Inspection Report

2023-2024

Reayrt ny Baie

Adult Care Home

12 March 2024

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 12 March 2024. The inspection was led by an inspector from the Registration and Inspection team who was supported by another inspector.

Service and service type
Reayrt ny Baie is a residential 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.

Reayrt ny Baie can accommodate up to forty-five people over three floors. Forty-one people were living at the home on the day of the 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 have been made in relation to health and safety, staff recruitment, notifications, medication errors, care records, training, supervision and appraisals, capacity recording, the annual report, policies and procedures and management oversight.

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

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

People received individualised care and support to meet their needs.

Staff believed that the home had a clear set of values which were discussed and put into practice.

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
Reayrt ny Baie is registered as an adult care home.

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. The acting manager had been at the home for approximately six weeks at the time of the inspection.

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 8 March 2024. We visited the service on 12 March 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 eight people who lived in the home and observed staff support being provided. One visiting family member was spoken to.

We spoke with three members of staff, three housekeepers, 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
Seven family members provided feedback 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 not be safe.

Assessing risk, safety monitoring and management
The front and back doors of Reayrt ny Baie were unlocked during the day. This meant people could enter the building without staff being aware. The security procedures for the building had been reviewed by the provider. We were informed that any resident at risk of wandering would have a robust risk assessment in place.

A range of safety checks were being completed throughout the building, including electrical, fire and gas safety. There were gaps in the recording of fire drills from October 2021 to October 2023. The last emergency lighting annual test was June 2022. Actions had been identified but there was no evidence of completion. A fire detection and alarm system inspection in December 2023 had actions identified but again, no evidence of completion. Weekly alarm testing was being carried out. There had been issues with door closures with no evidence that this had been fixed.

A fire risk consultant had completed a risk assessment on the home in March 2023 and five areas required action being taken. There was no evidence of completion. Following an incident in the home in February 2024 when the Fire Brigade attended, several issues had been raised. There was no evidence that these had been addressed.

Each resident had a Personal Emergency Evacuation Procedure (PEEP) written and stored on file. Some had gone past the date of review. Staff had received training on fire safety.

An electrical installation condition report, completed in December 2019, had been identified as suitable for continued use, but the overall assessment was deemed unsatisfactory. PAT testing was last carried out in December 2022.

A risk assessment for Legionella disease had been written. An external agency had tested the water for the presence of Legionella bacteria in the water system and no bacteria was present. Thermostatic mixer valves were being serviced but when there were fails there was no evidence that the fails had been rectified. Water was being run in vacant rooms and staff were testing the temperature of the water prior to assisting people with a bath / shower.

The boiler had been serviced in January 2024. Issues had been raised with leaking but no evidence of this being fixed was provided.

The lift had been serviced in December 2023.

Staffing and recruitment
The provider could not evidence that staff had been recruited safely. The manager had limited access to staff pre-employment records, so full recruitment files were not available to view on inspection.

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 being assessed monthly, which was used to calculate the amount of staff required.

There was a mixed response from staff and family members when asked if there was enough staff on duty to support the needs of the people living in the home. On the day of the inspection there were no staff vacancies. We were informed that extra senior staff had been recruited in 2023, as well as laundry staff. Activities were being provided by members of staff.

Preventing and controlling infection
The home was clean throughout on the day of inspection. Housekeepers were 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. Infection control audits were taking place.

An infection control policy had gone past its review date of September 2020.

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

Not all staff had received training on food hygiene. 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. Food on each floor was being probed after it arrived from the main kitchen.

Learning lessons when things go wrong
Staff recorded incidents, accidents and safeguarding concerns involving the people living in the home 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, along with their line manager, reviewed all accidents, incident and safeguarding concerns, to ensure that processes, policies and procedures were followed, investigated and closed the incident, when necessary. Evidence was provided of specific learning following an incident / accident.

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 generally had submitted notifications of all significant events to the Registration and Inspection team in line with regulatory requirements, but following two recent medication errors, notifications had not been completed and submitted. Following a medication error, as per Manx Care medication policy, the staff member responsible must complete a reflective account of the incident, identifying a change to practice, as well as having their competency to administer medication assessed. This had not taken place after every medication error.

External safety alerts were shared with the team.

Action we require the provider to take

Key areas for improvement:

- Action must be taken to carry out fire drills at least twice per year.
  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 have an annual check / test of the emergency lighting.
  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 review resident PEEP's every six months.
  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 evidence completion when areas of action have been identified. Areas for action / completion which had been identified:
  - Emergency lighting
  - Fire detection and alarm system
  - Fire risk assessment
  - Fire incident report
  - Thermostatic mixer valves
  - Boiler maintenance

  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 carry out PAT testing annually.
  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 evidence that staff have been recruited safely.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action must be taken to submit a notification following a medication error.
  This improvement is required in line with Regulation 10 of the Care Services Regulations 2013 – Notifications.

- Following a medication error, action must be taken to ensure the staff member completes a reflective account of the incident and has their competency to administer medication assessed.
  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'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. One person did not have a care plan and risk assessment in place in relation to a specific health concern and an aspect of challenging behaviour.

Care records were regularly reviewed and a new assessment of needs formed part of the process. Residents and family members confirmed that they were involved in the assessments and regular reviews.

Staff support; induction, training, skills and experience
New staff received a structured induction into the home over a period of three months, including the completion of the care certificate. New staff shadowed experienced colleagues for a four week period before being included in the staffing numbers. Staff were being supported to attain a recognized qualification in health and social care.

Generally staff received training to meet the needs of the people living in the home, but not all staff had received training on food hygiene. There was no specific training on dementia and several staff were out of date with basic life support training.

Staff confirmed that they believed the training they received enabled them to provide excellent care.

Care staff were having regular supervisions and an annual appraisal, but the manager was not receiving these. One staff member had last received an annual appraisal in 2022.

Regular staff meetings were taking place on each floor, as well as care review meetings where residents were discussed. 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 not always being reassessed following a medication error.

Supporting people to eat and drink enough to maintain a balanced diet
Peoples' dietary / nutritional needs were being assessed on admission. There was evidence of seeking input from relevant professionals, such as speech and language and the dietician. Where required, eating and drinking care plans were in place and nutritional intake recorded. People at risk of weight loss were being regularly weighed.

The chef spoke about completing an eating and drinking assessment on any new resident. Allergen cards were in place and likes and dislikes recorded.

Menus were displayed and choices of meals were available. The chef actively sought feedback from people on the quality of the food served. A mealtime was observed on the inspection. The dining experience was relaxed. The feedback from residents on the quality of the food served was very positive. One person commented, 'the food was lovely and plentiful'.

Action we require the provider to take

Key areas for improvement:

- Action is needed to ensure detailed care plans and risk assessments are written on any specific need:
  This improvement is required in line with Regulation 13 of the Care Services Regulations 2013 – Service recipient's plan.

- Action is needed to ensure that all staff receive mandatory training, refresher training and specific training to meet the needs of the people in the home.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure that the manager receives regular supervisions and an annual appraisal. All staff to receive 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
Staff knew people and their individual needs. Positive interactions between people and staff were witnessed throughout the inspection. People informed us that staff were kind. Family members also confirmed this. Comments included, 'staff are nice and patient', and 'I have seen nothing but kindness, care and understanding'.

Where required, input was sought from external agencies.

Social 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
People and their relatives were involved in the discussing and reviewing of their care needs.

Minutes were seen of resident meetings that had taken place. Meals, menus and activity discussion formed part of these meetings.

People were asked to complete an annual survey, with the results published in the home's annual report and plan.

There was a mixed response from staff when asked if they had opportunities to spend quality time with people.

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 and 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.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) information on individuals was in place.

Where required, detailed best interest decision recording was in place, but not a decision specific capacity assessment.

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

Activity planners displayed what activities were on offer for the month. Generally there were activities on offer every day of the week.

The home's service user's handbook / statement of purpose was available in large print on request.

Improving care quality in response to complaints and concerns
A DHSC complaints policy and guidance should have been reviewed in November 2021. A complaint had been made in November 2023. This complaint was ongoing and had been passed onto the Care, Safety and Quality team.

The complaints policy was displayed throughout the home and information on complaints formed part of the service user's handbook / statement of purpose.

Feedback from people living in the home and family members confirmed that they would feel comfortable in making a complaint.

Action we require the provider to take

Key areas for improvement:

- Action is needed to ensure decision specific capacity assessments are carried out and recorded.
  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 does require improvements 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 believed that the home had a clear set of values which were discussed and put into practice. The manager said that values were embedded in job descriptions, the statement of purpose, inductions, training and the care certificate. Manx Care had a set of published values.

People said that they liked living at Reayrt ny Baie.

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.

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
Systems were in place to monitor and review the quality of care and experience of living at Reayrt ny Baie. Regular checks and audits were taking place throughout the home, including infection control, fire and health and safety.

Regular staff supervisions and appraisals for taking place for care staff.

Formal systems were in place for seeking feedback from residents and staff.

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 taken place and detailed reports written.

Management must have greater oversight of health and safety issues in the home, due to the numerous issues detailed in the safe section of this report.

An annual report and plan 2023 had been written. This report did not contain an improvement plan based on the feedback from residents and staff.

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 to ensure that management have greater oversight of the health and safety in the home.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

- Action is needed to ensure that the annual report and plan includes an improvement plan based on staff and resident feedback.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

- Action is needed by the provider to update all policies and procedures, as necessary.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records.

If areas of improvement have been identified the provider will be required to produce an action plan detailing how the areas of improvement will be rectified within the timescales identified. The R&I team will follow up and monitor any actions undertaken.