Inspection Report 2023-2024

Southlands - Gansey

Adult Care Home

2 November 2023 &

3 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 2 November 2023 and 3 November 2023. The inspection was led by an inspector from the Registration and Inspection team.

Service and service type
Southlands – Gansey, known as 'Gansey', is an adult care home, operated by Manx Care and based in Port St. Mary, providing care and support to older people living with dementia. The home is registered to look after a maximum of twelve 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 nine 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 health and safety, staff training and annual appraisals, care planning and policies and procedures.

Systems were in place to protect people from abuse or harm. Staff received effective training in keeping people safe.

People had their assessed needs, preferences and choices met by staff with the right skills and experience. Staff worked together to ensure people received consistent, person-centred care and support.

People were treated with kindness and respect in their day-to-day care and support. Staff showed concern for people's wellbeing in a caring and meaningful way.

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

The manager understood their role and responsibilities to deliver what is required. Staff spoke positively about the manager and felt supported, respected and valued.

At this inspection, we found improvements had been made in response to the previous inspection.

SECTION B The Inspection

About the service
Gansey is part of a larger building, which also has two other separate residential homes and a day centre. Gansey is on the ground floor of the building. Each resident in the home had their own bedroom with an en-suite toilet, shared access to a lounge, dining room and shower rooms. There was a small, enclosed garden area accessible to the 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 inspection was part of our annual inspection programme, which took place between April 2023 and March 2024.

Inspection activity started on 1 November 2023. We visited the service on 2 November 2023 and 3 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 each member of staff asking for feedback. We received a number of responses prior to the inspection.

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 observed interactions between staff and the residents living at the home. We spoke with the manager throughout the inspection.

After the inspection
We contacted three family members of service user's for feedback. We also received further information 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 one improvement in this area.

This service was found to be 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.

Staff had completed fire safety training. All emergency fire exits were clear of obstructions.

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

All staff had received training in moving and handling people. The home had lifting equipment to support the mobility needs of the residents; however, this equipment was out of commission. At the time of the inspection, none of the residents needed the use of lifting equipment, but the home had access to a hoist from the adjoining residential homes, if required. We recommend the home's lifting equipment is replaced or repaired and fully functional before a resident requires its use.

Each resident had a Personal Emergency Evacuation Plan (PEEP's) in place.

Staffing and recruitment
Recruitment files were available for us to view with the use of 'Job Train', an agreed portal between the provider and their Human Resources Department. This meant we could ascertain that staff had been recruited safely.

Evidence of Disclosure and Barring Service (DBS) checks for all staff were available; however, the DBS checks had lapsed for one member of staff but application had been forward to the provider's Human Resources Department. We recommend that the manager have a system to inform when current DBS checks require renewing prior to the expiry date.

There were sufficient staff on duty to meet the needs of the residents. The home had access to bank staff to cover any shortfall in staffing.

The rotas were clear and legible; however, they did not identify bank staff with their full name. We recommend that all staff be identified on the rota with their full name, so identification is easier for future reference.

Senior Support Care Workers (SSCW) were identified on the rota and had attained a QCF/RQF level 3 in Health and Social Care.

The home had completed a comprehensive assessment of the resident's needs using a 'Dementia and Support Services Eligibility Assessment' tool, to determine the level of support for the people residing at the home.

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. Daily cleaning schedules identified the various cleaning tasks for the home, which the housekeeping staff maintained. There was evidence that the housekeeper had completed weekly and six-monthly cleaning tasks. The housekeeper had also deep cleaned rooms on a regular basis.

The inspector observed staff members using the appropriate Personal Protective Equipment (PPE) to the task they were performing. All staff members had completed infection control training; however, two staff had not completed 'safer food' training. This will be an area for improvement under the 'Effective' domain.

The manager undertook an annual infection, prevention, control self-audit and toolkit, last completed in June 2023. At the time of the inspection, two actions were outstanding; however, these actions were relying on the Isle of Man Government Estates Department to carry out the works and out of the provider's control. This will be an area for improvement until the provider has addressed the outstanding actions.

Cleaning products falling within the Control of Substances Hazardous to Health (COSHH) regulations were stored in a locked cupboard. Safety data information on the safe use of the hazardous products was available for staff.

The home had recorded fridge and freezer temperatures on a daily basis. Staff had appropriately labelled open food stored in the fridge.

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 and service manager reviewed all accidents, incident and safeguarding concerns, to ensure that processes, policies and procedures were followed, investigated and closed the incident, when necessary. During management meetings, the service manager introduces the top three themes with the managers, to identify trends and areas of learning.

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.

There was evidence within the resident's files, demonstrating when there had been learning from accidents and incidents. The home had made referrals and consulted with health care professionals and social workers, following concerns regarding the resident's health and wellbeing. The home had also made referrals to other placements when they could no longer meet the changing needs of their residents.

Action we require the provider to take

Key areas for improvement:

- Action is required to ensure that recommendations from the infection, prevention and control self-audit are completed.
  This improvement is required in line with Regulation 22 of the Care Services Regulations 2013 - Fitness of premises: Health and Safety

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 not to be 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 comprehensive 'Eligibility Assessment' tool with the residents, and their family if necessary, upon admission, to develop person-centred support plans and risk assessments. This assessment tool does not determine the service user's preference in gender-specific support with personal care. We recommend that the home obtain this information upon admission to the home. The home employs staff of either gender to address the preferences of the residents.

The home completed an 'eligibility review' four weeks after the resident had moved in, to determine if the placement is most appropriate and meeting the needs of the new resident.

The home had conducted a review of the eligibility assessment every four months to determine any changes to the health or wellbeing of the resident. There was evidence that family members had attended the admission of the resident and the four-monthly review meetings. Family members told us they had attended review meetings and had an opportunity to discuss the support plans with the resident and the staff team.

The home had consulted with 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 health and social care professionals, as necessary.

The manager kept himself or herself informed of the latest legislation, standards or evidence-based research by attending management meetings and completing mandatory training. 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) and/or the Alzheimer's Society.

Staff support; induction, training, skills and experience
Training records showed that 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.

Some staff had not received training in dementia. The manager reported that the provider no longer arranged for staff to receive accredited training in caring for people with dementia; however, the service manager provided staff with relevant training in dementia.

Staff one-to-one supervisions were up-to-date. The manager supervised the senior support care workers and the seniors supervised the other staff members. No staff members had received an annual appraisal of their performance. The manager assured us they had supported staff members to develop their career, as they have wish.

The manager had conducted team meetings on a monthly basis.

Staff tasked with administering medication to residents had been assessed by their line manager annually.

Supporting people to eat and drink enough to maintain a balanced diet
The Eligibility Assessment tool included a section identifying the resident's eating, drinking and dietary requirements. The resident's 'eating and drinking' 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 also included in their 'This is me' document, which had been completed by either the resident or their family/representative.

The residents were asked at the beginning of the week what they wanted for their weekly meals. Staff passed this information onto the main kitchen staff. The kitchen staff were aware of residents' allergies and dietary requirements.

We had an opportunity to observe lunch with the residents. Staff members supported the residents with preparing for lunch and supported with constant observations and prompts, where necessary. The mealtime was casual and conducive for the meal. The residents had previously made choices in what to eat; however, they were given opportunity to change their mind, if they wished. Staff also administered the lunchtime medication to the residents, as necessary.

All staff had received Malnutrition Universal Screening Tool (MUST) training.

Staff had kept records of the resident's food and fluid intake for the day. This information was stored on their electronic files.

Action we require the provider to take

Key areas for improvement:

- Action is necessary to ensure all staff have completed all mandatory training.
  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 in dementia to enable staff to support the individual needs of the residents.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- Action is needed by the manager to ensure that staff receive an annual appraisal of their performance.
  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 in accordance with the inspection framework.

Ensuring people are well treated and supported; respecting equality and diversity
Staff had a comprehensive understanding of the residents and their individual needs. Staff appeared relaxed and natural and communicated well with the residents, showing compassion and understanding. Staff listened and responded with warm, sociable interactions throughout the inspection.

Staff had attended communication awareness training and showed an awareness of the residents' communication needs, offering choices throughout. Staff had consulted with relevant professionals, such as the speech and language therapy service, to support the residents with their communication needs, when necessary.

One family member told us, "There is lots of care and respect from the staff, for both me and my [relative]. They show so much kindness and compassion. It's always difficult when I return back to the home with [name], but the staff know just what to do to make it easier."

Staff told us they could spend some quality time getting to know the residents well. One staff member said, "All staff have enough opportunities to spend time with the residents, at times, one-to-one support."

The residents' initial assessments had identified their individual needs and the home had collaboratively developed appropriate care plans to support the planning of social events and activities, as necessary.

Residents were encouraged to maintain meaningful relationships with members of their family and friends.

Supporting people to express their views and be involved in making decisions about their care
Residents had received a review of their care and support every four months, or sooner if their needs had changed. There was evidence that the residents and their family members were involved with the reviews, where possible, and the home had kept family members informed, if they had not attended the resident's review meeting. All of the residents had family members supporting them with making informed decisions about their on-going care.

Staff supported the residents with attending activities and social events, both within the home and in the community.

We were assured, through the inspection process, that all of the residents have the ability to communicate and staff had sufficient quality time to get to know the residents well, and develop good relationships with them all.

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 improvement 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; however, one resident was receiving their medication covertly. Their medication support plan did not inform staff as to how, or what, medication should be administered covertly. The manager reported that a separate plan was stored in the person's Medication Administration Record file. The person's doctor reviewed this plan annually.

The resident's Eligibility Assessments, their Eligibility Reviews and 'This is me' documents 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.

The home re-assessed the support offered to the residents at four-monthly review meetings, with their family, if possible. Support plans identified personal goals and objectives, designed to maintain the resident's independence.

Family members told us they had always been invited to review meetings, where they discussed the care and support the resident was receiving.

The home had followed best practice principles in relation to capacity assessments and best interest decision making, including areas involving restrictive practices. The home had included the resident, their family, where possible, and consulted with medical professionals, where necessary, in completing the best interests' decision meetings.

Improving care quality in response to complaints and concerns
The provider had a complaints policy, which was effective from October 2022. A copy of the complaints procedure was on a notice board immediately outside the home. The home did not have an 'easy read' version of the complaints procedure. We recommend the provider consider producing an easy-read version of the complaints procedure, for the benefit of the residents who can read.

Since the last inspection, the provider had received two complaints about the same problem. The complaint was resolved when the Isle of Man Government Estates department replaced a section of flooring.

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

A family member told us, "I know how to make a complaint, but I'm really happy with the way [my relative] is being looked after. I would speak with the manager if I wasn't happy." Another family member said, "I'm not sure how to make a complaint. I think I would speak to the manager."

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 necessary to ensure care plans fully inform staff of the correct procedures in addressing the individual needs of the residents.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service

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 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
Staff told us they were very happy working at Gansey. One member of staff said, "I really enjoy working at the Gansey Unit. I'm proud of my work and I think we deliver really good person-centred care, and we form great connections with our residents and family members too."

The provider had a set of principles and values for staff to implement in their daily work. Staff members told us that the values are discussed during one-to-one supervisions and staff meetings. Staff members also told us that the service manager had met with the team to include them in the development of the Home's values and principles. These had been included in a poster, put up in the home, and smaller copies placed in each of the resident's care plans.

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 registers to receive newsletters from organisations, such as the Social Care Institute for Excellence (SCIE), the Care Quality Commission (CQC), the National Institute for Health and Care Excellence and the Alzheimer's Society.

The manager had an up-to-date job description and received regular supervision; however, did not have an annual appraisal of their performance.

Team meetings occurred approximately once every two months. An agenda was available prior to the meeting, with a number of standing items. Staff also had an opportunity to include topics for discussion, including matters relating to the running of the home and the residents. Minutes were produced and available to all staff after the meeting.

How does the service continuously learn, improve, innovate and ensure sustainability
The manager had received training specific to providing staff with one-to-one supervisions.

The provider measured success in a number of ways. The manager completed a series of audits to identify the incidents, accidents, safeguarding incidents, complaints and compliments for the service. This information is included in the Homes' annual report. The service manager also arranged for bi-annual audits of the home to be carried out by an independent person, which produced a report and an action plan for improving the services provided by the home.

The provider also conducted an annual survey of their services. The service users and/or their families had each received a questionnaire, asking for their opinions and experiences of the services provided by the home. The manager worked regular 'office hours', which provided an opportunity to gather formal and informal feedback from the staff, residents and family members of the residents.

The manager had produced an annual report, identifying the successes of the home, compliments and complaints, outcomes from various audits and an action plan for improving the quality of services.

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.

Staff members told us that the manager was very approachable and had 'an open door policy'. One staff member said, "I feel supported by Gansey Unit and the manager."

One family member of a resident said, "The home seems to be well managed. I am very happy with the support [name] is getting. The home is always very clean and everything is well organised."

Action we require the provider to take

Key areas for improvement:

- Action is required by the provider to ensure the manager receives an annual appraisal of their performance.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing

- 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.