Inspection Report 2023-2024

Sweetbriar

Adult Care Home

21 March 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.

Service and service type
Sweetbriar 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.

Sweetbriar can provide care for up to sixteen people. The home consists of fifteen bedrooms for permanent residents who live with dementia and one bedroom reserved for people to stay on a respite basis. On the day of the inspection fifteen people were using the service.

Sweetbriar is situated on the top floor of a two-storey building. Bedrooms have an en-suite sink and toilet. Bathing facilities were shared across adapted bathroom and shower rooms.

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 fire, electrical safety, care records, water safety, the environment, staff, allergies, advocacy, manager oversight, the annual report and policies and procedures.

The provider evidenced that they had recruited safely. The home was clean throughout on the day of inspection.

Detailed admission assessments had been completed on people prior to their move into the home. Regular staff meetings were taking place.

Staff were observed being attentive to peoples' needs and treating them with kindness and respect.

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

Staff believed that the home had a clear set of values which were discussed and put into practice. Staff felt supported and listened to by the management team.

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

SECTION B The Inspection

About the service
Sweetbriar 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 worked at the home for several years as a senior support worker.

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 18 March 2024. We visited the service on 21 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 three people who lived in the home and observed staff support being provided.

Six members of staff completed a feedback questionnaire on inspection. We spoke with the acting manager.

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
Four family members were telephoned for feedback.

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 health and safety checks were being completed throughout the building, including electrical, fire and gas safety. The last recorded fire drill was in February 2022. Fire drills must be carried out at least twice per year. Portable Appliance Testing (PAT) was last completed in 2022.

Each resident had a Personal Emergency Evacuation Procedure (PEEP) written and stored on file, but several needed reviewing due to other residents names recorded on the document. Staff had received training on fire safety.

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 not being regularly serviced.

Equipment servicing was being completed and certificates were in place to demonstrate this.

A tour of the home was carried out. Generally the home was in good condition, but the flooring in the dining area was in need of repair.

A critical incident plan was in place to address any potential disruptions.

Staffing and recruitment
The provider evidenced that they had recruited safely. The file of one staff member who had started at the home was scrutinized. All required pre-employment checks were in place.

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

Staff rotas evidenced that shift leaders were clearly identified. On the day of the inspection the rota did not accurately reflect the actual staff on duty. A key must be added to the rota to evidence the actual hours worked by staff. Correction fluid must not be used on the rota.

Staffing levels and staff deployment must be determined following a written dependency assessment of peoples' needs. This was not taking place. There was a mixed response from both staff and family members when asked if there was enough staff on duty to support the needs of the people living in the home. We were informed that there were bank staff available to cover sickness absence.

We observed staff interactions and there appeared to be enough staff on duty to meet people's needs. There was one vacancy for a senior staff member.

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 as well as housekeeping audits. The provider's infection control policy was in need of review.

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

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. The temperature of food was being probed when 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, incidents 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 had submitted notifications of all significant events to the Registration and Inspection team in line with regulatory requirements.

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. A reflective account 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 carry out regular PAT testing.
  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 to ensure they contain accurate information.
  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 regularly service the thermostatic mixer valves.
  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 repair / replace the dining room flooring.
  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 ensure the staff rotas: reflect the actual person's working / hours of work per shift are shown / no correction fluid is used.
  This improvement is required in line with Regulation 14 of the Care Services Regulations 2013 – Records.

- Action must be taken to ensure staffing levels and staff deployment are determined following a written dependency assessment of peoples' needs.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Following a medication error, action must be taken to ensure the staff member completes a reflective account of the incident. 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 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 detailed care plan in place in relation to an aspect of challenging behaviour.

There was evidence of care packages incorporating advice and guidance from other health and social care professionals.

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

The manager said that monthly managers' meetings gave the opportunity for the sharing of information and evidence based research.

Staff support; induction, training, skills and experience
New staff received a structured induction into the home. Staff were being supported to attain a recognized qualification in health and social care.

Staff had completed mandatory and additional training, but some staff had not completed refresher training at the frequency set by the provider. Staff members believed that they had received the training and support to provide excellent care to the people in the home.

Generally, staff were receiving regular supervision, but no annual appraisals / performance reviews had taken place.

Regular staff meetings were occurring.

Staff responsible for medication were having their competency to administer medication assessed annually, but one staff member had not been assessed since 2022.

Supporting people to eat and drink enough to maintain a balanced diet
Peoples' dietary / nutritional requirements were assessed on admission. Eating and drinking assessments were completed and care plans developed. There was evidence of involvement of other health professionals such as speech and language and dietician. Allergies were recorded. One person's specific allergy had not been communicated to the main kitchen. The kitchen was aware of peoples' likes and dislikes.

Peoples' food and fluid intake was being recorded. Pictorial menus were displayed on a board in the dining area. Choices of meals were available but people had to make menu choices a

week in advance. The people spoken to on inspection were complimentary about the food being served.

A mealtime was observed on the inspection. The dining experience was relaxed. Staff were seen assisting people where required and 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 required to ensure care / support plans are written on any behaviours that challenge.
  This improvement is required in line with Regulation 13 of the Care Services Regulations 2013 – Service recipients plan.

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

- Action is needed to ensure that staff receive an annual appraisal / performance review.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure staff have their competency to administer medication assessed annually.
  This improvement is required in line with Regulation 16 of the Care Services Regulations 2013 – Staffing.

- Action is needed to ensure that the main kitchen are made aware of any allergies that people may have.
  This improvement is required in line with Regulation 15 of the Care Services Regulations 2013 – Conduct of Care Service.

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 were observed being attentive to peoples' needs and treating them with kindness and respect. Staff knew people and their individual needs and preferences.

People spoke positively about the staff. Family members also confirmed that their relation was treated respectfully.

Social and cultural needs were identified when developing care plans and planning social events and activities. On the day of inspection a person's birthday was being celebrated.

Where required, input was sought from external agencies, such as speech and language.

Supporting people to express their views and be involved in making decisions about their care
People were involved in decisions about their care when they were able to do so. Family members confirmed that they had been involved in the reviewing of care records.

People were given support to express their views as demonstrated in care records and observations.

People's rooms were personalised.

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.

Staff received training in dementia capable care and care plans were created using a person-centred approach. Generally care plans identified people's needs and provided guidance for staff on how to meet those needs.

Information individuals could not easily share themselves was recorded in "This is Me" documents by people who knew them best.

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

A person's capacity was assessed upon admission and best interest decision making in place for care and accommodation.

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

Staff were responsible for organising and facilitating activities. A large board in the hallway showed pictures of the activities on offer for the month. Staff were observed engaging in activities with people and respectfully encouraging participation.

The home's statement of purpose was given to people on admission into the home and was available in large print on request.

It is recommended that dementia clocks – which display the time as well as additional information, including the day and date – are provided in the home.

Improving care quality in response to complaints and concerns
A DHSC complaints policy and guidance should have been reviewed in November 2021.

The complaints policy was displayed in the home and information on complaints formed part of the statement of purpose.

No formal complaints had been received during this inspection year.

Feedback from family members confirmed that they would feel comfortable in making a complaint.

There is a lack of independent advocacy on the island for people with specific needs. This is of particular concern for people who have difficulty speaking for themselves and do not have

appropriate representation from family or significant others. The provider is required to support people to access independent support and / or advocacy service.

Action we require the provider to take

Key areas for improvement:

- Action is required to support people 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

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 and shared in staff meetings and one to one supervisions and training. The home's values were displayed on a board for all to read and Manx Care had a set of published values.

Staff felt supported and listened to by the management team. One staff member commented, 'our management team is very supportive in all aspects and take immediate action if there is any concern from the staff'.

The manager was present, visible and accessible to the staff team. The manager felt supported, received regular supervision and attended meetings with managers in other parts of the service.

The manager was in the process of obtaining an RQF Level 5 award.

Areas of improvement from the last inspection had been achieved.

How does the service continuously learn, improve, innovate and ensure sustainability
There were quality assurance and governance arrangements in place to monitor the quality of the service and identify risks. The home completed audits in a range of areas in relation to care, safety and quality.

The management should strengthen local quality assurance systems to capture the gaps we have highlighted in this report.

Regular staff supervisions were taking place for the staff and manager.

Formal systems were in place for seeking feedback from staff. We were informed that families and carers were asked to complete a survey as part of the home's quality assurance process, but this information did not form part of the home's annual quality report 2023. We also recommend seeking feedback to health and care professionals who engage with the home.

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.

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 for the manager to take action to ensure quality assurance monitoring is adequately identifying gaps in systems and processes.
  This improvement is required in line with Regulation 23 of the Care Services Regulations 2013 – Review of quality of care.

- Action is needed to reflect responses from families and carers in the home's annual quality report.
  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.