# Inspection Report 2023-2024

# Viva Heights

Adult Care Home

7, 8 and 16 February 2024

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 the 7, 8 and 16 February 2024. The inspection was led by an inspector from the Registration and Inspection team who was supported by a colleague.

**Service and service type**
Viva Heights is a residential care home. People in care homes receive support and accommodation as a single package under a contractual agreement. At the time of the inspection there were ten people using the service. The service provides support and assistance to people who require support with their mental health.

Viva Heights is located in Douglas and is registered to accommodate up to thirty-one people over four separate floors.

**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 of improvement were made in relation to the environment, medication administration, care records, training and management supervision and appraisals.

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. New staff completed a structured induction programme.

The home worked closely with a range of health professionals. People were being supported to take part in social activities both in the home and in the community.

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. The management team regularly observed staff practice by working alongside colleagues.

At this inspection, we found some improvements had been made in response to the previous inspection. Any outstanding areas for improvement have been addressed in this report.

## SECTION B The Inspection

### About the service
Viva Heights is registered as an adult care 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 2 February 2024. We visited the service on 7, 8 and 16 February 2024.

### 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 three people who lived in the home and observed staff support being provided.

We spoke with six members of staff, the registered manager and deputy 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.

## 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 not always 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 been serviced, as well as the nurse call system. Equipment was being serviced at the required frequency.

Each resident had a Personal Emergency Evacuation Procedure (PEEP) written and stored on file. Some had gone past the date of review but all had been reviewed on the second day of the inspection. An easy reference guide relating to individual PEEP's was readily available for staff to refer to in an emergency. Staff had received training on fire safety.

A fire risk consultant had completed a risk assessment on the home and two areas required action being taken. These had been completed.

A Legionella risk assessment had been reviewed in March 2023. An external agency had tested the water for the presence of Legionella bacteria in the water system and no bacteria was present. Staff were checking water temperatures and thermostatic mixer valves were being serviced. Showerheads were cleaned and disinfected every three months and water was run in empty rooms weekly.

A tour of the home was carried out. Generally the home was in good condition and attractively decorated. There was damage to a wall in a communal hallway and some damage to the ceiling in the home's quiet room.

The provider had a continuity and resilience plan to address any potential disruptions.

**Staffing and recruitment**
The provider had recruited safely. The files of three 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 six monthly or when required.

There was a mixed response from staff when asked if there was enough staff on duty to support the needs of the people living in the home.

**Safe use of medicines**
An inspection of the home's medication systems was undertaken due to ongoing medication errors that were taking place. A discussion was had with management as to the current issues and possible reasons why these errors were taking place.

A routine medication round was monitored with two members of staff, to establish and identify the key areas during administering medication that had been highlighted. Competencies and practice were identified as significant areas of error, and following discussion with the management an action plan was devised moving forward. Establishing and maintaining these areas of good practice were to be discussed in staff meetings, handovers and supervisions, ensuring that identified areas could be improved with a plan in place. Staff were encouraged to take ownership of their practice and to identify their own learning needs where necessary and to record and communicate any areas of concern.

**Preventing and controlling infection**
The home was clean throughout on inspection. A housekeeper was observed carrying out cleaning tasks and cleaning schedules were being completed. Personal Protective Equipment (PPE) was available for staff use and staff had received training on infection control. Monthly infection control audits were taking place.

An infection control policy had been reviewed in November 2023.

COSHH products were kept in a lockable cupboard and safety data sheets on these products were kept.

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

**Learning lessons when things go wrong**
Staff feedback confirmed that they knew their responsibilities in reporting concerns and responding to incidents. Systems were in place to record any accidents, incidents and safeguarding concerns.

There was evidence that the manager had reviewed and responded to incidents and safeguarding concerns and changed practice accordingly.

## Action we require the provider to take

Key areas for improvement:

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

- Medication must be administered safely.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of care services.

## 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. This document led to the development of care plans and risk assessments. Gender preferences for personal care were identified.

From the care records examined it was not always clear that a reassessment of needs had taken place. Some care plans and risk assessments had not been reviewed six monthly or sooner. There was not always evidence of involvement of the resident / representative in the review process. Care plans and risk assessments were not always written on individual's identified needs. Greater detail was required in some care records to further inform and guide the reader. Information on a person was spread throughout several documents and it is recommended that information is included in fewer documents.

We were informed that the home was following Social Care Institute for Excellence (SCIE) guidelines for person-centred care and the promotion of peoples' choices and preferences in their daily lives. The manager was also informed of the latest legislation, standards and research by SCIE.

People had their ability to self-medicate assessed.

**Staff support; induction, training, skills and experience**
Generally staff received training to meet the needs of the people living in the home, but moving and handling training was no longer a mandatory course for staff to complete. Some staff had received this training but not all. This must be completed for all staff. Staff confirmed that they believed the training they received enabled them to provide excellent care. One staff member commented, 'specific training is asked for and actioned'.

New staff completed a structured induction programme into the home. We were informed that all new staff were enrolled onto the RQF level 3 within two years of service.

Care staff were having regular supervisions and an annual appraisal, but the manager and deputy manager were not.

Regular staff meetings were taking place. Generally, staff felt supported and listened to by the management team.

Staff responsible for medication were having their competency to administer medication assessed annually. Competency was being reassessed following any medication error.

**Supporting people to eat and drink enough to maintain a balanced diet**
Peoples' dietary / nutritional needs were being assessed on admission, but important information was not always carried through into care plans and risk assessments with any detail, including the monitoring of weight and food and fluid recording. Creative ways had been introduced to encourage food to be attractive as possible, themed nights were also introduced. The service had identified the eating and drinking risks for those with complex needs and had adapted the menus accordingly. People are fully involved and helped to plan their meals with staff. 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 community dietician.

A menu was displayed in the dining area. People confirmed that choices were available. Meals and menus were discussed in resident meetings with the chef present. A mealtime was observed on the inspection. The dining experience was relaxed. Staff confirmed that they could assist people at mealtimes in an unrushed, caring manner.

## Action we require the provider to take

Key areas for improvement:

- Action is needed to:
  - Review support plans and risk assessments every six months or sooner.
  - Complete a reassessment of needs as part of the review process.
  - Evidence the involvement of the resident and / or representative in the review process.
  - Ensure that any dietary / nutritional need is detailed in care plans and risk assessments.

  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 in moving and handling.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure that the manager and deputy manager receive regular supervisions and an annual appraisal.
  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**
Generally staff interactions with residents were observed to be very warm and friendly. We did observe one staff interaction with a resident which did raise some concerns and this was discussed with the manager on inspection.

The home worked closely with a range of health professionals, including the Community Mental Health Team.

Staff got to know peoples' needs and preferences by spending time with them and being knowledgeable about a person through reading of assessments, care plans and risk assessments.

Religious and cultural needs were identified on admission and care plans developed where required. People were supported to be involved in social activities both in the home and out in the community. 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**
Resident / representative involvement in the reviewing of care plans and risk assessments was not always evidenced.

Minutes were seen of resident meetings that had taken place in 2023. Meals, menus and activities discussion formed part of these meetings. Keyworkers gave regular one to one support to people.

Staff and residents were asked to complete an annual questionnaire as part of the home's quality assurance process.

Generally staff believed they had opportunities to spend quality time with people. Several staff mentioned that this was dependent on staffing levels.

## 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 not require any improvements 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. Care records did not always evidence involvement of the person themselves in the review process.

Where required, adaptations to aid independence were provided in the home.

Staff were familiar and knowledgeable about peoples' needs and preferences.

People were supported to develop and maintain relationships that were important to them.

People who struggled to understand written format had pictorial cards to assist them with understanding, as well as easy read version of documents.

Residents each had an activity planner that detailed their plans for the week ahead.

People had access to a resident handbook and the statement of purpose was also available.

Any capacity assessment and best interest decision making was done in conjunction with statutory professionals.

**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 and people moving in to the home were given information on the complaints process.

Two complaints had been made and these had been recorded in detail. There was evidence that there were elements of learning following these complaints.

Feedback from residents confirmed that they believed that any complaint they may make would be taken seriously. One person commented, 'when I have been annoyed staff have helped me'.

## 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 not always be well-led.

**Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people**
Staff feedback confirmed that the home had a clear set of values which were discussed and put into practice. Comments included, 'there is an open door policy', 'residents come first', and 'the values are person led and person centred'. The manager spoke about the importance of communicating the right kind of values in the recruitment process - on job interview and on induction. The manager also spoke about having a no blame culture.

The manager and deputy manager were present, visible and accessible to the staff team and staff felt supported by management.

Regular staff meetings were taking place.

The manager had a current up to date job description.

Residents and staff were given questionnaires to complete as part of the home's quality assurance exercise.

The manager had attained a Level 5 Diploma in Leadership for Health and Social Care Services. The manager received and updated their mandatory training, as well as completing extra training to increase their knowledge and experience. The manager said that they had regular contact with the responsible person.

Examples were seen of how equality and inclusion was promoted in the staff team.

**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. Following any medication error, the responsible staff member would then have their competency reassessed. The management team had worked hard in seeking to eliminate medication errors that were taking place.

The manager and deputy manager regularly observed staff practice by working alongside colleagues.

The home had formal systems for seeking feedback from residents and staff.

Auditing throughout the home was taking place, with different areas being audited on a weekly, monthly, three monthly, six monthly and annual basis. Staff members were given

areas of responsibility. Management must have greater oversight of resident care records as there were deficiencies, such as the reviewing and level of detail recorded.

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. These had been completed in June and October 2023. These reports were brief and it is recommended that greater detail is included.

## Action we require the provider to take

Key areas for improvement:

- Action is needed to ensure that management have greater oversight of the auditing of care records
  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.