, we were assured, through the inspection process that, with the service manager's support, issues had been addressed and resolved.

**How does the service continuously learn, improve, innovate and ensure sustainability**
Staff were not able to access some specific training to meet the individual needs of the service users. This is an area for improvement under the 'Effective' domain. Staff had received input from medical professionals to guide their practice, when necessary.

The manager had received training specific to providing staff with 1:1 supervisions.

The provider measured success in a number of ways. The manager completed a number of in-house audits to identify the incidents, accidents, safeguarding incidents, complaints and compliments for the service. Each audit developed an action plan, to identify the required improvements within that area.

The manager had produced an annual report and plan, identifying the successes of the home, including compliments and complaints. Information regarding the various in-house audits was also included in the Homes' annual report and plan. The service manager also completed bi-annual audits of the home, which produced a report and an action plan for improving the services provided by the home.

The provider had conducted an annual survey of their services and family members of the residents said they had received a questionnaire; however, the questions were directed at the residents and was not relevant to the family members. Staff reported they had not received any such questionnaire's asking them of their views of the service.

The provider had a number of policies and procedures that were out of date and still identified with the Department of Health and Social Care (DHSC). Manx Care moved away from the DHSC in April 2022. Policies and procedures must be up-to-date to inform staff of current guidance and best practice.

## Action we require the provider to take

Key areas for improvement:

- Action is needed by the provider to ensure the manager has an up-to-date job description identifying that they have to be registered under the Regulation of Care Act 2013 to manager the home.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- Action is necessary to ensure the provider establishes and maintains a system for consulting with service recipients, or their representatives, and a range of stakeholders, as part of the quality assurance audit.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – review of quality of care.

- Action is required by the provider to update all policies and procedures, as necessary.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service.

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.